

AQUATICS PROGRAM: MEDICAL CLEARANCE FORM

Overbrook School for the Blind - Health Service Department

Fax Number: 215-689-0137

Student Name: _____ Date of Birth: _____

1. _____ To my knowledge this student has no special needs that significantly increase the risk in a Aquatic Program. (skip to #3)

2. Special characteristics of the student that may influence safety in an aquatics program are checked. (please check all that apply)

_____ behavior is unpredictable

_____ fecal incontinence

_____ Gastric/GJ tube/NG tube

_____ Functional issues of musculo-skeletal system

_____ severe cognitive delay

_____ diabetes mellitus

_____ renal disease

_____ eye prosthesis

_____ seizure disorder

_____ ostomy

_____ hearing aid

_____ myringotomy tubes

_____ predisposed to infection _____

_____ potential for respiratory compromise (eg. Trach) _____

_____ impaired skin integrity _____

_____ known contagious disease _____

3. Please Check One

_____ Student has medical clearance to swim in the pool

_____ Student does not have medical clearance to swim in the pool

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____