WAIVER, RELEASE OF LIABILITY, AND ASSUMPTION OF RISK

When used properly, the facilities and activity programs offered by the Student Health and Wellness Center have been designed to provide the optimum level of beneficial exercise and enjoyment. Inherent in any exercise program, however, is the risk of injury through improper use of the equipment or imprudent exercise beyond your capability. Prior to beginning this program, you will be instructed in the proper use of all equipment and will be taught how to monitor your heart rate and minimize any risk on the part of the Health and Wellness Center. It is important that you learn these tasks and faithfully and regularly incorporate them into your exercise program.

Since many individuals are unaware of the state of their physical health, it is recommended that you consult with your physician before engaging in any activities that are part of the Fitness Program.

In consideration of the above factors, I, the undersigned participant, acknowledge the existence of risks connected with the exercise programs and activities that take place in the Health and Wellness Center. I agree to assume such risks and agree to accept the responsibility for any injuries sustained by me or my dependents in the course of using the facilities and equipment. More specifically, I acknowledge and accept responsibility for injuries arising out of those activities that involve risks in one or more of the following general areas:

(a) the use of exercise equipment;
(b) participation in the unsupervised activities which are made available on the running track, in the gym, and in other individual or group exercise activities;
(c) participation in individual or joint exercising which could result in such injuries or disorders as heart attack, stroke, heart stress, sprains, broken bones, torn muscles, torn ligaments, etc.
(d) accidents occurring within the auxiliary facilities such as locker rooms, dressing rooms and showers.

I further acknowledge the existence of and need for certain rules and procedures concerning the use of the equipment, facilities and activities of the Health and Wellness Center. I agree to abide by those rules and procedures and shall make every effort to ensure that the equipment and facilities are kept in a safe and useable condition.

HAVING READ THE FOREGOING, I ACKNOWLEDGE MY UNDERSTANDING OF THOSE RISKS SET FORTH ABOVE AND KNOWINGLY AGREE TO ASSUME FULL RESPONSIBILITY FOR SAME.

Dated this ______day of _________________, 20______.

Participant Signature:  __________________________________
Spouse Signature:  __________________________________
Dependant 1 Signature:  __________________________________
Dependant 2 Signature:  __________________________________
Dependant 3 Signature:  __________________________________
Wellness Center Official:  __________________________________
PRIMARY PARTICIPANT

YOUR HEALTH AND FITNESS

Physician Name: ____________________________ Physician Phone: ____________________________ Date of Last Physical: ____________________________

Do you have any health conditions? (Please circle) YES or NO
If you answered yes to the above questions please explain:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you presently involved in a regular exercise program? YES NO

___________________________________________________________________________________________

List all drugs/medications you are taking and the reason:
1._________________________________  2._________________________  3.__________________________

Are you aware of any allergies to any medications? Y N If yes, please list:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you aware of any allergies to any medications? Y N If yes, please list:

___________________________________________________________________________________________

___________________________________________________________________________________________

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature ____________________________  Date ____________________________

SPOUSE

YOUR HEALTH AND FITNESS

Physician Name: ____________________________ Physician Phone: ____________________________ Date of Last Physical: ____________________________

Do you have any health conditions? (Please circle) YES or NO
If you answered yes to the above questions please explain:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you presently involved in a regular exercise program? YES NO

___________________________________________________________________________________________

List all drugs/medications you are taking and the reason:
1._________________________________  2._________________________  3.__________________________

Are you aware of any allergies to any medications? Y N If yes, please list:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you aware of any allergies to any medications? Y N If yes, please list:

___________________________________________________________________________________________

___________________________________________________________________________________________

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature ____________________________  Date ____________________________

DEPendant 1

YOUR HEALTH AND FITNESS

Physician Name: ____________________________ Physician Phone: ____________________________ Date of Last Physical: ____________________________

List any health conditions you may have including drugs/medications you are taking:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you aware of any allergies to any medications? Y N If yes, please list:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you presently involved in a regular exercise program? (Please circle) YES or NO
If yes, please list activities/duration/frequency/intensity

___________________________________________________________________________________________

Are there any other comments you would like to give concerning your health history or fitness goals?

___________________________________________________________________________________________

___________________________________________________________________________________________

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature ____________________________  Date ____________________________

DEPendant 2

YOUR HEALTH AND FITNESS

Physician Name: ____________________________ Physician Phone: ____________________________ Date of Last Physical: ____________________________

List any health conditions you may have including drugs/medications you are taking:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you aware of any allergies to any medications? Y N If yes, please list:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you presently involved in a regular exercise program? (Please circle) YES or NO
If yes, please list activities/duration/frequency/intensity

___________________________________________________________________________________________

Are there any other comments you would like to give concerning your health history or fitness goals?

___________________________________________________________________________________________

___________________________________________________________________________________________

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature ____________________________  Date ____________________________

DEPendant 3

YOUR HEALTH AND FITNESS

Physician Name: ____________________________ Physician Phone: ____________________________ Date of Last Physical: ____________________________

List any health conditions you may have including drugs/medications you are taking:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you aware of any allergies to any medications? Y N If yes, please list:

___________________________________________________________________________________________

___________________________________________________________________________________________

Are you presently involved in a regular exercise program? (Please circle) YES or NO
If yes, please list activities/duration/frequency/intensity

___________________________________________________________________________________________

Are there any other comments you would like to give concerning your health history or fitness goals?

___________________________________________________________________________________________

___________________________________________________________________________________________

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Participant Signature ____________________________  Date ____________________________