DURHAM WARM WATER AQUATIC PROGRAM

This is an arthritis friendly program designed for people who:

- are **INDEPENDENTLY MOBILE** and do **NOT** require assistance
- do **NOT** have any infectious conditions, diseases or are incontinent.
- would possibly benefit from gently range of movement exercises in a warm pool.

PHYSICIAN CONSENT FORM

(please type or print clearly the information below)

Name: _____

Address: _____

City: _____ Postal Code: _____

Home Telephone: _____ Work Telephone: _____

E-Mail Address: _____

Type of Arthritis or related condition: _____

Does the client have any other chronic illness? Please specify: _____

_____

Please indicate if any of the following conditions exist:

	Yes	No
Seizures?	(….)	(….)
Heart Condition?	(….)	(….)
Blood Pressure?	(….)	(….)
Diabetic?	(….)	(….)
Stroke?	(….)	(….)
Hearing Impaired?	(….)	(….)
Sight Impaired?	(….)	(….)

Breathing problems, please specify? _____

_____

This applicant has my consent to participate in the Durham Warm Water Aquatic Program

_____ _____

Signature of Physician Date

Address: _____

_____

Official stamp required

Note: This is the only consent form which will be accepted.