Medical Information Form for Participants

1. Please check aquatic program you will be participating in:
   Open Swim ____ Aerobics _____ Independent Swim ___ Baby & Me____

2. Please complete participant contact information:
   Name:_____DOB:_____
   Phone:_____ Email:_____
   Address:_____
   City:_____ State:_____ Zip:_____
   Emergency Contact Person:_____
   Emergency Contact Phone: _____
   Family Physician:_____ Phone: _____

3. Please list any special precautions:
   a. Joint replacement _____
   b. High Blood Pressure _____
   c. Heart Condition _____
   d. Diabetes _____
   e. Seizure disorder/Epilepsy _____
   f. Allergies/Asthma _____
   g. COPD _____
   h. Other Medical Precautions _____

4. Please return this completed form to Whitman Therapy Pool within the first week of participant's first swim session.

I understand and agree that there are risks, both foreseeable and unpredictable, associated with any exercise program. I am aware of these risks and agree that my participation is at my own risk. I hereby understand and agree that neither the Whitman Therapy Pool nor the Whitman Hospital & Medical Clinics, officers, directors, employees, or volunteers, shall assume or have responsibility or liability for expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in this program. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising our of or in any way connected with my participation in this or any future programs. I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

Signature _____ Date _____

5. Office Use: Date form received _____
6. Office Use: Medical RX received _____
7. Office Use: Payment received _____