

# 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