



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Adaptive Aquatic Participant Care Form

Participant's Name: _____

DOB: ____|____|____

Male Female Age _____

Primary Diagnosis: _____

Secondary Diagnosis (other medical conditions): _____

Parent/Guardian Name: _____ DOB: ____|____|____

Address: _____

Email: _____ Primary Phone Number: (____) _____

Communication:

Verbal Nonverbal

Comprehends:

- Gestures
- Postures
- Facial Expressions
- Spoken Words

Mobility:

- Independent
- Lower Extremity Braces
- Crutches
- Cane
- Walker

Please continue onto next page

Behavior Concerns, Sensory Aversions , Triggers, Fears, things that should be avoided:

Technique that help calm the participant:

Swimmer's strengths:

Goals for this program:

Additional suggestions:

Please describe participants previous swimming experience:

Scheduling Preferences

Days Available: Mon Tues Wed Thurs Fri Sat Sun

Desired Start Times: _____ AM PM

If you have any questions regarding our new Adaptive Aquatics program, please feel free to contact:

Gertrude Suhajda, Aquatic Director, gertrude.suhajda@glymca.org
Becca Skomski, Aquatic Coordinator, aquatic.coordinator@glymca.org
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Return Form

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