**CITY OF WINTER SPRINGS**
**THERAPY POOL**
400 N. Edgemon Avenue
Winter Springs, FL 32708
Phone: 407-327-6577
Fax: 407-327-8965

# PHYSICIAN CONSENT FORM

**PARTICIPANT / PATIENT INFORMATION:**

Name: ________________________________________________ Date of Birth: _______________

Address: _______________________________________ Phone Number: ____________________

City: _________________________________________________ State: _______ Zip: _________

**PHYSICIAN INFORMATION:**

Name: ___________________________________________________________________________

Phone Number: ____________________________ Fax Number: ____________________________

Address: ________________________________________________________________________

City: _________________________________________________ State: _______ Zip: _________

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**PHYSICIAN PLEASE INITIAL:**

_________ Open Swim

_________ Low Intensity Water Exercise Classes

_________ Medium Intensity Water Exercise Classes

The above patient has my approval to participate in the above initialed water exercise classes and/or open swim which all have water temperatures ranging from 92° to 95°. Classes are approximately 45 minutes and there is no time limit on open swim.

_____________________________________________ ______________________

**Signature of Physician** **Date Signed**