**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)