Class: _____ **Days/Time:** _____

_____
Last Name First Name Middle Initial

_____
Address Apt.

_____
City State Zip Code

_____
Phone (home) Phone (work)

_____
Emergency Contact Phone Relationship

Medical History

Medications you are currently taking that you may need in an emergency: _____

_____

Medical conditions for which you are currently under a physician's care: _____

_____

Primary care physician name: _____ Phone: _____

Address: _____

Allergies/Allergic reactions to the following: _____

Assessment:

Do you currently exercise? _____

Have you participated in aquatic or wellness programs before? What kind? _____

1. Check any of the following conditions you now have or have had in the past:

____ Coronary heart disease	____ Heart attack, cardiac surgery	____ Rheumatic heart disease
____ Angina	____ Congenital heart disease	____ Irregular heartbeats
____ Heart valve problems	____ Heart murmurs	____ High blood pressure
____ Epilepsy	____ Low blood pressure	____ Stroke
____ High cholesterol	____ Osteoporosis	____ Diabetes ____ Pregnancy

____ Cancer/What kind? _____

____ Lung disease (asthma, emphysema, other)/What kind? _____

____ Arthritis/In what joints? _____

____ Joint replacements	____ Hip problems/pain	____ Knee problems/pain
____ Shoulder problems/pain	____ Back problems/pain	____ Dizziness

____ Other(s) (please explain): _____

2. Do you have any medical conditions for which a physician has ever recommended some restrictions on activity (including surgery—e.g., eye surgery)? Circle one: YES NO Please explain:

_____

3. Please list any and all illnesses, hospitalizations, or surgical procedures you have had within the past two years:

_____

_____
Signature of Participant/Patient/Guardian Date