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		
☐	☐	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? Tubes currently in place?	
☐	☐	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 or mobility (e.g., knees, ankles)?	
☐	☐	13. Have any skin problems (e.g., itching, rash)?	
☐	☐	14. Have diabetes? _____ Type 1 _____ Type 2 _____ Diabetes Insipidus	
☐	☐	15. Have asthma or exercise-induced 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

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)**:**
   - ☐ Behavior is unpredictable
   - ☐ Gastric tube
   - ☐ Jejunostomy tube
   - ☐ Severe cognitive delay
   - ☐ Kidney disease
   - ☐ Fecal incontinence
   - ☐ Central line catheter, PIC line
   - ☐ Functional inadequacy of musculoskeletal system
   - ☐ Inadequately controlled diabetes mellitus
   - ☐ Seizure disorder
   - ☐ Potential for respiratory compromise _____(e.g., tracheotomy, asthma)
   - ☐ Predisposed to infection _____ (e.g., exposed tissue, immunocompromised)
   - ☐ Technology dependent _____ (e.g., suctioning, monitoring device, oxygen)
   - ☐ 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
   - ☐ 1:1 attendant (health technician/nurse)
   - ☐ No aquatics at this time
   - ☐ 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 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.

- ☐ 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 _____

_____