

Student Information:

Name _____
Age in Months ____ Weight Now _____ DOB _____ Birth Weight ____
Milestones: Sit Unassisted _____ Crawl _____ Stand Alone _____ Walk _____
Street Address / City / State / ZIP _____



Parent or Guardian's Contact Info:

Mother _____ Occupation _____
Phone _____ Cell _____ Email _____
Father _____ Occupation _____
Phone _____ Cell _____ Email _____

Aquatic History (check all that apply)

Previous Swim Lessons? Program/ When? _____
Negative Experience with water? _____
Flotation devices? _____ Comfort Level in the water _____
Family has or Vacations Near: Pool _____ Hot Tub _____ Pond/Lake _____
River/Canal _____ Ocean _____ Boat _____ Other _____

Medical Information or Problems: (check all that apply PAST and CURRENT)

- | | | |
|---|--|--|
| <input type="checkbox"/> On Prescription Medication | <input type="checkbox"/> Sensory Integration Dysfunction | <input type="checkbox"/> Cardiac Abnormality/Murmur |
| <input type="checkbox"/> Ear Tubes/Frequent Infections | <input type="checkbox"/> Needed CPR | <input type="checkbox"/> Allergies Epi-pen? _____ |
| <input type="checkbox"/> Special Needs/Exceptionalities | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Fever for More Than 48 Hours |
| <input type="checkbox"/> Seen by Medical Specialist/ER | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Ear Tubes/Frequent Infections |
| <input type="checkbox"/> Bowel or Bladder Infections | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Chronic Illness |
| <input type="checkbox"/> ADD or ADHD | <input type="checkbox"/> Seizures | <input type="checkbox"/> Fever for more than 5 days |
| <input type="checkbox"/> Surgery (not circumcision) | <input type="checkbox"/> Asthma/Chronic Respiratory | <input type="checkbox"/> Chronic diarrhea/constipation |
| <input type="checkbox"/> Gastro-Esophageal Reflux | <input type="checkbox"/> Therapy: OT/PT | <input type="checkbox"/> Continued birth complications |

Please explain any checks above and list all current medications or treatments: Need more space? You may attach a sheet.

If your child has or has had any of the above in his/her medical history, please make sure your instructor has this information at least 3 days prior to your first scheduled lesson. It is important that your instructor is able to fully understand your child's medical history in order to provide a safe and effective lesson. You may choose to e-mail this form if you would like, but please understand that HIPPA guidelines prohibit us from requesting any medical information via unsecured electronic communication. Also, you will still need to bring a signed copy on the first day.

The information I have provided is correct and complete. I have reviewed and signed both the Enrollment Packet and the Waiver of Liability and have discussed and understand the nature of the lessons provided by SOS Swim School/Julia Daum and approve my child, _____, to participate in lessons.

Signature (Mom) _____ Date _____ Signature (Dad) _____ Date _____

REQUIRED: PayPal Receipt # for Registration _____

YOU MUST BRING A PRINTED AND SIGNED COPY OF THIS FORM ON THE 1ST DAY OF LESSONS.