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

Participant Enrollment Form

Contact Information

Today's Date: _____

ALL sections of these forms must be completed. **Incomplete forms will delay processing.**

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

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

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.

Complete all sections of the form. Incomplete forms will delay the registration process.

REQUIRED: List Conditions/Diagnosis: ***(information is REQUIRED in order to provide appropriate service)***

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:

_ Arthritis
_ Diabetes
_ Low Blood Circulation
_ Heart Pacer
_ Joint Paint
_ High Blood Pressure
_ Dizziness/Fainting
_ Respiratory Difficulties
_ Vertigo
_ Impaired Speech
_ Digestive Problems
_ Dementia
_ Obesity
_ Alzheimer's
_ Mental/Emotional Challenges
_ Surgery (Provide a list of surgeries on the back page)
_ Skin Conditions

_ Stroke
_ Parkinson's Disease
_ Memory/Concentration Difficulties
_ Balance Challenges
_ Bowel or Bladder Incontinence
_ Vision Impairment
_ Limited Range of Motion of the:
___Arms ___ Legs ___Shoulders
_ Autism:
__ High Functioning __ Low Functioning
__ Verbal __ Non Verbal
_ Seizures
_ Hearing Impairment
_ Behavioral Challenges
_ Numbness/Tingling of Limbs
_ Balance: Irregular Walking Pattern
_ Difficulties: __Bending __ Standing __ Sitting

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

I am aware that the Josephine Kernes Memorial Pool (JKMP) and its staff do not diagnose or provide medical treatment. I have disclosed all my known medical conditions and medications, and I will keep the organization updated on any changes in my medical condition or medications in writing. I myself, my heirs, executors and administrators, waive and release any all rights and claims for damages I have or may hereafter have against the JKMP, its principals, employees, volunteers, or funders as a result of my participation in the JKMP, including travel to and from the facility provided by or on behalf of JKMP for me.

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

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

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Medical Practioner Consent Form

This form must be completed by your health care professional

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 light 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. The Aquatic Instructors are trained in adapted aquatic and hold Aquatic Therapy & Rehab Institute, Lifeguard, CPR and First Aid Certifications. Your patient will receive aquatic exercise in a 16'x30' indoor pool with a water temperature of 90°- 92°. A lift is available to assist non-ambulatory individuals to enter and exit the pool.

This Section to be completed by Medical Professional (Dr., PT, or OT)

Information for each section below is required from the Medical Professional (Dr, PT, OT). *(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?: (Purpose of the activity)
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.

_____ _____
Medical Practioner's Signature (Physical Therapist/Physician) Date

_____ _____
Print Medical Practioner's (Physical Therapist/Physician) Office Phone

_____ _____
Address/City/State/Zip FAX