CITY OF WINTER SPRINGS THERAPY POOL
400 N. Edgemon Avenue
Winter Springs, FL 32708

PHYSICIAN CONSENT FORM

(*Please type or print all information clearly*)

PARTICIPANT / PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Sex: M / F
Address:_____ City: _____ State:_____ Zip:_____
Phone Number: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone Number(s): 1._____ 2._____

PHYSICIAN INFORMATION:

Name: _____ Phone Number:_____
Address:_____
City: _____ State: _____ Zip_____

Participant will be in water temperature of approximately 92°F. Please list any restrictions or precautions they may have concerning warm water exercise below:

_____

_____

Please Initial (**PHYSICIAN ONLY**):
_____Open Swim
_____Low Intensity Water Exercise Classes
_____Medium Intensity Water Exercise Classes

The above patient has my approval to participate in the above initialed water exercise classes and/or open swim which all have water temperature of approximately 92°F. Classes are approximately 45 minutes and there is no time limit on open swim.

_____ _____
Signature of Physician **Date Signed**

In consideration for the acceptance of my participation in the Arthritis or Water Aerobics classes, I, for myself, my heirs, executors and administrators, release and forever discharge the City of Winter Springs, its officers, employees, attorneys, volunteers and all aquatic instructors of all liabilities, claims, actions, damages, costs or expenses which I may have against them arising out of or in any way connected with my participation in the classes, including injuries which may be suffered by me before, during or after my participation. I understand that this waiver includes any claims based on negligence, action or inaction of any of the above parties.

_____ _____
Participant's Signature **Date Signed**