

**REBOUND THERAPY**

**CONSENT & MEDICAL FORM**

**Participants name: ………………………………………………………….. Date of Birth: ……………….**

|  |  |  |  |
| --- | --- | --- | --- |
| **Does the participant have any of the following** | **YES** | **NO** | **Comments** |
| Spinal rodding  |  |  |  |
| Dwarfism |  |  |  |
| Brittle bones |  |  |  |
| Pregnancy  |  |  |  |
| Atlanto-axial instability (confirmed) |  |  |  |
| Detaching retina(s) |  |  |  |
| Detached retina)s) |  |  |  |
| Osteoporosis |  |  |  |
| Haemophilia |  |  |  |
| Cardiac or circulatory problems  |  |  |  |
| Epilepsy |  |  |  |
| Arthritis or Stills Disease |  |  |  |
| Asthma / respiratory problems  |  |  |  |
| Cystic Fibrosis |  |  |  |
| Muscular Dystrophy |  |  |  |
| Spina Bifida or Hydrocephalus |  |  |  |
| Changeable muscle tone |  |  |  |
| Dislocated hip(s) / other joint problems  |  |  |  |
| Vertigo, blackouts, nausea  |  |  |  |
| Hernia / prolapsed |  |  |  |
| Open wound(s) |  |  |  |
| Gastrostomy |  |  |  |
| Incontinence  |  |  |  |
| Tracheostomy  |  |  |  |
| Recent serious illness / surgery  |  |  |  |
| Tender / Fragile skin |  |  |  |
| Implant (e.g. Baclofen pump) |  |  |  |

***If you answer yes to any of the above conditions we will need a letter from a medical professional authorising participation in rebound therapy***

Continued overleaf …….

Are there any other conditions / information which we should be aware?

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**CONSENT**

I give my consent for the person named on this form to take part in Rebound Therapy sessions and I understand that it is my responsibility to inform the school of any changes to their condition.

**This information was provided by: ………………………………………………….. (Please print)**

**Relationship to the participant : ……………………………………………………..**

**Signed: …………………………………………………… (Parent / Carer)**

**Date: ……………………………………………………..**