Arthritis Foundation Aquatic Program at Southern Indiana Rehab Hospital
PARTICIPANT APPLICATION FORM

Name_____

Address_____
Street City State Zip

Telephone_____
Home Business

In case of emergency who can we contact?
1._____
Name Phone Relationship
2._____
Name Phone Relationship

Type of Arthritis:_____
Precautions:_____
Medications:_____

Where did you hear about the Arthritis Foundation Aquatic Program at Southern Indiana Rehab Hospital? _____

Registration is taken on a first come first serve basis. Early registration is recommended. **No refunds will be granted.**
Make check payable to: **Southern Indiana Rehab Hospital.** Please send your completed application, along with your check to:
SIRH Arthritis Foundation Aquatic Program, 3104 Blackiston Blvd., New Albany, IN 47150

RELEASE FORM

If my application for the Aquatic Program is accepted, and I am permitted to participate in the program, I understand and agree that neither the Arthritis Foundation nor the co-sponsoring organization or facility, nor their respective chapters, officers, directors, employees, agents, members, or volunteers, shall assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in this program. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this program.
I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

_____
Name Date
I give permission to:
_____
Name of Physician
_____
Address
_____
City State Zip
_____
Phone

To complete the Physician Information Form.
_____
Signature of Participant Date

PHYSICIAN INFORMATION FORM

Your patient named below has indicated an interest in participating in the Arthritis Foundation Program. In order for him/her to do so, we ask that you please complete the section below which he/she will return to us.
This Aquatic program is a collaborative effort of the Arthritis Foundation, Kentucky Chapter and Southern Indiana Rehab Hospital. The program has been reviewed and approved by the Arthritis Foundation's Medical and Scientific Committee.

The program consists of range of motion, muscle strengthening and endurance building activities. Persons with total joint replacements, multiple joint involvement may require individualized instruction, you may want to refer him/her to a therapist prior to participation in the program. If you have questions about this matter or any other aspect of this program, please feel free to call the chapter. Thank you for your cooperation.

_____
Patient Name
_____
Diagnosis

Please indicate any special precautions or reasons why this patient should limit their participation or any reasons why, in your opinion, this patient should not participate in this Aquatic program.

_____
Physician Signature Date