



MEDICAL FORM

1. Personal Information

- Name:
- Date of birth:
- Age:
- Gender:

Instructions

- Both parts of the form (Part 1 y Part 2) must be completed and submitted in **printed and signed original** form when collecting the Swimmer's Kit. Failure to submit the completed form will invalidate your participation in the event.
- An incomplete form or one with missing information will also invalidate your application.
- This form must be completed, scanned, and **emailed** to info@santafecoronda.com.ar before September 30, 2025.
- It is recommended that you keep a personal copy of the Medical form you submit.

PART 1: MEDICAL HISTORY (to be completed by the swimmer)

If you answer "YES" to any of the questions below, attach further explanation.

1. Have you ever suffered from any of the following:
 - a. Ear problems, earache , discharge or deafness: YES / NO
 - b. Sinusitis: YES / NO
 - c. Lung disease such as asthma or bronchitis: YES / NO
 - d. Fainting or blackout : YES / NO
 - e. Seizures or nervous system diseases: YES / NO
 - f. Anxiety, stress or nervous breakdowns: YES / NO
 - g. Heart disease YES / NO
 - h. High blood pressure: YES/ NO
 - i. Diabetes or hypoglycemia: YES/ NO
2. Do you regularly take medication? : YES / NO
3. Are you under medical treatment or have you seen a doctor last year? YES / NO
4. Have you ever had an unsatisfactory result in a medical exam for a sports event?
YES/ NO
5. Have you been rejected for life insurance? : YES / NO
6. Have you been hospitalized during last year? YES / NO
7. Do you smoke or take illegal drugs? YES / NO
8. Are you allergic to any medication? YES/ NO



SWIMMER'S STATEMENT

Hereby I certify that, to the best of my knowledge, I am in good health and have not omitted any information that may be relevant to my fitness in order to participate in the Santa Fe-Coronda Swim.

I authorize my physician to provide details of my past or present medical history to the event representatives upon request. I also agree that the information provided on this form may be disclosed with persons directly involved in my participation, including the boat crew, my coach and the medical team

Swimmer's signature:

Date:



PART 2: MEDICAL EXAMINATION (to be completed by the physician)

Patient's name:

Date of birth: **Age:** **Gender:**

The above mentioned swimmer wishes to be examined in order to determine his/her physical fitness to participate in the First Santa Fe-Coronda Swim, over a distance of 58 kilometers (about 36 miles)

Note: This is an extremely demanding swim, both physically and mentally.

Before signing this form, additional tests can be carried out (chest X-Ray or ECG) if necessary.

Physical examination

Examination date:

- Height: _____
- Weight: _____
- Blood pressure: _____
- Pulse: _____

Medical certificate

After examination, I consider the swimmer mentioned above is

FIT UNFIT

to attempt the 58 kilometers (36 miles) Santa Fe-Coronda Amateur Swim.

Physician's name:

Registration No:

e-mail address:

Physician's signature:

Date: