



WCRH Adaptive Swimming Health Screen and Consent Form

Name: _____	Birthday/Age: _____
Address: _____	Phone: _____
City/State: _____	Zip Code: _____
Caregiver's Name: _____	Caregiver's Email: _____
Child's Diagnosis: _____	

Health Check:
Please check the following:

Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Difficulty swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____
Open wound/infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: _____

Please list all medications and uses: _____

Does participant need assistance with toileting? Yes No
If yes, please explain: _____

Describe participant's previous experience with swimming/lessons and/or reaction to water (i.e. sensitivity to stimulating environments): _____

How does your child communicate with others? _____

Does your child exhibit any negative behaviors under stress? If so what are they and how does your child best calm/redirect? _____

What are some strategies that help your child follow directions? _____

Please list any additional information that maybe important: _____

Waiver:

I am aware of the nature of the swimming program and give my child permission to participate: I release Weisman Children's Rehabilitation Hospital from all liability related to any injuries resulting from participation in this swimming program. I also verify, by signing this waiver, the above participant is covered by a medical health plan. If the above participant is not covered by a health plan, I, the undersigned, will assume all financial responsibilities for any injuries that might occur including emergency medical care. I give permission to Weisman Children's Rehabilitation Hospital to secure emergency medical treatment if necessary.

Signature: _____

Date: _____

I understand that Weisman Children's Rehabilitation Hospital uses community volunteers in this program.

Signature: _____

Date: _____

The information I have given is correct and is meant to protect the health of my children, and the other children in the hospital and their parents.

Signature: _____

Date: _____

Physician Consent

I give the above child medical clearance to participate in WCRH Adaptive Swim Lessons.

Signature: _____

Date: _____

Please return signed forms with payment one week prior to the start of class to:

Attention: Therapeutic Recreation Department

Weisman Children's Rehabilitation Hospital

92 Brick Road

Marlton, NJ 08053