

**PERSONAL INFORMATION FORM FOR  
AQUATIC EXERCISE PARTICIPANTS**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

EMERGENCY CONTACT AND PHONE: \_\_\_\_\_

Can you get your head wet? \_\_\_\_\_ If not, please give reason. \_\_\_\_\_

Can you swim underwater? \_\_\_\_\_ Are you comfortable in the deep end? \_\_\_\_\_

Can you swim the width (approximately 45 feet) \_\_\_\_\_ or length (approximately 75 feet) \_\_\_\_\_ of this pool?

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (\*PLEASE SPECIFY BELOW.)

_____ Pregnancy	_____ Diabetes	_____ Knee Injuries*
_____ Asthma	_____ Hypertension	_____ Chronic Back Problems*
_____ Arthritis	_____ Upper Respiratory	_____ Head/Neck Injuries*
_____ Epilepsy	_____ Panic Attacks	_____ Heart Illness, Angina*
_____ Hip Replacement	_____ Knee Replacement	
_____ Limited range of motion (please specify) _____		

\*PLEASE SPECIFY FROM ABOVE: \_\_\_\_\_

Other conditions: Please specify and explain. \_\_\_\_\_

Are you under a physician's care for any of the above? \_\_\_\_\_

Are you taking medication for this condition? \_\_\_\_\_ If so, please identify medication(s) by name. \_\_\_\_\_

Are you taking any other medications? \_\_\_\_\_ If so, please list. \_\_\_\_\_

I voluntarily consent to participate in Emmaus Aquatic Club Aquatic Exercise Classes. I am aware of the risks to person and property know to be associated with any of the Emmaus Aquatic Club programs and the facility, including but not limited to: the pools, tennis courts, locker rooms, common areas, revolving doors, diving boards, equipment, blocks, steps, foliage, insects, gas grills, parking lot and surrounding areas. These risks include but are not limited to: ear and eye infections, colds, abrasions, cuts, nosebleeds, burns, stings, rashes, head injuries, injured or broken limbs, paralysis and even death.

The undersigned hereby gives permission for any necessary medical care to be given in case of accident or illness. I agree to assume full responsibility for the costs of any treatment provided.

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

PHONE: \_\_\_\_\_

ALL INFORMATION KEPT CONFIDENTIAL. EMAC reserves the right to cancel classes due to minimal attendance; classes with less than four (4) participants will be reviewed and eliminated.

