Scottish Swimming

MEDICAL CONSENT FORM

Athlete Details

Surname:	Forename:
Address: Postcode:	
Doctor's Name:	
Doctor's Address: Doctors contact number:	

MEDICAL INFORMATION

1. Do you have any dietary requirements / food allergies? YES/NO
   If YES, give additional information.

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   _____

2. Do you have any medical conditions requiring medical treatment, please include allergies and medication? YES/NO
   If YES, please state

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3. Do you have health insurance (for travel abroad)? YES/NO
   If YES, please state (i.e. EHIC / Private insurance)

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