

MEDICAL DECLARATION FORM

This form **MUST** be completed by anyone that is representing Great Britain or their Home Country internationally or competing in a British Swimming, Scottish Swimming, ASA or WASA National event (all disciplines, excluding masters) and returned to the Scottish Swimming at the address below.

A new form **MUST** be completed annually even if the medication prescribed has not been altered or if no medication is being taken and whenever the medication is changed. If the competitor is under the age of 16 this form should be completed and returned by the parent or person in loco parentis but must still be signed by the competitor. This form should be sent direct to Scottish Swimming, not via the club secretary. The data contained in this form is classed as sensitive personal data under the Data Protection Act 1998 (DPA). Scottish Swimming, ASA or WASA will process the data provided in accordance with the DPA. Your express written consent to hold this data is required under the DPA, which by signing this form you are providing. The data will be held securely in accordance with the DPA and will be used to administer you as a member of Scottish Swimming, ASA or WASA. The Medical Declaration Information Sheet will assist in completing this form.

PLEASE COMPLETE IN BLOCK CAPITALS

Surname																					
First Name									Miss / Mr / Ms / Mrs												
Address																					
Post Code					Tel No (inc. STD Code)																
E-mail:																					
Date of Birth												Membership No									
Club																					

Please indicate medication taken for treatment of asthma by ticking the appropriate box

FORMETEROL (i.e. Symbicort)	<input type="checkbox"/>	FLUTICASONE (i.e. Flixotide)	<input type="checkbox"/>
TERBUTALINE (i.e. Bricanyl)	<input type="checkbox"/>	BUDESONIDE (Pulmicort)	<input type="checkbox"/>
SALBUTAMOL (i.e. Ventolin)	<input type="checkbox"/>	BECLOMETHASONE (i.e. Becotide)	<input type="checkbox"/>
SALMETEROL (i.e. Serevent)	<input type="checkbox"/>		<input type="checkbox"/>
Other medication taken for the treatment of asthma:		(name of medication)	

Please list below ALL medication currently being taken for any other medical condition including vitamins and dietary or nutritional supplements in the space below:

Other medication			
Vitamins			
Supplements			

I declare that I **do not** take any form of MEDICATION (this includes vitamins and supplements) - please tick box

Signature of competitor:			
If under 16 years of age signature of parent or person in loco parentis:			
Date:			