



REHABILITATION INSTITUTE OF SOUTHERN CALIFORNIA
Adaptive Swim Lesson Registration Form

Client Last Name: _____ First Name: _____

Address: _____ City: _____ Zip _____

Home Phone number (____) _____ Date of Birth _____ Sex: Male ___ Female ___

Today's Date: _____ Start Date: _____ Schedule M ___ T ___ W ___ Th ___ Fri ___ Times: _____

PARENT/GUARDIAN

Client Last Name: _____ First Name: _____

Address: _____ City: _____ Zip _____

Relationship _____

Who should we contact in an emergency (Must have at least two)

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

List any physicians currently treating you:

Name: _____ Type/Specialty _____

City: _____ Phone _____

Name: _____ Type/Specialty _____

City: _____ Phone _____

Name: _____ Type/Specialty _____

City: _____ Phone _____

List any medical conditions:

Diagnosis: _____

List any allergies conditions:
