

# INFORMATION FORM FOR DISABLED SWIMMERS

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

AGE AND BIRTHDATE: (\_\_) \_\_/\_\_/\_\_ PHONE (\_\_\_\_) \_\_\_\_\_

EVENTS TO BE SWUM \_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_/\_\_\_\_

TYPES OF DISABILITY:

Blind \_\_\_\_ Mentally Retarded \_\_\_\_ Deaf \_\_\_\_ Physical \_\_\_\_

Other \_\_\_\_\_

EXTENT OF DISABILITY: Be specific e.g. totally or partially blind, totally or partially deaf, loss of one of more limbs, multiple disabilities, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The following person(s) will accompany the swimmer for any needed assistance:

\_\_\_\_\_

Seizures? Yes \_\_\_ No \_\_\_ Are you on medication? Yes \_\_\_ No \_\_\_

Name of Medication and amount \_\_\_\_\_

PARENT'S OR GUARDIAN'S NAME \_\_\_\_\_

PARENT'S OR GUARDIAN'S SIGNATURE \_\_\_\_\_

ATHLETE'S SIGNATURE \_\_\_\_\_

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PHYSICIAN'S NAME (Please Print) \_\_\_\_\_

PHYSICIAN'S ADDRESS \_\_\_\_\_

PHYSICIAN'S PHONE NUMBER (\_\_\_\_) \_\_\_\_\_

I have examined the above Entrant and, in my opinion, there is no mental or physical reason why he or she should not participate in United States Swimming competitions.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date