ADAPTED AQUATICS PARTICIPANT APPLICATION
RALPH RICHARDSON CENTER

4848 Cottage Way, Carmichael, CA 95608 Fax: (916) 971-7737

THIS PORTION TO BE FILLED OUT BY PARENTS/GUARDIAN OR CARE PROVIDER

Participant:_____
DOB_____ Medical record #_____
Physician's Name: _____
Phone #: _____ Fax #: _____

By signing this form, I understand that I am giving permission to the Aquatic Instructor to fax this form to the Physician to be filled out.

Parent/Guardian or Care Provider
Signature:_____ **Date:**_____

THIS PORTION TO BE FILLED OUT BY PHYSICIAN

1. Diagnosis/Health Conditions:_____
_____
2. May be submerged: _____
3. Specific body movements or positions desired.(e.g., flexion, extension-right arm)
_____
4. Contraindications to exercise (this section must be completed by attending Physician): _____
5. Seizures; _____ No _____ Yes, please describe: _____
_____
6. Special Health/Safety Precautions:(Allergies, "frequent ear infections, Heat Intolerance, etc): _____
_____
Tubes in ears_____ No _____ Yes. Needs ear molds____No _____Yes.
The student listed above has my/our permission to participate in the Aquatic Motor Development Program. The water temperature in the pool is 90 to 94 degrees.

Physician's
Signature:_____ **Date:**_____
Address:_____ **Phone:**_____

For RRC use only:
School Nurse:_____ Aquatic Staff_____