

IISA® MEDICAL ASSESSMENT FORM

Valid for 12 months from the date of assessment



Full Name _____ Assessment date: _____

SECTION A – SWIMMER DETAILS [filled in by the Swimmer]

Date of Birth (DD/MM/YYYY) _____ AGE _____ years
PARA [if applicable]. _____ SEX _____ M/F/O _____
Physical address _____
City / Town _____ Post Code _____ Country _____
Email address _____ Phone _____
Occupation _____
Next of Kin (name) _____ Relationship _____ Phone _____

SECTION A1 – SWIM DETAILS [filled in by the Swimmer]

Maximum Swims distance (m) _____
Expected Swims dates (month) _____
Anticipated water temperatures _____

SECTION B – SWIMMER MEDICAL HISTORY [filled in by the Swimmer]

SWIMMER:

Have you experienced or are you aware of: (Y/N - If yes, please provide short details):

1. High Blood pressure (Hypertension)?

2. Palpitations? (Irregular heartbeats or a racing heart)?

3. A heart condition or had a stroke? (If yes, date of last occurrence)

4. Fainted or blacked out during or after exercise?

5. Had an unexpected dizzy turn during or after exercise?

6. Suffer from chest pain, tightness or heaviness in the chest during or after exercise.

7. Are you short of breath or tired more quickly than others during exercise?

8. Do you have a Pacemaker or Defibrillator? (if yes – date of installation)

9. Do you have Marfan's syndrome (an inherited disorder that affects connective tissue)

FAMILY HISTORY - Cardiovascular [filled in by the Swimmer]

10. Has an immediate family member had a heart attack or sudden cardiac death less than 50 years old?

11. Has an immediate family member been diagnosed with a cardiovascular condition, e.g. Cardiomyopathy, Marfan's syndrome, Long QT, Heart rhythm disorders, or require a pacemaker?

SWIMMER: Do you have?

12. A respiratory condition? –e.g. Asthma, Sleep apnoea, other

13. Have you had an asthma attack requiring urgent medical attention in the last 12 months?

14. Gastrointestinal /Abdomen problems? Reflux, Inflammatory bowel disease, Irritable bowel disease, other...?

15. Bleeding disorders or previous blood clots?

16. Epilepsy, Parkinson's, Migraines Other

17. Musculoskeletal or Rheumatological problems:

18. Eyes – Visual problems:

19. Endocrine problems: eg Diabetes, Thyroid, other...

20. Psychiatric problems: e.g. Depression, Anxiety, ADHD, ASD, etc.

21. Skin conditions: Psoriasis, Eczema etc

22. Other Medical conditions or Disability not already mentioned

23. Past Surgery History: (List operations)

24. Current Medication:

25. Allergies:

26. Have you been hospitalised in the past five years? (If yes, why?)

27. Have you been refused Life Insurance? (If yes, why?)

28. Have you been told it is dangerous to participate in physical activity? (If yes, why?)

29. Have you failed an IISA medical? (If yes, why?)

30. Previous Cold H2O Swimming Experience:

31. Date and Distances in the last two years:

32. Previous issues on rewarming – hypothermia, arrhythmias? (if yes, what happened?)

33. Altitude experiences: (If yes, please give details)

34. Previous issues at altitude: (If yes, please give details):

Comments:

SWIMMER’S 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 pertinent to my Ice Swim attempt. At this assessment, I authorise my doctor and medical staff attendants to disclose any relevant information to my Swim Medical Officer or Safety staff. I am aware that an ICE Swim is an extreme challenge, mentally and physically. I am obligated to inform IISA and the Swim Medical and Safety staff of any changes in my health from this assessment to the date of my swim. I will deliver this assessment to the Swim - Observers/IISA Officials/Medical Officer and include this when applying to verify my Swim by IISA. I hereby acknowledge that the Swim is done at my own risk. I understand all the risks involved, and I hold none involved in my Swim attempt responsible for any mishap that may occur to me because of this Swim.

Date _____ Signature _____

Section C – For the Examining Doctor

I have examined _____

Date: _____

Wishing to attempt an Ice Swim. An Ice Swim requires the swimmer to swim at a water temperature of 5C or lower, unassisted and wearing a standard swimming costume, one cap and a pair of goggles. Please indicate your assessment outcome:

PRE-SWIM MEDICAL

Weight _____ kg

Height _____ cm

BMI _____

Temperature _____ C

Waist _____ cm

Pregnant _____

Disability? _____

GENERAL EXAMINATION

Heart Rate _____

Blood Pressure _____

Cardiovascular examination: _____

Respiratory Rate _____

Oxygen Saturation _____

Peak Flow _____

Respiratory examination: _____

ENT:

Drums _____

Pharynx _____

Abdominal examination: _____

Neurological examination: _____

ECG /EKG assessment: _____

MEDICAL DOCTOR DECLARATION

After my examination, I saw no medical issues preventing the above Swimmer from attempting the ice swimming event.

Full Name _____

Date _____

Address _____

Email _____

Qualifications _____

Signature _____

