Southwestern Community College District
Crown Cove Aquatic Center
5000 Highway 75
Coronado, California 92118
(619) 575 – 6176

PLEASE BRING A HARD COPY OF THIS COMPLETED FORM TO THE FIRST DAY OF CAMP

Camp Participant Health History & Medical Authorization

Last Name _____ First Name _____ Initial _____ Birth Date _____ Age _____ Sex (M) (F)

Street Address _____ City _____ State _____ Zip _____

Name of Parent or Guardian _____ Home Phone _____ Work Phone _____ Cell Phone _____

Name of Other Emergency Contact _____ Emergency Phone _____ E-mail _____

Medical Authorization

I do hereby authorize any Southwestern Community College District or California Department of Parks & Recreation representative or board certified physician or surgeon as agent for the undersigned, to consent with respect to any x-ray, anesthetic, dental or surgical diagnosis of treatment or hospital care deemed advisable by, and rendered under the general or special supervision of any board certified physician or surgeon, be it in or out of an office or hospital. I understand that Southwestern Community College District, California Department of Parks & Recreation, California Department of Boating & Waterways, their staff, officers or directors are not responsible for any cost incurred on my, or my assigns, behalf for medical care as a participant in any part of the program, whether as a volunteer aid or instructor, or as a spectator or participant.

Moreover, to my knowledge there are no existing conditions that would preclude participation by the above named in any aquatic sports activity.

Participant's Signature _____ Printed Name _____ Date _____

Parent / Guardian Signature _____ Printed Name _____ Date _____

Health History
(Check if Applicable)

*** Requires a doctor's written authorization to participate**

☐ Asthma*	☐ Recent Hospitalization	**Allergies**:
☐ Seizures*	☐ ADD/ADHD	☐ Hay Fever
☐ Heart Problems*	☐ Tuberculosis	☐ Food Products
☐ Congenital Defects*	☐ Chicken Pox	☐ Bee Sting
☐ Diabetes*	☐ German Measles	☐ Animals
☐ Currently Under Doctor's Care*	☐ Measles (Other)	☐ Drugs

Please provide additional information on checked items:

Current medications to be continued at camp:

Medicine Name/Dosage/Frequency _____

Inhaler or Epi pens brought to camp? YES NO List reason and instructions _____

Participant's Signature _____ Date _____ Parent / Guardian Signature _____ Date _____