STATEN ISLAND DEVELOPMENTAL DISABILITIES SERVICES OFFICE
ELIZABETH A CONNELLY COMMUNITY RESOURCE CENTER

THERAPEUTIC POOL
MEDICAL CLEARANCE FORM

Swimmer's Name: _____

Agency / Group Name: _____

Address: _____

Contact Person: _____ Emergency Phone: _____

Medical / Physical Limitations

1. SEIZURES: [ ] Yes [ ] No
   Physician indicates seizures under control:
   [ ] Yes [ ] No
2. VISION: _____
3. HEARING: _____
4. SKIN INTEGRITY: _____
5. CARDIAC: _____
6. RESPIRATORY: _____
7. DRUG ALLERGIES: _____
8. PULMONARY: _____
9. INCONTINENT: [ ] Yes [ ] No

List any behaviors / additional information that may warrant our attention:

_____

_____

Physician's Statement of Clearance

On _____/_____/_____, I examined the above named individual and my findings indicate that with proper supervision he/she is capable of participating in the aquatic activities at your therapeutic pool.

Physician's Name and Address: _____

_____

_____

Physician's Signature: _____

Date: ____/____/____ ***(This form must be updated every 3 years)***

FOR EAC/CRC USE ONLY

Approved by: _____ Disapproved by: _____ Date: ____/____/____