Irish Long Distance Swimming Association (ILDSA)

www.ildsa.info www.northchannel.info

Medical Application Form – North Channel Swim

*** only valid dated up to 16 weeks prior to the date of your swim**

All sections must be fully completed. All information will be stored confidentially, but certain information may be made available to your Pilot or Observer as required to ensure your safety. The closing date for receipt of completed Medical Application is 01 June in the year of your swim.

Name of swimmer		Date of birth	
If part of relay, enter relay team name			
Gender		Occupation	
Address Including Postal / Zip code			
Day time telephone		Evening telephone	
Email			

Swimmers Declaration

I have answered all questions truthfully, and to the best of my knowledge I am in good health and declare my fitness to attempt to swim the North Channel. I understand:

- I may be asked to supply further information on my medical history if requested to do so by the ILDSA
- medical information may be shared with my Pilot, but shall otherwise remain confidential
- the risks associated with this Challenge.
- I will notify the ILDSA if there are any changes to my fitness or ability to participate in my North Channel Attempt.

Signed: ______________________ Date: ______________________

Self Declaration – to be completed by the swimmer:

Have you ever suffered from:	
Ear trouble	YES / NO
Sinus trouble	YES / NO
Chest disease	YES / NO
Fainting / Blackouts	YES / NO
Anxiety disorders	YES / NO
Diabetes	YES / NO
Heart or circulation problems	YES / NO
Do you take medication regularly?	YES / NO
Are you pregnant?	YES / NO
Do you consider yourself to have a disability	YES / NO

If you answered YES to any question, please give further information below:

To the Doctor: The North Channel is a sea swim, 21.6 miles long, temperature around 54°F (12°C.) Applicant is attempting a 2 way crossing. These tests are to confirm that the Applicant is in a suitably fit condition to attempt such a feat of endurance. Please fill in all fields in the presence of the applicant.

Name of Doctor			
Address Including Postal / Zip code			
Day time telephone		Evening telephone	
Email			

To be completed by the Doctor:

Height		Weight	
EARS – left drum		Right drum	
Left canal		Right canal	
Is hearing impaired?	YES / NO		
Sinuses		Nose		Throat	
Cardio Vascular system		Blood Pressure (BP)	
Urine – Albumen		Urine – Glucose	
Nervous System		Pulse Oxygen percentile	
ECG			
Additional Notes:	Please continue on separate sheet if required.		

Doctors Declaration

The above tests were carried out by me on the date specified below, and, to the best of my medical knowledge, I believe the Applicant is suitably fit to attempt such a feat of endurance.

Signed: ______________________ Date: ______________________