

REGISTRATION INFORMATION
WASIE THERAPEUTIC SWIMMING POOL
ABBOTT NORTHWESTERN HOSPITAL/SISTER KENNY INSTITUTE



2009



Name _____ Today's Date _____

Address _____

City, _____ St _____ ZIP _____

Phone (H) _____

(W) _____

(Area Code)

(Area Code)

In case of an emergency
contact: _____

name

phone number

Diagnosis: _____

Dr. Name _____ Phone _____

Date of Dr. Order _____ (Area Code)

Medical Information:

Seizures: No _____ Yes _____ If yes, please comment:

High Blood Pressure: No _____ Yes _____ If yes, please comment:

Cardiovascular Problems: No _____ Yes _____ If yes, please comment:

Respiratory Problems: No _____ Yes _____ If yes, please comment:

Are you on any medications that may affect your exercises session? _____ If yes, please comment:

PLEASE NOTE: IF YOU HAVE THE NEED FOR A SNACK (FOR DIABETIC REACTION), NITRO TABLETS, OR ASTHMA INHALER, PLEASE BRING THESE ITEMS TO THE POOL DECK AND INFORM THE AQUATIC STAFF. THANK YOU.

Please check which program(s) will you be attending?

Arthritis Swim ARTH Community Swim COMM Fibromyalgia Aquatic Exercise Program FIBR

Senior Swim SRS Independent Aquatic Exercise Program IAE Day(s) _____ Time _____

Independent Lap Swim Program IAE Day(s) _____ Time _____

Independent Low Back Aquatic Exercise Program LB Swim Lesson LES Day _____ Time _____

Dear Doctor:

The above patient is participating in Independent Aquatic Exercise Programs at the Wasie Therapeutic Swimming Pool at Abbott Northwestern Hospital Sister Kenny Institute. An annual order is required for participation. Thank you for your signature indicating you feel that such participation would benefit the patient. This order will expire 12/31/09.

Doctor's Signature _____ Date _____

Sincerely,

Aquatic Staff Wasie Therapeutic Swimming Pool

Please return this form to the patient, email to wasielapool@allina.com, fax to 612-863-4080, or mail to:

Wasie Therapeutic Swimming Pool, 12107

Abbott Northwestern Hospital

800 28th Street

Minneapolis, MN 55407

Thank you.