Name: _____

Orange City Area Health System

Aquatic Exercise Risk Assessment Questionnaire

In order to provide optimal health/fitness safety standards, please check the following health risks that apply to you. Because these risk factors indicate the risk of cardiovascular disease and bodily injury, a physician approval will be required before participating in any type of wellness/aquatic program in our facility. Following review of your medical health history and risk assessment questionnaire, we will request physician approval for medical clearance prior to your participation in our aquatic program.

( ) Age: Men – greater than 45 years old; Women – greater than 55 years old.
( ) Women: Post menopausal without estrogen replacement therapy or history of cancer.
( ) Family History: Heart attack or sudden death of father, brother, or uncle before the age of 55 years of age OR mother, sister, or aunt before the age of 65 years.
( ) Heart Disease: Heart condition that requires regular check-ups with doctor or medication management of condition.
( ) Cigarette Smoker: Currently smokes OR a history of smoking in the past 12 months.
( ) Respiratory Condition: Any respiratory abnormalities that requires regular check-up with a doctor OR medication management of condition.
( ) High Blood Pressure: Greater than 140/90 mmHg on at least 2 separate occasions OR currently taking medication for high blood pressure management.
( ) High Blood Cholesterol: Total serum cholesterol greater than 200 mg/dl or HDL less than 35. (CHECK HERE IF YOU DO NOT KNOW YOUR CHOLESTEROL LEVEL.)
( ) Diabetes: Have insulin dependent diabetes OR non insulin dependent diabetes & older than 35 years.
( ) Seizure Disorder: History of seizure disorder in the past year, taking medications for seizure disorder OR history of fainting, light headedness, or dizziness of unknown cause.
( ) Musculoskeletal/Bone Joint Injury or Pain: Recent history OR chronic pain and/or injury that requires regular check-ups with a doctor or medication management of condition.
( ) Overweight: Over 20 pounds of ideal weight.
( ) Pregnancy: Currently pregnant or post-partum less than 6 weeks.
( ) Other health condition not listed above: Please list_____.

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Family Physician_____

I understand that I must obtain physician consent/medical release before participating in a wellness/aquatic exercise program. I have completed the form to the best of my knowledge and ability, and if needed, hereby authorize release of the above information to my physician to obtain a medical release before participation in any of the wellness/aquatic programs.

Signature:_____ Date:_____

.....

I have reviewed the above information provided and…….
( ) give consent for the above named to participate in an aquatic exercise program.
( ) do not recommend that the above named participate in an aquatic exercise program.

Physician Signature:_____ Date:_____

****You do <u>not</u> need to obtain your physician's signature. Return form to OCAHS and we'll submit to your physician****

Last Updated: 2/5/21