swimyourswim.com
open water coaching for your swim

INFORMATION ABOUT YOU					
First Name		DoB		Age	
Last Name		Sex	☐ Male ☐ Female		
Address			OFFICE NOTES:		
City					
County					
Postcode					
Country					

	MEDICAL HISTORY Have you suffered, at any time, from any of the following:	YES	NO
1	Ear trouble, earache, discharge or deafness….	☐	☐
2	Sinus trouble…	☐	☐
3	Chest disease, including asthma, bronchitis, collapsed lung or TB…	☐	☐
4	Attacks of giddiness, blackouts or fainting…	☐	☐
5	Fits, nervous disorders, persistent headaches or concussion	☐	☐
6	Anxiety, “nerves”, nervous breakdown…	☐	☐
7	Diseases of the heart and circulation, including high blood pressure…	☐	☐
8	Do you have diabetes…	☐	☐
9	Do you regularly or frequently take any medication…	☐	☐
10	Are you currently receiving medical care or have you consulted any doctor in the past year…	☐	☐
11	Have you ever been refused life insurance or failed a medical…	☐	☐
12	Do you smoke…	☐	☐
13	Have you attended or been admitted to hospital…	☐	☐
14	Eyesight: is your eyesight outside the normal limits of vision…	☐	☐
15	Have you had a previous medical for a CHILLYDIP or COLD WATER swim event…	☐	☐
	If YES - was the result satisfactory…	☐	☐

ADDITIONAL NOTES
If you answered 'YES' to any of the questions 1-14 please tell us more information here - use an additional sheet if required…

DECLARATION

I hereby declare that to the best of my knowledge, the information in this form is true, complete and not misleading. I authorise my doctor to disclose any detail of my past or present medical history if requested to do so by a CHILLYDIP, YOS or SYS officer. I also agree that this form and/or the information on it may be disclosed by CHILLYDIP/YOS/SYS to the persons directly concerned with my involvement in the event. I declare that I will inform CHIILYDIP/YOS/SYS team in writing of any fact, matter or circumstance arising or becoming known to me after submitting this form which would prevent me from repeating this declaration at any time up to the event.

Signature:	Date:
Print Name:	

DOCTORS NOTES

- The above named person wishes to be examined by a medical expert to verify that his or her medical condition, health and fitness is sufficient to attempt to swim in an ice water event as stipulated by the International Ice Swimming Association (IISA) and described at www.internationaliceswimming.com.
- An ECG is a required test for swimmers wishing to complete an IISA 1km or 1mile event.
- IISA welcomes swimmers with disabilities which can be managed for the duration of an attempt without materially increasing risks to the health and safety of swimmers or others.
- Any doubts that you, as the medical expert, may have about the applicant's medical condition, health and fitness must be resolved before declaring the applicant fit to swim. IISA can not be responsible for assisting with any certification or referral and the provision of any view, opinion or recommendation by any IISA officer may not be relied upon.

DOCTORS INFORMATION

Doctors Name		**Address**	
Professional Affiliation		**City**	
		Postcode	
Telephone		**County**	
Fax		**Country**	
Email			

MEDICAL EXAMINATION
To be completed by a Medical Doctor

Applicant Name					
Height (m)		**Weight (kg)**		**BMI**	
EARS: right		**EARS: Left**		**Is hearing impaired?**	☐ Yes ☐ No
Nose		**Throat**		**Sinuses**	
Respiratory System			**Chest X-ray (If required)**		
Cardiovascular System					
Blood Pressure			**ECG**		
Abdominal System			**Urine dipstick**		
Musculoskeletal System					
Neurological System					

ADDITIONAL NOTES

DOCTORS SIGNATURE

After examination I consider _____ (Swimmers name)

to be ☐ FIT ☐ UNFIT to enter the following ice-swimming event(s)

☐ 450m ☐ 1km ☐ 1 mile

Signature _____

Print Name _____

Date _____

Doctor's stamp: