Little Flippers Aquatics and Swim

STUDENT INFORMATION

STUDENTS NAME _____ AGE _____YRS _____ MO DATE OF BIRTH _____

ADDRESS _____ CITY _____ ST_____ ZIP_____

PHONE HOME _____ CELL _____ EMAIL _____

MOTHERS NAME _____ FATHERS NAME _____

STUDENT MEDICAL INFORMATION

GENDER M F O BIRTH WEIGHT _____ HT _____ PREG OR DELIVERY PROBLEMS _____

FULL TERM _____ PREMATURE _____ WEEKS PREMATURE _____ ICU _____ OXYGEN NEEDED _____

DEVELOPMENTAL MILESTONES SIT ALONE ____ mos CRAWL _____mos STAND ALONE _____ mos WALKING _____ mos

PEDIATRICIANS NAME _____

PLEASE ANSWER THE FOLLOWING (CIRCLE YES OR NO) (IF YES EXPLAIN PLEASE ON THE BACK)

Y N Seen by medical specialist
Y N Bowel or Bladder problems
Y N Surgery
Y N Heart Murmur or defect
Y N Allergies
Y N Gastro-esophageal Reflux

Y N CPR
Y N Chronic Illness
Y N Head injury/loss of consciousness
Y N Fever for longer than a week
Y N A.D.D./autistic spectrum
Y N Therapy OT PT Speech Other

Y N Seizures
Y N Lactose Intolerance
Y N Asthma
Y N Respiratory problems
Y N Ear Infections
Y N Ears Tubes

Explanation _____
_____

STUDENT AQUATIC HISTORY

Family has or vacations near (circle if applicable)
Pool Hot tub Pond/Tank Lake Canal Ocean Boat Other

Previous aquatic Instruction if any
Program Type _____ Where _____ When _____

Are parents/guardians aquatically skilled Y N Has your child ever used a floatation device? Y N Type of Device _____ How long? _____

Has your child ever had an aquatic accident? Y N If yes, explain _____