



# 2024 Galway Bay Swim - Medical and Waiver Form

**This form is to be used for both solo and relay team swimmers. All members of a relay team are required to complete this form.**  
**This medical form must be completed within 3 months of the swim date.**

Section B of this form, (Medical Approval & Swimmer Waiver) must be completed in full and returned no later than July 1<sup>ST</sup>, 2024.

Section A will be reviewed by the swimmer and their doctor. The medical examination (SECTION A) will take your doctor a little time. Please make sure that you book an appropriate appointment. Any fee in respect of this medical examination is the responsibility of the person named (swimmer).

**Return Section B (Page 3 of this form) signed and stamped by your doctor:**  
Scan and email to: [David.ODonnell@cancercarewest.ie](mailto:David.ODonnell@cancercarewest.ie) OR Post to: Galway Bay Swim, C/o Cancer Care West, Inis Aoibhinn, University Hospital Galway, Galway H91 T861

## Section A. Medical History & Examination - Page 1

**FOR THE EXAMINING DOCTOR**  
The below named person (Swimmer) wishes to be examined with a view to checking his/her physical fitness to participate in an attempt to swim across Galway Bay. The Galway Bay Swim is a cold water (10°C - 15°C) sea swim of 13 km distance that can take between 3 & 6½ hours to complete. All joints & limbs must be capable of this length and intensity of exercise. Please bear in mind that this is an arduous physical undertaking involving cold water swimming with long exposure to the elements over a long distance.

**To be completed in your examining doctor's presence.** (PLEASE COMPLETE THIS FORM IN BLOCK LETTERS)

Swimmer Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Sex: male/female Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Post Code: \_\_\_\_\_  
Town/City: \_\_\_\_\_ County: \_\_\_\_\_ Country: \_\_\_\_\_

Have you ever suffered at any time from any of the following?

- |   |          |
|---|----------|
| 1. Ear trouble, earache, discharge or deafness  | YES / NO |
| 2. Sinus trouble  | YES / NO |
| 3. Chest disease, including asthma, bronchitis, collapsed lung or TB                                      | YES / NO |
| 4. Attacks of giddiness, blackouts or fainting  | YES / NO |
| 5. Fits, nervous disorders, persistent headaches or concussion  | YES / NO |
| 6. Anxiety, "nerves", nervous breakdown   | YES / NO |
| 7. Diseases of the heart and circulation, including high blood pressure                                   | YES / NO |
| 8. Do you have diabetes?  | YES / NO |
| 9. Do you regularly or frequently take any medication<br>Or other treatment with or without prescription? | YES / NO |
| 10. Are you currently receiving medical care, or have you<br>consulted any doctor in the past year?       | YES / NO |
| 11. Have you ever been refused life insurance or failed a medical exam?                                   | YES / NO |
| 12. Do you smoke?   | YES / NO |
| 13. Have you attended or been admitted to hospital?   | YES / NO |
| 14. Eyesight - is your eyesight within normal limits  | YES / NO |

**If the answer is YES to ANY of questions 1-13 above, please give further details below or on a separate page for review by your doctor.**



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## Section A. Medical History & Examination - Page 2

**SWIMMER'S FULL NAME:** \_\_\_\_\_

Height: \_\_\_\_\_ Metres. Weight: \_\_\_\_\_ Kg. Build: \_\_\_\_\_

EARS: R.DRUM _____	R.CANAL _____	Is hearing impaired
L.DRUM _____	L.CANAL _____	YES / NO

SINUSES \_\_\_\_\_ NOSE \_\_\_\_\_ THROAT \_\_\_\_\_

CHEST X-RAY\* \_\_\_\_\_ CHEST \_\_\_\_\_

\*(A chest X-ray should be considered if there is previous history of chest disease.)

CARDIOVASCULAR SYSTEM \_\_\_\_\_ BP \_\_\_\_\_

URINE: Albumen \_\_\_\_\_ Glucose \_\_\_\_\_

JOINTS & LIMBS \_\_\_\_\_

NERVOUS SYSTEM \_\_\_\_\_

ECG\* \_\_\_\_\_

\*(At doctor's discretion if any relevant abnormality is found on examination of CVS)

**SWIMMER DECLARATION:**

I hereby declare that to the best of my knowledge, I am in good general health and that I have not omitted any information that might be relevant to my fitness to swim. I authorise my medical attendants to disclose any detail of my past or present medical history if requested to do so by a FTMGBS official. I also agree that relevant information about my health may be disclosed to the persons directly concerned with my attempt to swim across Galway Bay.

I DECLARE THAT I WILL INFORM THE ORGANISERS OF THE FRANCES THORNTON GALWAY BAY SWIM (FTMGBS) OF ANY MEDICAL CONDITION THAT OCCURS AFTER THE PRESENTATION OF THIS MEDICAL APPLICATION FORM AND BEFORE I MAKE MY SWIM ATTEMPT.

**SIGNED: (Swimmer)** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Incomplete forms will be returned & your swim application will be delayed. Please answer all questions & check the final page fully before submitting.**

Make sure you and your doctor sign in all the relevant places and your doctor has crossed out either the **"FIT or UNFIT"** part of the declaration in "Section B" below.

**Keep a copy of Section A for your records.**



## Section B. Medical Approval & Express Assumption of Risk - Waiver, and Release of Liability

To be completed by all SWIMMERS - taking part as Solo or as a member of a Relay team.

After examination, I consider \_\_\_\_\_ (Swimmer's name) to be  
**-- FIT - or - UNFIT --** (Please cross out/delete as appropriate)  
to attempt to swim across Galway Bay (c. 13km) in water temperatures of 10°C - 15°C as a solo swimmer or relay team member.

Signature of Examining Doctor \_\_\_\_\_ Date. \_\_\_/\_\_\_/\_\_\_

Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_

Doctor's Stamp

By submitting your event application, waiver, and/or registering for the *Frances Thornton Memorial Galway Bay Swim*, you agree to the following terms.

### ASSUMPTIONS OF THE RISKS OF OPEN WATER SWIMMING

The Galway Bay Swim is a 13km OPEN WATER SWIM from Aughinish, Co. Clare to Blackrock Tower, Salthill, Galway. Open water swimming is inherently dangerous. Open water swimmers have been injured and killed. For example, swimmers have been hit by boats and kayaks. Jellyfish and other marine animals have injured swimmers. Swimmers have been injured by objects in the water, both floating and fixed. There may be health hazards associated with pollution in the bay. Weather conditions can change quickly in Galway Bay. Bay currents have swept swimmers off course. Bay waters are cold with water temperatures typically ranging between 9 and 15 degrees Celsius. Swift currents and cold water have precipitated drowning, heart attacks, and hypothermia. These are just some of the hazards and dangers of OPEN WATER SWIMMING.

### WAIVER AND RELEASE OF THE FRANCES THORNTON MEMORIAL GALWAY BAY SWIM

On behalf of my heirs, assignees, personal representatives, and next of kin, I hereby release and hold harmless the Frances Thornton Memorial Galway Bay Swim organisation, its officers, members, officials, agents, employees, volunteers and other participants, with respect to all injury, disability, death, loss, injury, or damage to me or my property, whether arising from the negligence of Frances Thornton Memorial Galway Bay Swim its members, officers, or otherwise.

BY SIGNING THIS WAIVER AND RELEASE, I CERTIFY THAT I UNDERSTAND THAT I CANNOT SUE ANY PERSON, VOLUNTEERS, OR THOSE WHO ACT ON BEHALF OF THE *Frances Thornton Memorial Galway Bay Swim* ORGANISATION OR THOSE WHO MAY HAVE AUTHORITY OVER THE ORGANISATION, AND NO ONE ELSE CAN SUE ON MY BEHALF.

- In consideration of the acceptance of my entry in the *Frances Thornton Memorial Galway Bay Swim*, I hereby:
1. agree to comply with all rules and regulations and event instructions of the swim;
  2. attest and verify that I am physically fit and have sufficiently trained for open water swimming and that my physical condition is in optimal condition;
  3. consent to be stopped from swimming and agree to leave the water if directed by any officer for any reason during the Galway Bay Swim.
  4. agree that in the event of the bay swim cancellation due to conditions beyond the control of Frances Thornton Memorial Galway Bay Swim, including but not limited to high winds, a storm, rain, fog, inclement seas or weather, "Acts of God", or other conditions, that the event organisers will have no responsibility for any costs that I have incurred due to my participation in the swim.

I UNDERSTAND AND ASSUME ALL RISKS ASSOCIATED WITH SWIMMING IN THE *Frances Thornton Memorial Galway Bay Swim* which is a 13Km open water swim across Galway Bay.

**SWIMMER NAME: (Block Capitals)** \_\_\_\_\_

**SIGNED: (Swimmer)** \_\_\_\_\_ **Date:** \_\_\_\_\_

Return Section B (Page 3 of this form) signed by you and your doctor along with your doctor's stamp: Scan and email to: [David.ODonnell@cancercarewest.ie](mailto:David.ODonnell@cancercarewest.ie) OR Post to: Galway Bay Swim, C/o Cancer Care West, Inis Aoibhinn, University Hospital Galway, Galway H91 T861