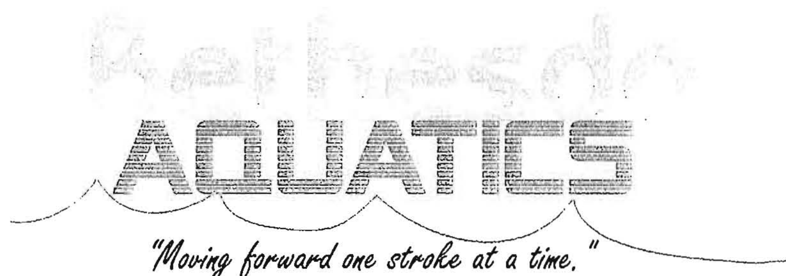

PATIENT INFORMATION SHEET
FOR
AQUATIC EXERCISE THERAPY

DAY PROGRAM

Participants Name:____

Parent/Guardian Name: ______________________________________

Telephone Number:__________________ Mobile Number:_____________________

Mailing Address: ____

____

Emergency Contact Person :______________________ Telephone: _____________

Relationship ____

Therapist's Name: ____

Therapist's Telephone Number: _____________________________________

Physician's Name: ____

Physician's Telephone Number: _____________________________________

1710 First Avenue #124, New York, New York 10128
Tel: 718-448-3133 Fax: 718-448-3633

RELEASE FORM

This form is to be signed by the participant/parent or guardian.

In consideration of ***New York City Department of Parks and Recreation*** providing facilities for____.

(NAME OF PARTICIPANT)

To obtain with others therapeutic water instructions in the swimming pool used by ***Bethesda Aquatics, LLC*** and all servants, agents and employees of ***Bethesda Aquatics, LLC*** and of said owners and operators from all liability for injuries or accidents which may happen to said patient as a result of participation in such activities, or while he or she is on the premises of said premises for the aforesaid, I/we jointly and severally hereby agree to indemnify and save harmless ***New York City Department of Parks and Recreation and Bethesda Aquatics, LLC*** and said owners and operators and said servants, agents and all employees from all claims and demands whatsoever, which may be made in respect of any injuries or accidents which may happen to said patient.

I/we will also advise the instructor if there are any changes in my physical condition that would alter my performance in this program. I/we also agree to abide by all posted and otherwise mentioned rules and regulations of ***New York City Department of Parks and Recreation and Bethesda Aquatics, LLC.***

Participant/Parent or Guardian: ____

Relationship: ____________________________________ Date: ______________

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Bethesda AQUATICS

"Moving forward one stroke at a time."

AUTHORIZATION FOR USE OR DISCLOSURE

OF PROTECTED HEALTH INFORMATION

HIPAA FORM

I, ______________________________ hereby authorize my Healthcare Provider
Print Name of Participant/Guardian

____
Healthcare provider's name, address and telephone number

____

to release my/my child's health information/record to ***Bethesda Aquatics LLC***.

I also give permission for the Aquatic Instructors to have knowledge of the medication that I/my child takes. This information will be used only for the time period that the above is part of ***Bethesda Aquatics, LLC*** programs.

NAME:______________________________ RELATIONSHIP: ______________________
PRINT

SIGNATURE: ______________________________ DATE: ______________________

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