Directions to Pool

Insert full address

Pool times – check which day you are booked

- ☐ Wednesdays / Fridays: Arrive at _____
- ☐ Mondays / Thursdays: Arrive at _____

You will be in the water about 45 – 50 minutes – less if you require extra change time after your session.

- Detailed directions:

Facility Photo:

DO NOT COME TO THE POOL IF YOU ARE ILL! **Phone the clinic & cancel your session.**
(Examples: Fever, cold, flu, cough, open skin, rash, diarrhea, stomach cramps, not feeling well)
Call the clinic (_____) and cancel your pool session if you are sick.

SWIMMING POOL FULL AND FINAL RELEASE

Re: _____ (___) _____ _____
Print Patient Name Telephone # Date of birth

Emergency contact: _____ Phone #: _____

IN CONSIDERATION OF THE USE OF THE SWIMMING POOL AND ANY OTHER FACILITIES OF_____, I hereby assume full and complete responsibility for the supervision and safety of myself thereof in the use of the swimming pool and other facilities and I hereby fully and forever release, acquit Volunteers and Agents from any and all actions, causes of action, claims and demands of whatsoever kind or nature on account of any and all known and unknown injuries, losses and damages sustained or received by me as a result of my use of the swimming pool and other facilities.

_____ **Date Signed:** _____
Signature of Applicant

_____
Recreation Department Signature **Medical Required** ☐ **Yes** ☐ **No**

Medical History: ***Please check all that apply***

☐	Diabetes	☐	Difficulty Breathing
☐	Heart Trouble	☐	Asthma
☐	Chest Pains	☐	Persistent Cough
☐	Fainting / Dizziness	☐	Recent Viral Infection
☐	Seizures	☐	Lower Body Swelling
☐	High Blood Pressure	☐	Recent surgery
☐	Low Blood Pressure	☐	Lymphedema
☐	Emphysema	☐	Recent chemotherapy or radiation
☐	Pregnant	☐	Open wounds

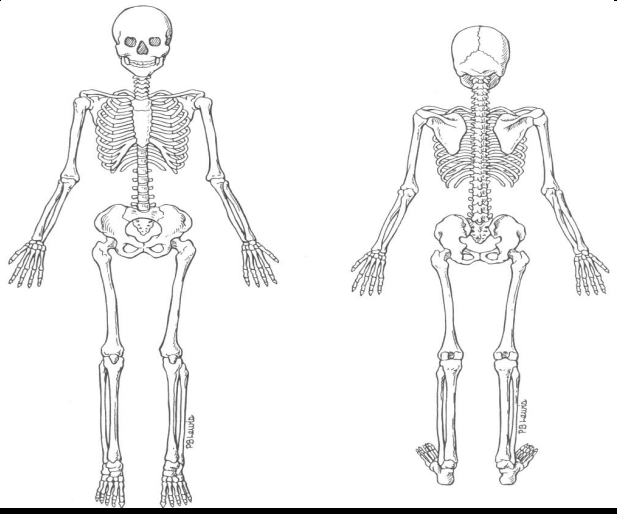
Physiotherapist / OT / Chiro / Kinesiologist / RMT Referral for Aquatic Therapy

Patient Name: **Date of Birth:**

Reason for Referral / Goal(s) for Aquatic Therapy:

History of Recent Injury:

Area of Injury:



Please circle / shade all body areas affected.

Stage of Treatment: ☐ **Acute** ☐ **Sub-Acute** ☐ **Chronic** ☐ **Pre /** ☐ **Post Surgical** ☐ **Other**

Frequency of Aquatic Treatment Recommended: ☐ 1 X / Week ☐ 2 X / Week ☐ Other:

Contradictions to *AquaStretch*™ or Aquatic Treatment Re: Past Medical Hx:

Other Comments:

_____ _____

Signature of referring health professional *Date*

Physician Release Required & Enclosed: ❑ **Yes** ❑ **No**

Clinic Contact Information: