Southern Indiana Rehab Hospital - Aquatic Wellness Program
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

Diagnosis:____
Precautions:____
Medications:____

Where did you hear about the Aquatic Wellness 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 the address at the bottom of this form.

RELEASE FORM

If my application for the Aquatic Wellness Program is accepted, and I am permitted to participate in the program, I understand and agree that SIRH nor its respective 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.

____
Date Signature of Participant

PHYSICIAN INFORMATION FORM

The patient named below has indicated an interest in participating in SIRH's Aquatic Wellness Program. In order for them to do so, we ask that you please complete the section below which they will return to us.

The program consists of warm water stretching, muscle strengthening, and endurance activities. If you have any questions about this matter or any other aspect of this program, please contact us
at (812) 941-6134. Thank you for your support.

____
Patient Name

____
Diagnosis

Please indicate any special precautions or reasons why this patient should limit their participation in this program.

____
Physician Signature Date

Southern Indiana Rehab Hospital
Aquatic Wellness Program
3104 Blackiston Blvd.
New Albany, IN 47150