



# Alsager Swans Swimmers Form

## Application for Membership

Information given on this form will only be passed to those persons within the Club who need to know.

*Please note that for safety and insurance purposes it will not be possible for the swimmers to swim in the pool until this form is completed and signed*

Full name:		Date of birth:	
Home address:			
		Postcode	
Email address:			
Telephone number:		Mobile number:	
<b>Emergency Contact Details</b>		Name:	
Telephone number:		Relationship to swimmer:	
Have you any of the following? (Please tick box)	Yes	No	Comments
Visual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing difficulties	<input type="checkbox"/>	<input type="checkbox"/>	
Speech & language difficulties	<input type="checkbox"/>	<input type="checkbox"/>	
Learning difficulties	<input type="checkbox"/>	<input type="checkbox"/>	
Balance problems or difficulty with movement	<input type="checkbox"/>	<input type="checkbox"/>	
Lung condition	<input type="checkbox"/>	<input type="checkbox"/>	
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	
Nerve or joint problems	<input type="checkbox"/>	<input type="checkbox"/>	
Fits	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Mental health concern	<input type="checkbox"/>	<input type="checkbox"/>	
Any other conditions (please state)	<input type="checkbox"/>	<input type="checkbox"/>	
Are you a wheelchair user?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use a walking aid?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a clinical diagnosis*? What is it?			
Please list medication being taken*:			
Any other relevant information or special considerations:			
Do you require assistance:			
In the changing room	<input type="checkbox"/>	<input type="checkbox"/>	



At the poolside



\*Notification of any change in medical condition or medication must be given to the Chief Instructor as soon as possible.

## Consent

This section to be completed by a medical practitioner

***Requirement to get consent from a medical practitioner will be at the discretion of the Chief Instructor.***

I agree that this application has been filled in correctly and know of no reason why the applicant should not take part in an organised activity.

Doctors name:

Doctors address:

Doctors telephone number:

Recommended date for review (if necessary):

Signature:

Date:

Whilst the club is affiliated to the Halliwick Association of Swimming Therapy, which is an expert body in teaching people with disabilities to swim by the Halliwick Method, we are unable to accept responsibility for loss or damage to a person or their belongings. Members joining must abide by the rules of the club and the Code of Good Practice.



Information contained within this form may be kept on a digital file in addition to this paper copy. If you object to this information being stored in this way, please inform the IT Media & Data Protection

Officer.

Please return this form to: Lisa Alcock (Chief Instructor) or Ann Parton (training officer)

Print name of person completing the form:	
Signed by person completing the form:	
If you are signing on behalf of someone else, what is your relationship to them?	
Date:	