

**STAN STRONGE POOL FOR PEOPLE WITH DISABILITY**

Stan Stronge Pool provides a safe aquatic environment for individuals with disabilities. The water temperature of the main pool is 34°C and the whirlpool's temperature is between 38°C and 40°C. The facility is completely wheelchair accessible; Lifts are available for transfers, water wheelchairs are provided for using the ramp into the pool and there is a railing encircling the inside of the pool.

APPLICATION FOR POOL USE – Please print

Name: \_\_\_\_\_  
 (Last Name), (First Name)

Personal Health Number: \_\_\_\_\_

Address: \_\_\_\_\_  
 (Street) (City)

Postal Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_  
 (Day) (Month) (Year)

Legal guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
 (As applicable)

Relationship to you: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
 (Name) (Number)

Release of information: I, \_\_\_\_\_ authorize \_\_\_\_\_ to complete the following  
 (name of participant/guardian) (referring professional)

information for the purposes of registration in Stan Stronge Pool swim programs of my choice.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (participant/guardian)

**(over please...)**

<p><u>OFFICE USE</u> Date Received: _____</p> <p>Comments: _____</p>
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**The following information must be completed by a Physician, Nurse Practitioner, Physiotherapist, Occupational Therapist, Social Worker, or Recreation Therapist**

Patients's Diagnosis/Disability: \_\_\_\_\_  
(reason for needing Stan Stronge Pool)

Other conditions pool staff should be aware of (as applicable):

Epilepsy: Yes No      Shortness of Breath: Yes No  
Heart Condition: Yes No      Bladder Consideration: Yes No  
High Blood Pressure: Yes No      Bowel Considerations: Yes No  
Diabetes: Yes No

Medications (that may affect pool or hot tub activities): \_\_\_\_\_

Allergies (specify): \_\_\_\_\_

Behavioural Issues (specify): \_\_\_\_\_

Specialized Communication Methods (specify): \_\_\_\_\_

Mobility

Independent Crutches Walker Wheelchair Cane Other \_\_\_\_\_

Transfers

Independent Requires Assistance Mechanical Lift

Range of Motion

No impairment Some impairment Specify: \_\_\_\_\_

Please specify any other medical contraindications or considerations to a swimming program that Stan Stronge Pool staff should be aware of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Referring professional's name (print): \_\_\_\_\_

Phone: \_\_\_\_\_

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

Referring professional's Signature: \_\_\_\_\_

Physician  Nurse Practitioner  Physiotherapist  Occupational Therapist  Social Worker   
Recreation Therapist

Date: \_\_\_\_\_