SAN DIEGO UNIFIED SCHOOL DISTRICT

Swimming Program: Medical History Form

Form to be completed by parent or guardian. Please print.

Note: Swimming programs involve certain inherent risks to all children (e.g., drowning, injury, infection). Students with special health, developmental or behavioral needs have magnified risks. A school-based swimming program may not be appropriate for these students. (This form needs to be updated annually, or more frequently if indicated.)

Student's Name ______________________ Parent's Name ______________________

Student's Address ______________________

Telephone: Home ______________ Work ______________ Emergency ______________

Student's Physician ______________________ Phone ______________________

Medical Insurance Carrier (if known) ______________________

Social Security number of insurance policy holder (or insurance policy no.) ______________________

List **all** medications taken (at home and at school) ______________________

List **all** allergies student has ______________________

General Questions

Has or does this student currently have the following:

YES	NO		
☐	☐	1. Any recent injury, illness or infectious disease?	
☐	☐	2. A chronic or recurrent illness/condition?	
☐	☐	3. Wear glasses, contacts, protective eyewear?	
☐	☐	4. Frequent ear infections?	
☐	☐	5. Tubes in ear?	
☐	☐	6. Ever passed out during or after exercise?	Date last occurred ________
☐	☐	7. Ever had a seizure?	Date last occurred ________
☐	☐	8. Ever had chest pain during or after exercise?	Date last occurred ________
☐	☐	9. Ever had high blood pressure?	Date last occurred ________
☐	☐	10. Ever been diagnosed with a heart murmur?	Date last occurred ________
☐	☐	11. Ever been dizzy during or after exercise?	
☐	☐	12. Ever had problems with joints (e.g., knees, ankles)?	
☐	☐	13. Have any skin problems (e.g., itching, rash)?	
☐	☐	14. Have diabetes?	
☐	☐	15. Have asthma?	
☐	☐	16. Have problems with diarrhea, constipation, or bowel or bladder control?	
☐	☐	17. **For girls:** Does your child menstruate (have periods)?	

18. List any other restrictions or health issues that may affect your child while in the water.
____
19. Please list and explain any other additional restrictions, not included above:
____

Please explain any "YES" responses here, noting the number of the question(s):
____
____

Parent/Guardian Authorization

This health history is correct and complete to the best of my knowledge. I agree to allow the school to contact my child's physician and to access the medical information from the physician, if it is needed (see the reverse side of this page).

Printed Name ______________ Signature ______________ Date ______________

Please return form to your child's ______________ teacher or to the school nurse ______________

School ______________________ Address ______________________

____

Note: The reverse side of this form must be completed **only** if the school nurse indicates that it is required.

Swimming Program: Medical Clearance Form

Form to be completed by school nurse at the nurse's discretion (with aquatic program input) after reviewing medical history form. (See reverse.)

Student Name ________________________________ Date of Birth ________________________________

School Contact ________________________________ School Phone Number ________________________

1. **Special characteristics of student that may influence safety in an aquatics program are** (check all that apply)**:**
   - ☐ Behavior is unpredictable
   - ☐ Gastric tube
   - ☐ Severe cognitive delay
   - ☐ Renal disease
   - ☐ Fecal incontinence
   - ☐ Functional inadequacy of musculoskeletal system
   - ☐ Inadequately controlled diabetes mellitus
   - ☐ Seizure disorder
   - ☐ Potential for respiratory compromise _____________(e.g., tracheotomy)
   - ☐ Predisposed to infection __________________ (e.g., central line catheter, exposed tissue)
   - ☐ Technology dependent __________________ (e.g., suctioning, monitoring device)
   - ☐ Other ____

2. ☐ **To my knowledge this student has no special needs that significantly increase the risk in an aquatics program.**

3. **Given these conditions, recommendation(s) are the following** (check all that apply):
   - ☐ 1:1 attendant
   - ☐ No aquatics at this time
   - ☐ 1:1 attendant (health aide/nurse)
   - ☐ Other special precautions ___________________
   - ☐ Physician authorization for aquatics (see below) is required based on condition(s) above (see item No. 1) and medical history form.

School Nurse ___________________________________ Date __________________________
Signature

Physician Authorization Form

To be completed only by request of the school nurse.

Dear Doctor:
The school district requires your authorization and recommendations before beginning an aquatics program with the above-named student. Please complete the bottom portion of this page and return to the school.

Doctor must complete the following portion.

☐ The following additional precautions are necessary to maintain the health and safety of this patient in a school swimming program:

☐ I do not wish this patient to participate in a school swimming program at this time.

Physician Printed Name ___________________________ Signature ________________________________

Telephone Number ___________________________________ Date ________________________________

Please return form to School Nurse________________________ Phone Number ______________________

School ____

Address ____

____