

# AQUA AEROBICS PHYSICIAN RELEASE FORM

**PROVIDENCE HOSPITAL  
WELLNESS INSTITUTE**

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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: \_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_