UR MEDICINE | THOMPSON HEALTH

Medical Clearance Form

Client: _____ Physician: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Dear Physician:

Please provide the following information to assist my instructor in implementing my **prehab aquatic exercise program.** Please verify this record with your signature along with your official stamp. Thank you.

Client signature: _____ Date: _____

_____ The client **may fully** take part in an aquatic fitness program including aerobic, muscular strength, and flexibility training without restriction.

_____ The client may take part in an aquatic fitness program as described above with the following recommended restrictions (please briefly note any special concerns or precautions you advise).

_____ The client **may not** take part in an aquatic fitness program as described above.

If the client uses any medication which may reduce exercise tolerance or alter heart rate or blood pressure response during exercise, please note:

Physician Signature: _____ Date: _____

Informed Consent / Assumption of Liability Form

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You are being invited to participate in an aquatic exercise program to improve strength and flexibility and prepare you for your total joint replacement surgery. Your **participation is entirely voluntary;** you may decline to participate, and you may withdraw from participating at any time. If you agree to participate, you will be asked to perform a series of exercises and activities in our 95 degree therapeutic pool. These exercises involve activities such as walking, standing, stepping and stretching. The risk of engaging in these activities is similar to the risk of engaging in all moderate exercise. The most common risks include muscular fatigue and soreness, sprains and soft tissue injury, skeletal injury, dizziness and fainting. **However, there is also the risk of cardiac arrest, stroke and even death.**

If any of the following apply, you should **not** participate in testing without written permission of your physician:

1. Your doctor has advised you not to exercise because of your medical condition(s)
2. You have experienced congestive heart failure.
3. You are currently experiencing joint pain, chest pain, dizziness, or have exertional angina (chest tightness, pressure, pain, heaviness (during exercise)
4. You have uncontrolled high blood pressure (160/100 or above)

During the prehab aquatic exercise program you will be asked to perform within your physical "comfort zone" and never to push to a point of overexertion or beyond what you feel is safe. You will be instructed to notify the person monitoring your program if you feel any discomfort whatsoever, or experience any unusual physical symptoms such as unusual shortness of breath, dizziness, tightness or pain in the chest, irregular heartbeats, numbness, loss of balance, nausea, or blurred vision. If you are accidentally injured during exercising, the instructor will be unable to provide treatment for you other than basic first aid. You will be required to seek treatment from your own physician, which must be paid for by you or your insurance company.

You may discontinue participation in testing whenever you wish by asking to do so. By signing this form, you acknowledge the following:

1. I have read the full content of this document.
2. I have been informed of the purpose of the exercise program and of the physical risks that I may encounter.
3. I understand those risks involve muscular fatigue and soreness, sprains, and soft tissue injury, skeletal injury, dizziness, and fainting.
4. I further understand that risks also can involve cardiac arrest, stroke, and even death.
5. I agree to monitor my own physical condition during exercise and agree to stop my participation and inform the instructor if I feel at all uncomfortable, or experience any unusual symptoms.
6. Should I suffer an injury or become ill during exercising, I understand that I must seek treatment from my own physician and that I or my insurance company will have to pay for this treatment.

7. I assume full responsibility for all risk of bodily injury and death as a result of participation in exercising.

My signature below indicates that I have had an opportunity to ask and have answered any questions I may have, and that I freely consent to participate in the prehab aquatic ex program.

Signature _____ Date _____

Print Name _____

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HEALTH AND FITNESS QUESTIONNAIRE

Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Sex: _____ Age: _____ DOB: _____

Height: _____ Weight: _____

In case of emergency, contact _____

Relationship: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Please check the following items if the answer is YES and then provide further information as requested. Leave blank if NO.

_____ Has a physician told you recently that you should not exercise? If yes, why?

_____ Have you been hospitalized during the past year? If yes, why?

_____ Have you seen a physician for a medical problem within the last six months? If yes, when and why?

_____ Have you had any new illnesses or injuries within the last six months? If yes, please describe:

_____ Have you fractured any bone within the past year? If yes, which bone and on what date?

_____ Has a physician diagnosed arthritis in your case? If yes, please specify which type of arthritis (if known) and describe your symptoms?

_____ Do you often feel short of breath?
_____ Do you experience pain or discomfort in the chest?
_____ Are there any other medical concerns that you feel your instructor or trainer should be aware of in connection with your physical exercise program? If yes, please explain:

Please list all medications you are taking, including those prescribed by your doctor and all over-the-counter medications.

_____ Are you currently involved in regular exercise? If yes, please describe?

I have read and understand the previous questions and have listed to the best of my ability an accurate representation of my current health status. I am in good general health and have no limitations other than those I listed which might predispose me to risk during this program. If I experience any unusual symptoms during or following exercise, I will alert the instructor immediately. I understand that my instructor (name: _____) is the only facility representative who is familiar with my health status/history and medications in use. I will notify this instructor of any changes in my health status or medication regimen.

Signed: _____ Date: _____