AQUA AEROBICS PHYSICIAN RELEASE FORM

PROVIDENCE HOSPITAL
WELLNESS INSTITUTE
1150 Varnum St. NE
Washington, DC 20017
Office: (202) 269 – 7000 • Fax: (202) 269 – 7048

Your patient ______________________ wishes to participate in an **aquatic group exercise** program. This program may include resistance training, flexibility and/or cardiovascular exercise; increasing in duration and intensity over time. Classes will not be modified to accommodate individual needs. This is a recreational program and ***is not** designed to be rehabilitative*. All classes are taught by trained instructors in a temperature controlled pool maintained between 90 – 92 degrees.

PATIENT NAME: ______________________

PHYSICIAN: ______________________

PHYSICIAN PHONE: ______________________

Please check appropriate conditions applying to this patient (currently undergoing treatment and/or has a medical history):

	Heart Disease		Asthma		High Blood Pressure		Circulatory Disorders
	Heart Attack		Palpitations/Rapid Breath		High Cholesterol		Kidney/Liver Disease
	Cardiac Surgery		Chest Pains		Diabetes		Thyroid Disease
	Major/Chronic Illness		EKG Abnormalities		Cigarette Smoking		Bone/Joint Problems
	Pregnant		Heart Murmur		Dizziness/Fainting		Back Injury
	Stroke		Ankle Swelling		Sedentary lifestyle		Arthritis/Bursitis
	Claudication		Leg Pain		Obesity		Seizures
	Difficult/Painful Breath		Recent Injury/Surgery		Family History of Coronary Disease (55yo)		Multiple Sclerosis
	Shortness of Breath		Exer. Induced Asthma		Taking Medication*		Open Wounds

Other areas of concern: ______________________

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PLEASE CHECK ONE:

- ☐ I fully endorse the participation in the aqua aerobics program for the patient listed above.
- ☐ I **do not** recommend participation in the aqua aerobics program for the patient listed above.

Physician Signature: ______________________ Date: __________