

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) \_\_\_\_\_

Insurance policy holder (or insurance policy no.) \_\_\_\_\_

List **all** medications taken (at home and at school) \_\_\_\_\_

List **all** allergies student has (medications, foods, environmental) \_\_\_\_\_

**General Questions**

Has or does this student currently have the following:

**YES NO**

- |                          |                          |   |                          |
|--------------------------|--------------------------|---|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Any recent injury, illness or infectious disease?  |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. A chronic or recurrent illness/condition?  |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Wear glasses, contacts, protective eyewear?  |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Frequent ear infections?   |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Tubes in ear? Tubes currently in place?  |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Ever passed out during or after exercise?  | Date last occurred _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Ever had a seizure?  | Date last occurred _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Ever had chest pain during or after exercise?  | Date last occurred _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Ever had high blood pressure?  | Date last occurred _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Ever been diagnosed with a heart murmur?  | Date last occurred _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Ever been dizzy during or after exercise?   |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Ever had problems with joints or mobility (e.g., knees, ankles)?                            |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Have any skin problems (e.g., itching, rash)?   |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Have diabetes? _____ Type 1 _____ Type 2 _____ Diabetes Insipidus                           |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Have asthma or exercise-induced asthma?   |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Have problems with diarrhea, constipation, or bowel or bladder control?                     |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. <b>For girls:</b> Does your child menstruate (have periods)?                                |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | 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

To be completed at the school 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):

- |   |  |
|---|--|
| <input type="checkbox"/> Behavior is unpredictable  | <input type="checkbox"/> Fecal incontinence                              |
| <input type="checkbox"/> Gastric tube   | <input type="checkbox"/> Central line catheter, PIC line                 |
| <input type="checkbox"/> Jejunostomy tube   | <input type="checkbox"/> Functional inadequacy of musculoskeletal system |
| <input type="checkbox"/> Severe cognitive delay   | <input type="checkbox"/> Inadequately controlled diabetes mellitus       |
| <input type="checkbox"/> Kidney disease   | <input type="checkbox"/> Seizure disorder                                |
| <input type="checkbox"/> Potential for respiratory compromise _____ (e.g., tracheotomy, asthma)   |  |
| <input type="checkbox"/> Predisposed to infection _____ (e.g., exposed tissue, immunocompromised) |  |
| <input type="checkbox"/> Technology dependent _____ (e.g., suctioning, monitoring device, oxygen) |  |
| <input type="checkbox"/> 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):

- |  |  |
|--|--|
| <input type="checkbox"/> 1:1 attendant   | <input type="checkbox"/> 1:1 attendant (health technician/nurse) |
| <input type="checkbox"/> No aquatics at this time  | <input type="checkbox"/> Other special precautions _____         |
| <input type="checkbox"/> 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

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## Physician Authorization Form

To be completed only by request of the school nurse.

Dear Doctor:

The San Diego Unified 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.**

<input type="checkbox"/> The following additional precautions are necessary to maintain the health and safety of this patient in a school swimming program:
<input type="checkbox"/> 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 \_\_\_\_\_

\_\_\_\_\_