Richmond Swims
Richmond Plunge Masters
Personal Health & Medical History

Name of Participant:_____ Middle Initial:_____
Date of birth:_____ Age:_____
Home Address:_____ Zipcode:_____
Home Phone:_____ Work:_____ Mobile:_____
Email:_____

In case of an emergency, notify:
Name:_____ Relationship:_____
Phone:_____
Name:_____ Relationship:_____
Phone:_____

Name of personal Physician:_____ Physician Phone:_____
Personal health/accident insurance carrier:_____
Policy number:_____

Name of Dentist:_____ Phone:_____

Allergies: Food, medicines, insects, etc: _____

_____

_____

Please include any relevant health or medical information you feel we should know:

_____

_____

IN CASE OF EMERGENCY, I hereby give my permission to the physician elected by the supervising swim instructor to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me.

_____

Participant's Signature Date: