LIU CENTER FOR PHYSICAL REHABILITATION (LIUCPR)
AGREEMENT TO PARTICIPATE IN THE
AQUATIC PHYSICAL THERAPY PROGRAM

Aquatic physical therapy can benefit individuals with a wide variety of diagnoses. This type of rehabilitation can help an individual regain function after an injury while maintaining or improving one's fitness level and allowing the body to heal. It is a safe and progressive type of rehabilitation that takes place in a gravity-eliminated or reduced environment with a diminished impact on weight–bearing joints.

Your treatment will be directed by a licensed physical therapist and will be designed based upon your specific needs as identified by your physical therapist during the initial evaluation and approved by your physician. You do not need to know how to swim to participate. Activities may include water walking or running, stabilization exercises, flotation activities and may use a variety of buoyancy or resistance equipment. General strengthening exercises using the water as resistance or assistance, depending on the goal of treatment, will also be incorporated into your program, depending on the treatment goals.

Treatment sessions will be approximately 45 minutes in duration. Supervision by the physical therapist ends once the treatment has concluded. At this time, you are to exit the pool with caution, since the pool deck and adjoining areas may be wet. Please leave yourself adequate time before and after your treatment session to allow yourself to change your clothing and attend to any personal care needs.

Risks may include, but are not limited to, allergic skin reactions, changes in blood pressure, lightheadedness, eye irritation, swimmers ear, dehydration and hyperthermia.

MEDICAL INFORMATION: (Please answer the following questions)

Do you have any physical condition that would limit your participation in this program? (If yes, please describe)

_____

Are you currently taking medication? (If yes, please give details)

_____

Do you require regular medication? (If yes, please specify)

_____

Do you have any allergies to medications, foods, or other substances? (Please describe)

_____

Please provide any other information relevant to your health, and disclose any conditions that may prevent, or be relevant to, safe participation in the aquatic physical therapy exercise program.

_____
_____
_____
_____
_____
_____
_____

I acknowledge that the above health history is correct, that I am in good health, and that I have no conditions that affect my ability to participate in any of the activities involved in the above-referenced program. I understand that I am responsible for notifying the Program coordinator immediately of any injury, sickness or other medical condition or change to the medical information herein provided.

I hereby release Long Island University/Brooklyn Campus, its Trustees, Officers, employees, administrators, agents, successors and assigns (Collectively referred to as the "University") from any and all liabilities resulting from this program. I agree that at all times I will follow the directions of "University" personnel in all matters connected with this program.

This Assumption of Risk and Consent is a legally binding agreement and will be construed broadly to provide a release and waiver to the maximum extent permissible under applicable law. Any provisions found to be void or unenforceable shall not affect the validity or enforceability of any other provisions.

I agree that the aquatic physical therapy program is a part of my physical therapy treatment, as outlined above. I have read the above information and understand that my participation is voluntary and I can chose to cease my participation at any time. I understand that participation in the aquatic physical therapy program will be based on the physical therapist's evaluation and will conclude once the treatment goals are met or my progress plateaus.

I have read and understand the "LIUCPR AGREEMENT TO PARTICIPATE IN THE AQUATIC PHYSICAL THERAPY PROGRAM". I understand that by signing below, I have given up substantial rights. I have voluntarily signed this release.

_____	_____
Patient Name (Please Print)	Date
_____	_____
Patient Signature	Signature of Parent/Guardian
_____	_____
Physical Therapist Signature (witness)	Date