NEW YORK STATE | Helen Hayes Hospital

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Commissioner of Health

**SALLY DRESLIN, M.S., R.N.**
Executive Deputy Commissioner of Health

**EDMUND J. COLETTI**
Chief Executive Officer

Dear Community Participant,

Thank you for your interest in the Community Pool Program at Helen Hayes Hospital. Our pool is a 25 x 60 foot deep, warm water pool. Its bottom progresses from 2.5 feet to 5 feet allowing accessibility to those of all abilities. The pool features an accessible lift and stairways fitted with handrails. A lifeguard is on duty at all times.

Our community pool offers an array of different services, designed to meet your individual needs, including independent pool exercise time, adapted fitness pool groups, and individual one on one sessions with our recreation therapist you can join. One on one sessions you must sign up for separate and there is an additional cost. Pool hours vary each day and group times are set throughout the week to accommodate all.

Group sessions are held daily during open pool times, there are morning and or afternoon groups held throughout the week. Each group may have a different focus or plan each day on type of exercises offered. A monthly schedule is located outside the pool on the bulletin board, please refer for the group that best meets your needs. Remember to check each month as we try to vary and keep things new in the groups each month.

**The Enrollment Process and Fees of Community Pool at Helen Hayes:**

To join there is a monthly charge, you may sign up to come one, two or three to five times weekly. If you are a community pool member, you may also sign up for one-on-one exercise sessions with our recreational therapist. One-on-one sessions include a brief meeting with the therapist prior to design an exercise program just for you and your needs, this can be done by phone.

1 day a week - $30 (any day you choose, you may vary day each week)

2 days a week - $60 (any 2 days—and you can vary day)

3 or more days a week- $90 (receive up to 5 days a week for price of 3)

Drop in/extra day rate $15 per day

1:1 with Recreation Therapist session fee - $40 per 1 hour session

To enroll in Community Pool please read, fill out and sign all community enrollment forms in the enrollment packet. Please include your address and an emergency contact. You may email the forms to **alyssa.chagares@helenhayeshosp.org** or deliver them back to the pool office. Upon acceptance into the community pool at Helen Hayes, you will receive notification of your start date.

For additional information, please contact Alyssa Chagares at 845-786-4457. Thank you for your interest. We look forward to having you join our Community Pool.

HELEN HAYES
HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

# Aquatic Exercise Program

## Community Pool Rules

1. Lifeguard must be present whenever pool is in use.
2. No diving.
3. No jumping.
4. Health Department rules for sanitation and safety must be observed by every patron. Persons with skin lesions, inflamed eyes, nose, mouth, ear discharges, or bandages may not swim in the pool.
5. Patrons must be continent of bowel and bladder.
6. Maximum number of bathers permitted is 50 (fifty).
7. No running on the deck.
8. No food or drink in the pool area or locker rooms.
9. No glass in the pool area.
10. Only persons in the proper bathing attire permitted in the pool, no street clothes in the pool area for example no cut off jeans or rolled-up pants.
11. No bare feet on the deck or dressing area. Non-slip shoes must be worn on pool deck and locker rooms.
12. No personal hair dryers allowed in locker rooms.
13. No gum chewing in the pool area or locker rooms.
14. No cell phones in pool, on pool deck or in locker rooms.

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# Aquatic Exercise Program
## Intake Form

Patient Name: _____ Date of Birth: _____

**Absolute Contraindications**

Do you have a history/presence of any of the following:

| | YES | NO |
|---|---|---|
| 1. Uncontrolled Seizures | ❑ | ❑ |
| 2. Incontinence of urine or feces, or unsuccessful bladder/bowel regimen? | ❑ | ❑ |
| 3. Any lines, drains or tubes? | ❑ | ❑ |
| 4. Acute infection (including conjunctivitis) | ❑ | ❑ |
| 5. Wounds with draining tubes? | ❑ | ❑ |

**Relative Contraindications**

Do you have a history/presence of any of the following:

| | YES | NO |
|---|---|---|
| 1. Open wounds that cannot be covered by op-site bandage (>2.5cm)? | ❑ | ❑ |
| 2. Tracheostomy | ❑ | ❑ |
| 3. Repeated Syncope | ❑ | ❑ |
| 4. Chlorine or chemical sensitivity? | ❑ | ❑ |
| 5. Sensitivity to heat/humidity? | ❑ | ❑ |
| 6. Autonomic dysreflexia? | ❑ | ❑ |
| 7. Symptomatic hypotension? | ❑ | ❑ |
| 8. Uncontrolled or severe cardiac conditions? | ❑ | ❑ |
| 9. Active DVT(s)? | ❑ | ❑ |
| 10. Severe renal dysfunction? | ❑ | ❑ |
| 11. Severe respiratory dysfunction? | ❑ | ❑ |
| 12. Hydrophobia? | ❑ | ❑ |
| 13. Fever? | ❑ | ❑ |
| 14. Transdermal pain patch? (cannot be worn in the pool) | ❑ | ❑ |

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HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

# Aquatic Exercise Program
## Participant Agreement

**RETURN TO POOL STAFF**

This agreement is made with

Participant: _____ Date: _____

**It includes the terms and conditions for participation in the Helen Hayes Hospital Aquatic Exercise Program as follows:**

**I. Attendance:**

I understand that:

A. The open format is based on a schedule with the month ending the last day of the month;

B. The fee is **NOT** pro-rated for missed classes;

C. There are **NO** refunds of any payment.

**II. Bathing Attire, Valuables and Shower Room Practices**

A. I will bring my own bathing suit, towel and **non-slip pool shoes** to each session.

B. I understand that if I am incontinent of urine I must supply and wear a diaper and rubber pants under my bathing suit. (If incontinent of feces-cannot participate unless on bowel regimen that is working).

C. I understand that I must bring someone to assist me if I am not independent in dressing/ undressing. (There will be no one available to assist me in the shower room).

D. I understand that both changing areas are co-ed to allow family members to assist participants as needed.

E. I will **not** disrobe or remove my bathing suit in the shower area or general locker room areas. Curtained areas have been provided for changing.

F. I am responsible for my valuables. There are lockers available for my use on which I can put my own lock. I must remove the lock before I leave. (Helen Hayes Hospital staff will remove any locks left on after a session has ended).

G. I will wear non-slip pool shoes at all times on the deck, in the pool and in the locker rooms.



**III. Pool Rules**

A. I understand that I must abide by the Helen Hayes Hospital community pool rules (see attached) **at all times**. If I fail to abide by the rules, my right to participate in this program will be jeopardized.

B. I understand that I may only use pool equipment approved for me by a HHH staff member.

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## IV. Medical Status

A. I understand that I must complete an Aquatics Intake Form (attached) before attending the aquatics program.

B. I understand that, if I have any open draining wounds or emergent skin conditions, I will not be able to go into the pool due to the risk of myself and others.

C. I understand that I am responsible for ensuring that Helen Hayes Hospital is informed of any medical problems which may impact on this program. I am also responsible for informing Helen Hayes Hospital of any medical problems which arise after my referral has been signed and reviewed. Failure to inform Helen Hayes Hospital will lead to my privileges being revoked.

D. I have read and understand all precautions contraindications of the pool. I understand I must abide by these recommendations and risk termination in the community pool program if I don't.

## V. Payment Agreement

A. All payments are due in advance by the 15th of the month for the following month you would like to attend. **You will not receive a bill.** There is a $25 fee for returned checks.

B. Pool participants **must** call the Aquatics Director at (845) 786-4457 to make arrangements to re-start this program.

C. **The fee is NOT billed to insurances**; it is a self-pay program. There is no carry over of make-up days into the next month.

D. You are welcome to attend your weekly session(s) any day/time we are open. **We are unable to offer a refund for any reason**, including temporary illness, traveling out of town or re-location.

E. All payments and completed payment forms may be put in an envelope and placed in the locked mailbox in the Pool Office or mailed to:

Helen Hayes Hospital, Rt. 9W
West Haverstraw, N.Y. 10993
Attn. Pool.

**Participant Contact:**

Name: _____

Address: _____

_____

Phone: _____

**Emergency Contact: (REQUIRED; PLEASE PRINT)**

Name: _____

Address: _____

_____

Phone: _____

Relationship: _____

How did you learn about this program? _____

I agree to participate in the Helen Hayes Hospital Aquatic Exercise Program to the best of my ability and agree to my responsibilities as outlined above.

_____
Participant Signature — For up to date info, please provide your E-mail

_____
Participant Name — Date

_____
Aquatic Director — Date

HELEN HAYES HOSPITAL

Helen Hayes Hospital, Route 9W, West Haverstraw, NY 10993

# Aquatic Exercise Program
## Payment Form

Name (please print): _____

Address: _____

(required if using credit card/want receipt)

**For Month of:** _____

Make checks payable to: ***Helen Hayes Hospital*** with ***Community Pool*** written in memo section.

Need receipt? ❑ Yes ❑ No

Check appropriate box for individual membership:

❑ $30 for 1x / week
❑ $60 for 2x / week
❑ $90 for 3 x 5x / weeks
❑ Ai Chi $30 for 1x / week
❑ One-on-One CTRS $40 / session
❑ $15 / day drop in rate

_____

Cashier's Signature (This signature verifies receipt of payment) Date

**CREDIT CARD PAYMENTS MUST BE requested on this form.**
**Payment CANNOT be accepted verbally over the phone.**

Name as it appears on the credit card:

FIRST NAME: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ MIDDLE INITIAL ☐

LAST NAME: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

TYPE OF CARD: ☐ VISA ☐ MASTERCARD

POOL
09/2018

CARD NUMBER: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

EXPIRATION DATE: MONTH: ☐☐ YEAR: ☐☐☐☐

DOLLAR AMOUNT TO BE CHARGED: $ ☐☐☐ . ☐☐

_____

Cardholder's Signature Date

Payment for Month of: _____