SWIMMER FORM

FOUNDED 1979

Swimming therapy for everybody

APPLICATION FOR MEMBERSHIP

Information given on this form will only be passed to those persons within the Club who need to know.

FULL NAME _____ DATE OF BIRTH _____

HOME ADDRESS _____

_____ POST CODE _____

TELEPHONE NUMBERS: DAY _____ EVENING EMERGENCY _____

EMERGENCY CONTACT DETAILS _____

Have you any of the following? (PLEASE TICK BOX)	YES	NO	COMMENTS
VISUAL DIFFICULTIES	☐	☐	
HEARING DIFFICULTIES	☐	☐	
FITS – EPILEPSY	☐	☐	
HEART CONDITION	☐	☐	
HIGH BLOOD PRESSURE	☐	☐	
ASTHMA – BRONCHITIS – BREATHING DIFFICULTY	☐	☐	
NERVE OR JOINT PROBLEMS	☐	☐	
BALANCE PROBLEMS – DIFFICULTY WITH MOVEMENT	☐	☐	
SKIN PROBLEMS	☐	☐	
BRITTLE BONES	☐	☐	
DIABETES	☐	☐	
HAEMOPHILIA	☐	☐	
ARE YOU A WHEELCHAIR USER?	☐	☐	
DO YOU USE A WALKING AID?	☐	☐	

Please list medicine being taken _____

Do you have clinical diagnosis? What is it? _____

Any other relevant information or special considerations – .g. continence appliances _____

Do you require assistance – in the changing room ☐ ☐
at the poolside ☐ ☐

Notification of any change in medical condition or medication must be given to the Committee as soon as possible.

PLEASE NOTE THAT FOR SAFETY AND INSURANCE PURPOSES IT WILL NOT BE POSSIBLE FOR SWIMMERS TO SWIM IN THE POOL UNTIL THIS FORM IS COMPLETED AND SIGNED

PLEASE COMPLETE PAGE TWO OVERLEAF

RELEVANT SKILLS

e.g. swimming awards, teaching skills, first aid, previous experience

I consent to the Alsager Swans Swimming Club seeking medical information from any doctor who, at any time, has attended me concerning anything that affects my physical or mental health.

FULL NAME DATE OF BIRTH

PLEASE NOTE: Parent or guardian must sign for anyone under the age of 18

THIS SECTION TO BE COMPLETED BY A MEDICAL PRACTITIONER

I agree that this application form has been filled correctly and that the applicant may take part

I agree that this application has been filled in correctly and know of no reason why the applicant should not take part in an organised swimming activity.

ADDRESS

TELEPHONE

RECOMMENDED DATE FOR REVIEW (IF NECESSARY)

SIGNATURE DATE

OPTIONAL EXTRAS

Whilst the Club is affiliated to the Halliwick Association of Swimming Therapy, which is an expert body in teaching people with disabilities to swim by the Halliwick Method, we are unable to accept responsibility for loss or damage to a person or their belongings. Members joining must abide by the rules of the Club.

Information regarding name, address, telephone number and date of birth may be kept on a word processor.

This information will only be used by Officers of the Club. If you object to this information being stored in this way please inform the Secretary.

Please return this form to: Dan Asprey, Amy Stephen or Mary Holford

I agree to this form being stored in your records.

SIGNATURE DATE