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| **Lets play swim school**  **701 Kango street Erasmuskloof 076 609 7203**  **Aqua Form** | |
| NAME : | |
| SURNAME: | |
| DATE OF BIRTH: | |
| CELL NR: | |
| OCCUPATION: | |
| EMAILADDRESS | |
|  | |
| SPOUSE NAME: | |
| OCCUPATION: | |
| HOME NR: WORK NR: | |
| CELL NR: | |
| EMAIL ADDRESS: | |
|  | |
|  | |
| POSTAL ADDRESS: | |
|  | |
| RESIDENTIAL ADDRESS: | |
|  | |
|  | |
| **PERSON TO BE CONTACTED IN CASE OF EMERGENCY:** | |
| **NAME: CONTACT NR:** | |
|  | |
| **Essential information in case of Medical treatment or hospitalization** | |
| **NAME OF MEDICAL AID:** | |
| **OPTION: MEDICAL AID NR:** | |
|  | |
| **MEDICAL CONDITION** | **ADDITIONAL INFORMATION** |
|  | |
| PEGNANT IF YES HOW MANY WEEKS | | |
| HIGH/LOW BLOOD PRESSURE | | |
| CHOLESETEROL | | |
| HEART DISORDER | | |
| LUNG DISORDER | | |
| DIABETIC | | |
| ASTHMA | | |
| MASTECTOMY DATE | | |
| BREAST IMPLANTS DATE | | |
| EPILEPSY | | |
| HIP REPLACEMENT DATE | | |
| ANY OTHER HIP DISORDER | | |
| KNEE REPLAEMENT DATE | | |
| ANY OTHER KNEE DISORDER | | |
| BACK PROBLEMS PLEASE SPECIFY | | |
| BACK SURGERY DATE | | |
| HRONIC MEDICATION | | |
|  | | |
| I fully understand that the programme and exercise require rigorous physical activity and I present that my physical condition permits e to safely participate in an aqua aerobic exercise session. I agree to release the owner of Lets Play Swim School or any of its employees and their representatives from any and all liability for injuries and/ordamages arising out of the aqua aerobic session. | | |
|  | | |
| I undertake to inform the instructor on duty should there be any changes in my health condition | | |
|  | | |
| Signature: Date | | |