CURAÇAO DOLPHIN THERAPY & RESEARCH CENTER N.V.
("CDTC")
At the Curaçao Sea Aquarium Park

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APPLICATION FORM PART 1

To be filled in by the participant, parents, representatives or guardians

CDTC considers the environment and kindly request you to limit your prints to only the last page of this document for your signature. All questions can be answered digitally. Click on the answer box and enter your information. Thank you for your cooperation!

PERSONAL INFORMATION

Last name:

First name:

Street:

Zip code:

City:

Country:

Date of birth:

Gender:

Phone (during the day):

Fax:

Phone (in the evening):

E-mail:

Insurance company:

Which languages do you/does the participant speak/understand?

Are you/the participant living at home? If so, with whom do you/the participant live?
(Include names and if applicable: age of siblings (date of birth)

If not, where and with whom do you/the participant live?

MEDICAL INFORMATION

Age: Weight: Lenght:

Diagnosis and relevant medical information:

Since which age have you/has the participant been disabled? What is the cause of the disability?

Relevant medical history: (hospitalization, operations, examinations; when and why?)

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

Are there any over-sensitive or paradoxical reactions to the medication?

QUESTIONS ABOUT YOUR/THE PARTICIPANTS FUNCTIONING

Can you/the participant see?	Yes	No
Can you/the participant hear?	Yes	No
Can you/the participant hold up his/her head by your-/him-/herself?	Yes	No
Can you/the participant sit by your-/him-/herself?	Yes	No
Can you/the participant stand by your-/him-/herself?	Yes	No
Can you/the participant walk by your-/him-/herself?	Yes	No
Can you/the participant talk?	Yes	No
Do you/does the participant understands language?	Yes	No
Do you/does the participant follow instructions?	Yes	No
Are you/is the participant aggressive towards animals?	Yes	No
Are you/is the participant aggressive towards people?	Yes	No
Are you/is the participant aggressive towards your-/him-/herself?	Yes	No
Are you/is the participant afraid of water?	Yes	No
Do you/does the participant have separation anxiety?	Yes	No
Do you/does the participant sleep during daytime?	Yes	No

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

Which previous therapies have you/has the participant received? In which period were they and what were the effects?

QUESTIONS ABOUT DOLPHIN ASSISTED THERAPY

Have you/has the participant ever participated in the dolphin assisted therapy program?

What were the results of the previous dolphin assisted therapy sessions)?

Do you/does the participant like being in water (the sea) or are you/is he/she afraid of it?

How would you describe your/the participants swimming abilities? Do you/does the participant have swimming diplomas?

Please describe also the swimming abilities of the siblings.

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Do you have/does the participant have experience with water therapy? If yes, how did this evolve and what was the effect?

How do you think you/the participant will react on swimming with a therapist and a dolphin is seawater that in 3 meters deep?

What are your/the participants expectations of the effect of the dolphin assisted therapy?
If improvement of communication is a goal/expectation, if existent, please bring the communication device you are using at home.

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

Please indicate your preferred periods of therapy.
Please consult the schedule on our website www.cdtc.info for possible dates and the serial number of the period. The therapy normally starts on Monday and ends on Friday two weeks later. These periods are numbered on the schedule as serial 1 to serial 25. Per year there are 25 2-week periods, not counting the last week of December and the first week of January.
Please realize that your/the participants indicated date preferences cannot be guaranteed; these depend on availability. After confirming your/the participants therapy period please note that although CDTC is always considering therapy families requests we cannot give any guarantee for therapy time, a specific therapist and/or a particular dolphin.

Preference 1 Year: Period number:

Preference 2 Year: Period number:

Preference 3 Year: Period number:

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

- Social Media
- Website
- Media
- Flyer
- Fair, if yes, which one?
- Google
- Informative evening
- Other parents
- Physician/therapist/hospital
- School/daycare
- Other

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 participant 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 form any liability and claim, regardless of its cause arising from of/or connected to his/her participant participation in the therapy program with the CDTC and limits its liability to the amount given by the liability insurance of the CDTC.

- **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 participant is requesting Dolphin Assisted Therapy at the CDTC.**

- **The undersigned hereby declares that this form has been completed truthfully. If it appears that the form has not been filled in truthfully, participation in the therapy cannot be guaranteed.**

- **The undersigned states that he/she agrees and has accepted with the general conditions of CDTC.**

Name:

Date:

Signature participant, parent, representative or guardian: