HARNETT HEALTH
BETSY JOHNSON HOSPITAL
(910)892-1000 Ext. 4610
AQUATIC EXERCISE PROGRAM
APPLICATION INFORMATION

ENROLLMENT START: Month: _____ Year: _____

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: DAY: _____ NIGHT: _____

PRIMARY PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S TELEPHONE NUMBER: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

DO YOU HAVE ANY MEDICAL CONDITIONS THAT WOULD AFFECT YOUR PARTICIPATION IN THE AQUATIC EXERCISE PROGRAM? YES: _____ NO: _____

YOU MUST HAVE YOUR PRIMAY PHYSICIAN'S CLEARANCE IN ORDER TO PARTICIPATE IN THE AQUATIC EXERCISE PROGRAM.

CHECKLIST FOR ENROLLMENT:

_____ APPLICATION INFORMATION COMPLETE

_____ WAIVER SIGNED

_____ ORIENTATION COMPLETED

_____ MEDICAL CLEARANCE OBTAINED

PARTICIPANT'S SIGNATURE: _____ DATE: _____