



Medication (active ingredient, brand, dosage, since when, effects, possible side-effects):

Are there any reactions to the medication in terms of over-sensitivity or paradoxical?

Which doctors are involved in your child's treatment? (name, specialty, hospital/ practice, address, phone number, kind of treatment/ guidance). Please indicate which doctor is involved the most in your child's treatment. We call this the main physician and this doctor needs to fill in part 2 of this form.

Which therapists are involved in your child's treatment? (name, specialty, hospital/ practice, address, phone number, kind of treatment/ guidance) Please indicate which therapist is involved the most in your child's treatment.

Which previous therapies has your child received? What was the period and what were the effects?

Questions about the functioning of your child.

	Yes	No
Can your child see?	<input type="checkbox"/>	<input type="checkbox"/>
Can your child hear?	<input type="checkbox"/>	<input type="checkbox"/>
Can your child hold up his/her head by him/herself?	<input type="checkbox"/>	<input type="checkbox"/>
Can your child sit by him/herself?	<input type="checkbox"/>	<input type="checkbox"/>
Can your child stand by him/herself?	<input type="checkbox"/>	<input type="checkbox"/>
Can your child walk by him/herself?	<input type="checkbox"/>	<input type="checkbox"/>
Can your child talk?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child understand language?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child follow instructions?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child aggressive towards animals?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child aggressive towards people?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child aggressive towards him/herself?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child sleep during daytime?	<input type="checkbox"/>	<input type="checkbox"/>
Is your child afraid of water?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child have detachment fear?	<input type="checkbox"/>	<input type="checkbox"/>



Questions about Dolphin Assisted Therapy

Has your child ever followed Dolphin Assisted Therapy?

If yes; where and when?

What were the results of the previous Dolphin Assisted Therapy sessions (please provide report if possible)?

Does your child like being in water (swimming pool, the sea) or is he/she afraid?

How would you describe your child's swimming abilities? Does he/she have swimming diplomas?

Does your child have experience with water therapy? If yes, how did this evolve and what was the effect?

How do you think your child will react on swimming with a therapist and a dolphin in seawater that is 3 meters deep (and without father or mother)?

What are your expectations of the effect of the Dolphin Assisted Therapy on your child?

Do you have any other remarks or questions that may be relevant to the question of whether dolphin assisted therapy is a good option for your child?



Please indicate your preferred periods of therapy.

Please realize that your indicated date preferences can not be guaranteed; this depends on availability.

Preference 1 Year: Period number + date:

Preference 2 Year: Period number + date:

Preference 3: Year: Period number + date:

To improve our information, we would like to investigate how people have become acquainted with the CDTC. That is why we would like to know how you heard about CDTC:

- Website
- Flyer
- Poster
- Other parents
- Physician/therapist/hospital
- School or daycare
- Internet
- Otherwise, name

The undersigned states by signing this form, that he/she has read and is fully aware of the contents of this Medical, Treatment and Safety form and in responsibility to the child is requesting Dolphin Assisted Therapy at the CDTC. The undersigned states that he/she agrees with the general terms of CDTC and by signing hereby releases CDTC, it's agents, officers and employees from any liability and claim, regardless of it's cause arising from of or connected to his/her child's participation in the therapy program with the CDTC. And limits its liability to the amount given by the liability insurance of the CDTC.

- Undersigned states by signing this form, that he/she has read and is fully aware of the contents of this Medical, Treatment and Safety form and in responsibility to the child is requesting Dolphin Assisted Therapy at the CDTC.**
- Undersigned states to be aware of and in agreement with the information mentioned on the CDTC website under the header "Medical".**
- Undersigned states that he/she agrees and has accepted with the general conditions of CDTC.**

Please mark the little squares for acknowledgement.

Name:

Date:

Signature Parent/ Guardian of participant: