

## Medical History:

Please check if the participant currently has, has a history of, or is subject to the following:

- |  | <i>Yes</i>               | <i>No</i>                |  | <i>Yes</i>               | <i>No</i>                |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Asthma or other respiratory problems    | <input type="checkbox"/> | <input type="checkbox"/> | 15. Unusual shortness of breath or dizziness while participating in sports               | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Diabetes                                | <input type="checkbox"/> | <input type="checkbox"/> | 16. Hospitalization/ Emergency room visit within the last year                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Alcohol and/or drug abuse               | <input type="checkbox"/> | <input type="checkbox"/> | 17. Neck/Back/shoulder operations/problems   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. High Blood Pressure, high cholesterol   | <input type="checkbox"/> | <input type="checkbox"/> | 18. Knee/ankle problems, including sprains and/or operations                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Kidney disease, urinary tract infection | <input type="checkbox"/> | <input type="checkbox"/> | 19. Any wrist/ hand/ arm problems including sprains and/or operations                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Recent illness                          | <input type="checkbox"/> | <input type="checkbox"/> | 20. Any cardiac conditions. Family history e.g. heart mummies, irregular heart beat      | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Infectious disease                      | <input type="checkbox"/> | <input type="checkbox"/> | 21. Epilepsy or a seizure within the past year   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Bleeding or blood disorders             | <input type="checkbox"/> | <input type="checkbox"/> | 22. Fainting or dizziness episodes   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Severe headaches/migraines              | <input type="checkbox"/> | <input type="checkbox"/> | 23. Any other medical issues or requirements are not stated above. If yes, explain below | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have any skin problems (itching, rash) | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 11. Chronic illness/autoimmune disease     | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 12. Bowel problems                         | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 13. Wearing glasses and/or contacts        | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 14. Neurological problems                  | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

Any checked Yes's? Tell us more.

## Allergies:

Allergy to medications. Specify:

Allergy to food/any restrictions:

Allergy to bee stings or insect bites\*. Type of reaction:

\*if yes, carry your current medication with you

**Medications:** List below any medications the participant is currently taking/will be taking during the program.

Medication:	Dose:	Administration Times:	Reason for medication	Side Effects:

## Exercise:

General Fitness Level:  I don't exercise  Moderately active  Active  Very Active

Swimming Ability: check one  Non-swimmer  Beginner  Moderate swimmer  Strong swimmer

If the participant has fear of water indicate here: