

INFORMATION FORM FOR ADAPTED
COMPETITIVE SWIMMERS

NAME: _____

ADDRESS: _____

AGE: ____ BIRTH DATE: ____/____/____ PHONE: (____) ____ - ____

EVENTS TO BE SWUM: ____ / ____ / ____ / ____ / ____ / ____ / ____

TYPE OF DISABILITY: Blind ____ Mentally Challenged ____ Deaf ____ Physical ____
Other _____

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

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

Seizures? Yes ____ No ____ Are you on medications? Yes ____ No ____

NAME OF MEDICATION & AMOUNT: _____

PARENTS OR GUARDIAN'S NAME: _____

PHONE: (____) ____ - _____

PARENT'S OR GUARDIAN'S SIGNATURE: _____

ATHLETE'S SIGNATURE: _____



PHYSICIAN'S NAME (Please print) _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE #: (____) ____ - _____

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 USA Swimming competition.

Physician's Signature

Date