



FBSA - MEDICAL ASSESSMENT FORM

Section A – Swimmer - Personal Details

Full Name	Date of Birth dd/mm/yyyy	Gender	Occupation
		M / F	

Address			
City/Town	Country	Post Code	
Email	Phone		

Section B – Swimmer Medical History

(please circle Yes or No, if you answered yes, please give further details in the line below)

1 Past Medical History	Yes	No
2 Past surgical history	Yes	No
3 Current Medication	Yes	No
4 Allergies	Yes	No
5 Cardiovascular - e.g. high blood pressure, arrhythmias	Yes	No
6 Parents/Siblings with cardiovascular conditions	Yes	No
7 Respiratory –e.g. asthma	Yes	No
8 Abdomen - GIT	Yes	No
9 Neurological – e.g. epilepsy	Yes	No
10 ENT (ear / nose / throat)	Yes	No
11 Eyes – Visual problems, surgery	Yes	No

12 Psychiatric	Yes	No
13 Disability	Yes	No
14 Hospitalised in past 5 years	Yes	No
15 Refused Life Insurance	Yes	No
16 Failed FBSA Medical	Yes	No
17 Previous Cold H2O Swimming Experience	Yes	No
18 Previous issues on rewarming – hypothermia, arrhythmias	Yes	No
Comments:		

Declaration:

I hereby declare that to the best of my knowledge; I am in good general health and I have disclosed all information relevant to this assessment and may be relevant to my Swim attempt. I authorise my Doctor and medical staff attendants at this assessment, to disclose any relevant information to my Swim Observer and the FBSA or Safety staff.

I am aware that my Swim is an extreme challenge, mentally and physically and I am obligated to inform the FBSA and the Swim Medical and Safety staff of any changes in my health since this assessment to the date of my Swim.

I will deliver this assessment to the Swim - Observers.

I hereby acknowledge that the Swim is done at my own risk, I understand all risks involved and I hold none involved in my Swim attempt responsible for any mishap that may occur to me because of this Swim.

Signature

Date:

Section C – For the Examining Doctor

The above names person wishes to attempt an FBSA solo Swim. The swim requires the swimmer to swim a distance of around 34km in water temperature of between 12C to 17C, unassisted and uninterrupted.

Please indicate your assessment outcome:

PRE-SWIM MEDICAL

General	Weight	Height	BMI	Temperature
	Waist cm	Pregnant?	Disability?	
General Examination				
Cardiovascular	Heart Rate	Blood Pressure		
Cardiovascular Examination				
Respiratory	Respiratory Rate	Oxygen Saturation	Peak Flow	
Respiratory Examination				
ENT	Drums	Pharynx	Other	
Abdominal Examination				
Neurological Examination				
ECG/EKG Assessment				

Medical Doctor Declaration:

After my examination, I see no medical issues preventing the above Swimmer (A) from attempting the False Bay Crossing Swim event.

Name _____ Date ____/____/____

Address _____

Email _____@_____

Qualifications _____

Signature _____