



ARTHRITIS FOUNDATION AQUATIC/YMCA AQUATIC PROGRAM (AFAP/AFYAP) PHYSICIAN INFORMATION FORM

Note to the Doctor:

The Arthritis Foundation is collaborating with _____ to conduct the Arthritis Foundation Aquatic Program. This series of recreational warm-water pool activities will be led by trained personnel and will cover a period of 6-8 weeks. This program has been approved by the Arthritis Foundation San Diego Chapter's Medical & Scientific Committee.

Your patient, named below, has indicated an interest in participating in this program. In order for him or her to do so, we ask that you please fill out this form which your patient will give to his or her trained Arthritis Foundation Aquatic Program Instructor.

The program consists of range of motion, muscle strengthening and endurance-building activities. Persons with total joint replacements, multiple joint involvement, or moderate to severe joint involvement may require individualized instruction by a physical or occupational therapist. If your patient requires this instruction, you may want to refer him or her to a therapist prior to participation in the program.

PART I. FOR THE APPLICANT TO COMPLETE

1. Name: _____
2. Address: _____
3. City/Zip: _____ Phone: _____
4. I give permission to Dr. _____ to complete this Arthritis Foundation Aquatic Program Physician Information Form.

Signature

Date

PART II. FOR THE PHYSICIAN TO COMPLETE

1. My patient has the following diagnosis (type of arthritis/rheumatic disease):
2. Please indicate if there are any special precautions or reasons why this patient should limit his or her participation or any reasons why, in your opinion, this patient should not participate in the Arthritis Foundation Aquatic Program **OR** if your patient is approved to participate.

Signature

Date

Physician Phone Number _____

Arthritis Foundation San Diego Area Chapter
Arthritis Foundation Aquatic
Program
Application and Release Form

I. GENERAL INFORMATION (Please print)

Name: _____

Address: _____

City/Zip: _____

Telephone: _____ Age: _____

Type of Arthritis: _____

Where did you hear of the program? _____

Ethnic Origin (Optional) Black Asian Hispanic White
 Native American Other _____

II. PARTICIPANT'S RELEASE

If my application for the Arthritis Foundation Aquatic Program is accepted, and I am permitted to participate in this program, I understand and agree that neither the Arthritis Foundation nor any co-sponsoring organization or facility, nor their respective chapters, officers, directors, employees, agents, members or volunteers, shall assume or have any 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 out of or in any way connected with my participation in the program.

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 any precautions or limitations to my participation.

Participant's Signature

Date

III. Please take these completed forms to the instructor on your first day of class at the Arthritis Foundation Aquatic Program. Thank You!