



Brecksville Human Services Center Therapy Pool Approval Form

Use of the Therapy Pool is for individuals who have received direction from a medical professional as to a regimen of exercise they are to perform in the Human Services Therapy Pool. Because the water temperature of the Therapy Pool is approximately 95 degrees, it is necessary that the participant's physician (MD or DO only) authorizes use of the pool.

To Be Completed by the Participant:

Name _____	Date: _____		
Address _____	_____	_____	_____
street	city	state	zip
Phone () _____	Email _____		

I, the undersigned, _____, hereby agree and acknowledge that I have been fully informed by my medical professionals concerning my participation in the activities at the Brecksville Human Services Center and the use of the Therapy Pool and related facilities. I agree to abide by all the rules and regulations of the Human Services Center. The undersigned, together with my heirs, administrators, successors and assigns, do hereby individually and collectively release, indemnify and hold harmless the City of Brecksville, its officials, agents, volunteers, and employees, from any and all liability of every kind, nature and description, derived in any way from my use of the Therapy Pool and related facilities, and other activities related thereto.

Participant Signature: _____ Date: _____

To Be Completed by the Physician:

Physician's Name _____			
Office Address _____	_____	_____	_____
street	city	state	zip
Phone () _____	Fax () _____		
Therapy Prescribed _____	_____		
Additional Health Considerations _____	_____		

I, _____, am the personal physician for the above named individual. I have devised and/or approved an exercise regimen for the above named individual which includes the use of the Therapy Pool located at the Brecksville Human Services facility. I am aware of that the water temperature of the Therapy Pool is approximately 90 degrees and the ambient air temperature in the area around the Therapy Pool is approximately 95 degrees. I hereby authorize my patient's participation in activities which utilize the Therapy Pool in accordance with the instructions given to my patient.

Physician's Signature: _____ Date: _____