PARENT-TOT PROGRAM
Wake Forest University Baptist Medical Center
Application, Medical Information, Liability Release & Parental Consent Form

Name: _____ Age: _____ Date of Birth: _____

Parent/Guardian Name: _____ Telephone: _____

Address: _____
Street City State Zip

Class will be held Tuesday at 6:00 PM

In case of emergency, contact: _____ Relationship: _____
Emergency contact's phone number: _____
Is child comfortable in the water? _____ Yes _____ No
Is parent comfortable in the water? _____ Yes _____ No
Does child have any water experience? _____ Yes _____ No
Can child float? _____ Yes _____ No _____ on front _____ on back
Has child previously worn swimmies or life jacket for comfort in the water? _____Yes _____No
Comments: _____

Release of Liability/Parental Consent Form

I, _____, hereby release, waive, discharge and covenant not to sue Wake Forest University Baptist Medical Center, North Carolina Baptist Hospitals, Inc. and Wake Forest University School of Medicine, their affiliates, agents, therapists, and other employees of the organization, other participants, sponsoring agencies, their heirs, successors and assigns, and if applicable, owners, and lessors and lessees of premises; all of which are hereinafter referred to as "releasees" from demands, losses or damages on account of injury, including death, or damage to property caused or alleged to be caused in whole or in part by the negligence of the releasee or otherwise.

I/We have read the above waiver and release, understand that I/we have given up substantial rights by signing it, have not changed it orally, and sign it voluntarily.

_____ _____
Participant's Name **Participant's Signature**

Please read and sign if participant is a minor or under the care of Person Authorized to Consent
This is to certify that I, as parent/guardian with legal responsibility for this participant, do consent and agree to his/her release as provided in favor of the Releasees, and, for myself, my heirs, assigns, and next of kin. I release and agree for myself and my minor child to indemnify and hold harmless the Releasees from any and all liabilities incident to my minor child's involvement or participation in this program as provided above.

_____ _____
Signature of Parent or Person Authorized to Consent for Participant Date

Medical Information (if applicable):

Diagnosis/Past Medical History and Surgeries: _____

Medications: _____

List special precautions (i.e. ear plugs required, feeding tubes, etc.) _____

_____

Seizure Occurrence? _____ Yes _____ No If yes, when was the last seizure? _____

How often do the seizures occur? _____ Date of last Tetanus Booster _____

Does the child use any of the following assistive devices? W/C _____ Walker _____ Crutches _____

Physician Information

Physician's Name: _____ Physician's Phone #: _____

Physician's Address: _____

You may return the completed form via mail to Aquatic Therapy, PO Box 571207, Winston-Salem, NC 27157-1207 or

By Fax to: Debbie Drayton 336-713-8193

Debbie Drayton's Office: 336-713-8190 Pool Office: 336-713-8082