

**Mail or Fax to:**

**Steve Hartman**, Adapted Physical Education Instructor  
(626) 914-8685, (626) 852-8018 Fax

**OR**

**Cliff Wurst**, Adapted Aquatics Instructor  
(626) 914-8845, (626) 852-8018 Fax

*(Please Print)*

Student Name, Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

**DESCRIPTION OF DISABILITY/DIAGNOSIS:** \_\_\_\_\_

Degree of Disability:  Permanent  Temporary (45 days or greater)  Temporary (less than 45 days)

Are there any medications or side effects from medications that we should be aware of relevant to this person's participation?

Medication	Purpose	Side Effects
_____	_____	_____
_____	_____	_____

Permission to return to exercise program:  Yes  No Date: \_\_\_\_\_

The following are **EXERCISES AND/OR ACTIVITIES RECOMMENDED:**

For this student, please be specific (attach sheet if necessary):

\_\_\_\_\_  
\_\_\_\_\_

The following are **PHYSICAL OR FUNCTIONAL LIMITATIONS** (contraindicated exercises):

For this student, please be specific (attach sheet if necessary):

\_\_\_\_\_

Has this person experienced seizures in the past?  Yes  No If yes, date of the last seizure \_\_\_\_\_

Is this person currently experiencing seizures?  Yes  No

Permission to begin exercise program?  Yes  No Date \_\_\_\_\_

**ADAPTED AQUATICS ONLY**

Should any special precautions be taken?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Needs to wear nose clip                    | <input type="checkbox"/> Should <b>not</b> dive           | <input type="checkbox"/> Should <b>not</b> put head under water                        |
| <input type="checkbox"/> Needs to wear ear plugs                    | <input type="checkbox"/> Should <b>not</b> hold breath    | <input type="checkbox"/> Has allergic reaction to pool cleaning agents (i.e. chlorine) |
| <input type="checkbox"/> Needs specific water temperature _____ °F. | <input type="checkbox"/> Should <b>not</b> hyperventilate | <input type="checkbox"/> Other (explain) _____   |

\_\_\_\_\_  
Licensed/Certified Professional (type or stamp)

\_\_\_\_\_  
Signature of Licensed/Certified Professional

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Date

**ALL** information will be held in strictest confidence and will in no way interfere with the student's educational plans. Please return this form to Citrus College as soon as possible to insure a class space for this student.