

# 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.

<b>Participant's Name:</b>	Date of Birth:	Age:	Weight:	Gender:
Address:	City:		Zip:	
Mobile Phone:	Other Phone:			
<b>Primary Emergency Contact Name:</b>				
Relationship: (If a minor: <b>Mother</b> /Guardian)				
Address:	City:		Zip:	
Mobile Phone:	Other Phone:			
<b>Secondary Emergency Contact Name:</b>				
Relationship: (If a minor: <b>Father</b> /Family/Friend)				
Address:	City:		Zip:	
Mobile Phone:	Other Phone:			
<b>Primary Physician:</b>				
Type of Physician:				
Address:	City:		Zip:	
Office Phone:	FAX:			
<b>Other Physician:</b>				
Type of Physician:				
Address:	City:		Zip:	
Office Phone:	FAX:			

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

Client Contact Log/Staff Notes	Scheduled Appointments
	Receipt Date:
	I.V. Date:                      Time:
	___ Mtg w/Office Manager
	___ Mtg w/Aquatic Coordinator
	Estimate Start Date:
	Actual Date:
	Program Level & Swim Schedule:

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## Participant Medical Information

The following information is required. This information is used to assess 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.**

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

**List medications currently taking.** *(Use back of page if necessary)*

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

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li><input type="checkbox"/> Arthritis</li><li><input type="checkbox"/> Diabetes</li><li><input type="checkbox"/> Low Blood Circulation</li><li><input type="checkbox"/> Heart Pacer</li><li><input type="checkbox"/> Joint Pain</li><li><input type="checkbox"/> High Blood Pressure</li><li><input type="checkbox"/> Dizziness/Fainting</li><li><input type="checkbox"/> Respiratory Difficulties</li><li><input type="checkbox"/> Vertigo</li><li><input type="checkbox"/> Impaired Speech</li><li><input type="checkbox"/> Digestive Problems</li><li><input type="checkbox"/> Dementia</li><li><input type="checkbox"/> Obesity</li><li><input type="checkbox"/> Alzheimer's</li><li><input type="checkbox"/> Mental/Emotional Challenges</li><li><input type="checkbox"/> Surgery (Provide a list of surgeries on the back page)</li><li><input type="checkbox"/> Skin Conditions</li></ul> | <ul style="list-style-type: none"><li><input type="checkbox"/> Stroke</li><li><input type="checkbox"/> Parkinson's Disease</li><li><input type="checkbox"/> Memory/Concentration Difficulties</li><li><input type="checkbox"/> Balance Challenges</li><li><input type="checkbox"/> Bowel or Bladder Incontinence</li><li><input type="checkbox"/> Vision Impairment</li><li><input type="checkbox"/> Limited Range of Motion of the:<br/>    <input type="checkbox"/> Arms   <input type="checkbox"/> Legs   <input type="checkbox"/> Shoulders</li><li><input type="checkbox"/> Autism:<br/>    <input type="checkbox"/> High Functioning   <input type="checkbox"/> Low Functioning<br/>    <input type="checkbox"/> Verbal   <input type="checkbox"/> Non Verbal</li><li><input type="checkbox"/> Seizures</li><li><input type="checkbox"/> Hearing Impairment</li><li><input type="checkbox"/> Behavioral Challenges</li><li><input type="checkbox"/> Numbness/Tingling of Limbs</li><li><input type="checkbox"/> Balance: Irregular Walking Pattern</li><li><input type="checkbox"/> Difficulties: <input type="checkbox"/> Bending   <input type="checkbox"/> Standing   <input type="checkbox"/> Sitting</li></ul> |
|---|---|

**Explain items checked above; indicate the item to which you are referring.** *(Use the back sheet of page if necessary)*

I acknowledge that the Kernes Adaptive Aquatics (Kernes) and its staff do not diagnose medical conditions or provide medical treatment. I confirm that I have disclosed all known medical conditions and current medications, and I agree to notify Kernes in writing of any changes to my medical condition or medications.

I, on behalf of myself and my heirs, executors, and administrators, hereby waive, release, and discharge any and all rights and claims for damages that I have or may hereafter have against Kernes, its principals, employees, volunteers, or funders arising from my participation in Kernes programs, including transportation to and from the facility when such transportation is provided by or on behalf of Kernes.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship *(If other than patient)*

\_\_\_\_\_  
Patient/Participant's Signature (or legal guardian)

\_\_\_\_\_  
Date

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## Medical Healthcare Practitioner Consent Form

I give my permission for the information requested below to be shared with Kernes Adaptive Aquatics for use in program participation and administrative purposes.

\_\_\_\_\_  
PRINT **Patient**/Participant's Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
**Patient**/Participant's Signature (or Parent/Legal Guardian)

\_\_\_\_\_  
Date

Your patient is interested in participating in therapeutic aquatic exercise at the Josephine Kernes Memorial Pool.

Aquatic sessions are developed and facilitated by qualified professionals trained and certified through the Aquatic Therapy & Rehab Institute (ATRI) to ensure quality of care, and are fully credentialed in Lifeguard, CPR, and First Aid certifications to maintain participant safety.

Our staff provides individualized adaptive aquatic exercises for adults, designed to accommodate each participant's specific condition, functional abilities, and special needs. We serve clients of all ages and all abilities. Aquatic staff are trained in working with children with special needs, including autism, developmental delays, physical challenges, and sensory processing differences. They provide individualized, inclusive aquatic programs which promote water safety, functional movement, and skill development for children and adults with special needs.

Aquatic sessions are conducted in a 16' x 30' indoor pool maintained at a water temperature of 90°–92°F. A hooyer lift is available to facilitate safe pool entry and exit for non-ambulatory individuals when necessary.

### This Section to be completed by Medical Healthcare Professional (MD., PT, or OT)

<b>Diagnoses and Conditions:</b> (List conditions we should be aware of in working with your patient)
<b>Are there specific activities you would recommend for your patient?:</b> (Purpose of the activity)
<b>Are there any activities contraindicated for your patient?:</b> (This information is <b>required</b> for the safety and well-being of your patient) <i>N/A when not applicable</i>

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

\_\_\_\_\_  
Medical Practitioner's Signature (MD/PT/OT)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Medical Practitioner's Name (MD/PT/OT)

\_\_\_\_\_  
Office Number

\_\_\_\_\_  
Medical Office Address/City/State/Zip

\_\_\_\_\_  
FAX Number