

Highland Park Hospital Health & Fitness Center
Arthritis Foundation Aquatic Program
Physician Consent Form



Dear Dr. _____:

The Arthritis Foundation is collaborating with Highland Park Hospital Health & Fitness Center in Buffalo Grove, IL, to conduct the Arthritis Foundation Aquatic Program. This series of recreational warm water pool activities will be lead by trained personnel and will cover a period of seventeen weeks. The Arthritis Foundation has approved this program. Your patient, _____, has indicated an interest in participating in this program. In order for him or her to do so, we ask that you please fill out this form and fax it back to us. The program consists of range-of-motion, muscle strengthening, and endurance-building activities that are **completed in a pool that is consistently at 93 degrees**. Persons with total joint replacements, multiple joint involvement, or moderate to severe joint involvement may require individualized instruction by a physical or occupational therapist. If your patient requires this instruction, you may want to refer him or her to a therapist prior to participation in the program.

Thank you,

The Fitness Department at Highland Park Hospital Health & Fitness Center

Please fax the form back to Attn: AFAP at 847-229-0453

Part One: For class applicant to complete

Print name: _____

I give permission to Dr. _____ to complete this AFAP Physician Consent Form and to release pertinent medical information in order for me to participate.

Date: _____ Your signature: _____

Part Two: For physician to complete

I hereby authorize my patient to participate in the AFAP & HPHHFC's program:

_____ With no restrictions

_____ With some restrictions, including: _____

_____ I do not allow my patient participate in this program.

Date: _____ Physician's signature: _____