Louisiana College Water Fitness Program Schedule

Time	Monday	Tuesday	Wednesday	Thursday	Friday
6:00 AM	Lap Swimming	Lap Swimming		Lap Swimming	Lap Swimming
7:00 AM	Lap Swimming	Lap Swimming	Lap Swimming	Lap Swimming	Lap Swimming
8:00 AM	Fit & Fun (Shallow)	Fit & Fun (Shallow)	Volleyball	Volleyball	Fit & Fun (Shallow)
9:00 AM	Fit & Fun	Fit & Fun	Fit & Fun	Volleyball	Fit & Fun
	(Shallow/Deep)	(Shallow/Deep)	(Shallow/Deep)	Fit & Fun (Deep)	(Shallow/Deep)
10:00 AM	*AFP Arthritis	*AFP Arthritis	*AFP Arthritis	*AFP Arthritis	
	(Shallow)	(Shallow)	(Shallow)	(Shallow)	
5:00 PM	Fit & Fun	Fit & Fun		Fit & Fun	
	(Shallow/Deep)	(Shallow/Deep)		(Shallow/Deep)	

AFAP Arthritis Foundation Aquatic Program
****AFAP-Plus Arthritis Foundation Aquatic Program Plus***
$35 fee a month
$40 one-time registration fee for new participants.

Louisiana College Water Fitness Program
Registration Form

Date_______________

Name________________________________ Email________________________________

Address________________________________ City____________________ State______ Zip__________

Home Phone (________)________________________ Cell (_______)________________________

Occupation________________________________ Referred by: ☐ Doctor ☐ Friend ☐ Brochure ☐ Media

Class Preference: ☐ Arthritis Aquatic Program ☐ Fitness/Recreation ☐ Rehabilitation

Participant Release Form

I understand that upon the acceptance of my application and participation in the Louisiana Water Fitness Program, I have agreed that Louisiana College officers, directors, employees, agents, members or volunteers shall not assume or have any responsibility or liability for expenses of medical treatment or for compensation for any injury I may suffer during, or resulting from, my participation in this program. I do hereby, for myself, my heirs, executors and administrators, waive, release and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of, or in any way connected with, my participation in this program.
I also represent and warrant that I may have been advised to see consultation with my doctor about whether I can safely participate in this program and whether there are any precautions or limitations to my participation.

Signature________________________________ **Date**______________________

Physician's Name________________________________ **Phone (   )**______________________

Address________________________________

City________________________________

Physician's Script Required________________________________

Sandy Rachal
Lisa Delrie
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