



SWIMMER APPLICATION

SPECIALIZED WATER INTEREST MOVEMENT, INC.,
120 FINDERNE AVENUE BRIDGEWATER, N.J. 08807 • (908) 685-0040

Date : _____
 Name : _____ Marital Status: _____
 (please print)
 Address: _____ Phone: () _____
 _____ Zip Code: _____
 Mobility: Good _____ Cane _____ Crutches _____ Walker _____ Wheelchair _____
 Person to contact in case of emergency: _____
 Address of above: _____ Phone: () _____
 Email address: _____

RELEASE FORM FOR S.W.I.M., INC. PROGRAM

"In consideration of your acceptance of this application and of the provision to me of aquatic exercise and other important services by S.W.I.M., Inc., its officers, directors, volunteers and agents, I hereby waive, release, remise, and discharge on behalf of myself, my heirs, my executors, and my administrators all claims for damages and otherwise that I may come to have against S.W.I.M., Inc., its officers, directors, volunteers, and agents, and/or any entity or individual providing facilities and services to S.W.I.M., Inc., for the conduct of its programs, by reason of any damage, injury, illness or death that I may suffer or come to suffer as result of participating in any S.W.I.M., Inc. program."

"I understand that as a result of the disabilities from which I suffer, S.W.I.M., Inc., its officers, directors, volunteers, and agents would not permit me to participate in S.W.I.M., Inc. programs or use S.W.I.M., Inc. facilities, except for my assumption of all risks of participating in programs conducted or

sponsored by S.W.I.M., Inc., and of using the facilities being provided by S.W.I.M., Inc., or being made available to S.W.I.M., Inc. for its programs."

I understand that my picture may be used for marketing purposes.

Read, understood, and agreed:

Swimmer Signature
 Please give this form to your Chapter Coordinator.

MEDICAL AUTHORIZATION

Please Print

1. Full Name of Diagnosis: _____
2. Does above have your permission to participate in S.W.I.M. Inc. aquatic exercise program? Yes _____ No _____
3. Any restrictions necessary? Yes (what) _____ No _____
4. Comments _____

Doctor Signature: _____ Phone: () _____
 Address: _____ Date: _____

Coordinator Comments: _____
 S.W.I.M. Representative accepting application: _____
 Chapter: _____

A signed copy of this form is necessary for your admission to chapter sessions in other pools.
Aquatic Exercise Programs for Adults with Mobility Impairments