Kernes Adaptive Aquatics
at the Josephine Kernes Memorial Pool
15 Portola Avenue, Monterey, CA 93940
Office: (831) 372-1240 Fax: (831) 372-3140
www.KernesPool.org

Today's Date: _____

ALL sections of these forms must be completed. Incomplete forms will delay the registration process.

Participant Contact Information Form

Participant's Name:		Date of Birth:	Age:	Gender:
Address:		City:		Zip:
Home Phone:	Work Phone:	Mobile Phone:		

Primary Emergency Contact Name: (List parent if for a minor)		Relationship:	
Address:		City:	Zip:
Home Phone:	Work Phone:	Mobile Phone:	
Secondary Emergency Contact Name:		Relationship:	
Address:			
Home Phone:	Work Phone:	Mobile Phone:	

Primary Physician:	Type of Physician:	
Address:	City:	Zip:
Office Phone:	FAX:	
Other Physician:	Type of Physician:	
Address:	City:	Zip:
Office Phone:	FAX:	

**********Office Use Only**********

Client Contact Log/Staff Notes	Scheduled Appointments
	Application Receipt Date:
	Initial Visit: Date Time:
	____ Mtg w/Office Manager ____ Mtg w/Aquatic Coordinator
	Estimate Start Date:
	Actual Date:
	Level of Instruction & Swim Schedule:

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Participant Medical Information Form

Complete all sections, Incomplete forms will delay the registration process. (N/A where not applicable).
The following information is required. This information is used to asses the participant's abilities and provide staff with an in-depth understanding of a participant's condition in order to ensure the appropriate level of services is provided.

Describe the primary condition or diagnosis that is the reason for wanting to participate in an aquatic exercise program.
List all medications currently taking and the condition that requires them. *(Use back of page if necessary)*

Check all that apply for current or past problems with any of the following listed below:

_ Arms, Hands, Shoulders	_ Arthritis
_ Back	_ Balancing
_ Bladder/Kidney	_ Bending, Standing, Sitting
_ Bowel or Bladder Incontinence	_ Diabetes
_ Circulation	_ Digestive Problems
_ Ears	_ Dizziness/Fainting
_ Eyes	_ Learning/Reading
_ Heart	_ Memory/Concentration
_ High Blood Pressure	_ Mental/Emotional
_ Joints	_ Nerves
_ Legs, Knees	_ Numbness
_ Lungs	_ Seizures
_ Skin	_ Unconsciousness
_ Speaking	_ Walking
_ Thyroid	_ Weakness
	_ Surgeries

REQUIRED: Explain items checked above, indicate the item to which you are referring. *(Use a separate sheet of paper if necessary)*

I, _____ understand that aquatic exercise provided by Kernes Adaptive
(PRINT Participant's name)
Aquatics is intended to reduce pain, enhance relaxation, increase range of motion, improve circulation and offer a positive experience. I am aware that the Aquatic Coordinator does not diagnose illness or disease. I have disclosed all my known physical conditions, medical conditions and medications, and I will keep the Aquatic Coordinator updated on any changes of my medical conditions.

_____ _____
Print Name Relationship *(If other than patient)*

_____ _____
Signature Date

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Physician Consent Form

I give permission for the information requested below to be given to Kernes Adaptive Aquatics:

_____ _____
(PRINT Patient/Participant's Name) Phone Number

_____ _____
Patient/Participant's Signature (or legal guardian) Date

Your patient is considering taking part in aquatic exercise at the Josephine Kernes Memorial Pool (JKMP). JKMP provides adaptive aquatic exercise and instruction that is individualized to each person's needs and physical condition. Aquatic Instructors are trained in adapted aquatics, arthritis aquatics, and hold Lifeguard, CPR and First Aid Certifications. The facility consists of a 16'x30' indoor pool with a water temperature of 90°- 92°. A lift is available to assist non-ambulatory individuals in and out of the pool.

Section to be completed by Physician

Information for each section below is required of the physician. (N/A where not applicable)

Diagnoses and Conditions: (List conditions we should be aware of in working with your patient)
Are there specific activities you would recommend for your patient?
Are there any activities contraindicated for your patient? (This information is **required** for the safety and well being of your patient)

The patient named above has my approval to participate in an adaptive aquatic exercise program at the Josephine Kernes Memorial Pool.

_____ _____
Physician's Signature Date

_____ _____
Print Physician's Name Office Phone

_____ _____
Address FAX