



Capital Area Recreation Inc.  
Aquatics Department  
Aqua Abilities - Registration Form

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GENERAL INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex :        M        F

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: (Home) \_\_\_\_\_

(Work) \_\_\_\_\_

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MEDICAL INFORMATION

Provincial Health Card Number: \_\_\_\_\_

Doctors Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Down's Syndrome        YES        NO

Date of last Atlanto-axial Dislocation X-ray: \_\_\_\_\_

Was the X-Ray negative or positive: \_\_\_\_\_

Seizures:        YES        NO

Type: \_\_\_\_\_

Frequency: \_\_\_\_\_

Treatment: \_\_\_\_\_

Please circle for any of the following medical conditions

1. Diabetic
2. Asthma
3. Autism Spectrum Disorder (IE. ADHD, ADD, PDD, Tourette's)
4. Cerebral Palsy
5. Heart Condition
6. Amputation
7. Allergies (Please List)
8. Bowl/Bladder Control Problems
9. Other Medical Conditions

Please Specify: \_\_\_\_\_

Does the participant have or use any of the following (please circle):

GLASSES

HEARING AID

DENTURES

CONTACT LENSES

**Instructors Are Not Responsible For Looking After The Above Items**

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**MEDICATIONS**

Self Administered:    YES            NO

MEDICATION	DOSAGE	TIME(S) ADMINISTERED

**Instructors Will Not Administer Medications**

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BEHAVIOUR

Does the participant exhibit any behaviour concerns that the instructor needs to be aware of? If so, please give suggestions as to how these behaviours are best dealt with.

Behaviour

Suggestions

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PREVIOUS SWIMMING EXPERIENCE

Please list in detail previous swimming experience (IE. Public swims, lifesaving society swimming lessons etc.)

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