OSHER MARIN JCC AQUATIC THERAPEUTIC PROGRAMS
PHYSICIAN CONSENT FORM

PLEASE CHECK ONE:
____ AQUATIC ARTHRITIS CLASS ____ HYDROTHERAPY PROGRAM ____ 1-ON-1 /SPECIALIZED AQUATICS

No participant is permitted to register for OMJCC Aquatic Therapeutic Programs without the consent of a physician. Please complete the requested information. Thank you

TO BE COMPLETED BY PATIENT

Patient's name: _____ Date of Birth: _____

Address: _____City:_____Zip Code_____

Phone: _____E-Mail: _____

MEDICAL RELEASE OF INFORMATION: for purposes of participating in the Osher Marin JCC Aquatic Therapeutic Programs, I agree that Dr._____may disclose the medical information as requested below:

Patient's Signature_____ Date: _____

TO BE COMPLETED BY PHYSICIAN

- DIAGNOSIS _____
- Disability Onset_____
- Has patient or is patient being treated for any of the following conditions?
  ____ Allergies ____ Arthritis ____Asthma ____Balance ____Cancer ____ Cardiac ____Dementia
  ____Epilepsy ____Seizures ____Stroke ____Behavioral Problems ____Joint Replacement
  ____High/Low Blood Pressure ____Incontinence
- Height _____ Weight _____
- Is patient taking any of the following medications?
  ___Beta blockers ___Anti-coagulants ___Statins ___Pain medication
- Is patient ambulatory? ___Yes ___No Use any special apparatus?
  ___Wheelchair ___Walker ___Crutches ___Cane ___Prosthesis
- Is Patient receiving PT/OT? ___Yes ___No

➢ Will patient need assistance entering/exiting pool? ____Yes ___No (using stairs) ___No (using lift)
  - Please note: If "yes", patient will be required to bring personal assistant

➢ Will patient require one-on one assistance while in pool? ___Yes ___No
  - Please note: If "yes", patient will be required to bring personal assistant

➢ Can patient use: SPA Facility (temp 102 degrees), Steam room, Sauna ____Yes ____No

Please indicate any special precautions that should be observed by this patient when participating in a water therapy program? _____
_____

Recommended Duration: No. of times per week ____ OR ___ 3 months ___6 months ___1 year

The patient named above has my permission to participate in the indicated Aquatic Therapeutic Program at the Osher Marin JCC:

Signature _____ Date:_____

Print Name _____

Please return completed form to:
Osher Marin Jewish Community Center
200 North San Pedro Road, San Rafael CA 94903
ATTENTION: Aquatic Therapeutic Programs
(Fax 415 491-1235)