**Movement Matters:**

**Physiotherapy for Children Pty Ltd**

ABN 42 161 869 841

PO Box 268, Brompton SA 5007

[www.movementmattersphysio.com.au](http://www.movementmattersphysio.com.au/)

**AQUATIC PHYSIOTHERAPY (HYDROTHERAPY)**

 **MEDICAL CONSENT FORM**

Child’s first name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |

Child’s DOB: \_ \_ / \_ \_ / \_ \_ \_ \_ NDIA No:

Parent(s) name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home address: ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best family member and contact phone number in an emergency: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the above child confident and safe in a pool/around water?

Please circle **YES / NO** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you (the parent/carer) confident and safe if required to be in a pool/around water?

Please circle **YES / NO** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consider that the above child would be medically safe in the water?

Please circle **YES / NO**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Main Diagnosis** (if known) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All other diagnoses present:**

***List and describe ALL medications the child is currently taking*:**

*The Australian Physiotherapy Association, Guidelines for Physiotherapists working in and/or managing hydrotherapy pool (2002),* [*http://almacen-gpc.dynalias.org/publico/Guia%20australiana%20de%20hidroterapia.pdf*](http://almacen-gpc.dynalias.org/publico/Guia%20australiana%20de%20hidroterapia.pdf) *, identified the following as screening issues prior to an individual participating in hydrotherapy.*

*Please consider the following and give your opinion regarding whether the issue(s) are relevant as precautions or contraindications to this child participating in hydrotherapy with a physiotherapist.*

|  |  |  |
| --- | --- | --- |
| **Body System** **(including some examples)** | **Issues relevant to this client that are definite contraindications and/or possible solutions to facilitate participation** | **If YES, please provide** **further Information** |
|  | **CHILD** | **ADULT / PARENT** |  |
| Cardiovascular system:* cardiac conditions
* uncontrolled BP
 | Yes / No | Yes / No |  |
| Respiratory system:* asthma
* tracheostomy
* poor cough or swallow
* chronic lung disease/O2 required
 |  Yes / No | Yes / No |  |
| Central nervous system:* epilepsy
* fluctuating tone
* CP shunt
 |  Yes / No |  Yes / No |  |
| Gastro-intestinal tract:* faecal incontinence
* gastroenteritis
* reflux/feeding concern
 |  Yes / No | Yes / No |  |
| Genito-urinary:* urinary incontinence
* menstruation
* pregnancy
 | Yes / No |  Yes / No |  |
| Infectious conditions:* airborne infections
* MRSA, Hepatitis
* any other...................
 | Yes / No |  Yes / No |  |
| Skin:* open wound
* rashes
* chemical sensitivity
* tinea or plantar warts
 | Yes / No |  Yes / No |  |
| Ears and eyes:* visual impairments
* hearing impairments
* grommets
* regular infections
 | Yes / No |  Yes / No |  |
| Other medical issues:* heat sensitivity
* fear water
* cognitive concerns
* behavioural concerns
 | Yes / No |  Yes / No |  |

I believe this child and/or parent/carer is/are safe to participate in hydrotherapy supervised by a physiotherapist.

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

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Medical Practitioner/Specialist/Parent)