WAIVER RELEASE

It is recommended that men over the age of 40 and women over the age of 50 consult a physician before beginning any exercise or fitness program. It is also recommended that anyone over the age of 50 receive annual physical evaluations by their physician. Follow the exercises carefully and exercise at your own pace. If you feel any strain, acute pain, dizziness, light-headedness, stop exercising and inform a staff person. Follow up by consulting your physician.

HARTLAND COMMUNITY EDUCATION - FITNESS PROGRAM - PARTICIPANT AGREEMENT, RELEASE AND ACKNOWLEDGEMENT OF RISK

In consideration of the services of Hartland Community Education (Senior Center) (CE) their employees, volunteers, participants, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as CE), I hereby agree to release and discharge CE on behalf of myself, my children, my parents, my heirs, assigns, personal representatives and estate as follows:

1. I assume that CE exercise classes, and any physical activities entail known and unanticipated risks which could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.

   The risks include, among other things: cardiovascular, (angina, hypertension, coronary artery disease, arrhythmia, cardiac arrest, heart attacks,) pulmonary system, musculoskeletal system (sprains, tears, breaks,) or any other health-related risk, known or unanticipated which could result in injury, death, illness, disease, emotional distress, or damage to myself, property, or third parties. Furthermore, you understand and acknowledge that we have no expertise in diagnosing, examining, or treating any medical condition.

2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

3. I warrant that I am in good health and that I have notified CE of any pre-existing medical conditions that I have.

4. I hereby voluntarily release, forever discharge, and agree to indemnify and hold harmless CE from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of CE's equipment or facilities, including any such claims which allege the negligent acts or omissions of CE.

5. Should CE or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

6. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the costs of such injury or damage myself. I further certify that I am willing to assume the risk of any medical or physical condition I may have.

7. In the event that I file a lawsuit against CE, I agree to do so solely in the state of Michigan, and I further agree that the substantive law of that state shall apply in that action without regard to the conflict of law rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

8. I give permission to CE to use and publish my photograph for promotional purposes without compensation.

By my signature below, I acknowledge that I have read the foregoing, understand it, and agree to the terms.

Signature of Participant: _____ Date: _____

Print Name: _____ Phone: _____

HEALTH AND MEDICAL INFORMATION

This form is purely voluntary. You are not required to complete this form but we do feel it is in the best interest of our members to gather health related information so we are prepared if an emergency situation should arise.

Yes, I plan to participate in one or more fitness programs offered at the Hartland Senior Center. In compliance with HIPPA we keep this information confidential in a locked office. It will only be shared with fitness instructors and emergency personnel if needed.

Name: _____ Date: _____

Address: _____ City/Zip: _____

Home Phone: _____ Age _____ Sex _____

Emergency Contact: _____ Emergency Phone: _____

HEALTH HISTORY

1. Have you ever had?

___ Heart attack	___ Asthma	___ Angina	___ High blood pressure
___ Epilepsy	___ Diabetes	___ Low blood pressure	___ High cholesterol
___ Heart medications	___ Anemia	___ Embolism	___ Aneurysm
___ Valve disease	___ Respiratory	___ Joint replacement surgery	___ Abnormal electrocardiograms

2. Has your physician ever advised you against exercise? ____No ____ Yes (If yes. Why?)

_____

_____

3. Have you had any orthopedic problems?

_____

_____

4. Current medical conditions:

___ Arthritis	___ Ankle/foot injury	___ Shoulder clavicle
___ Low back pain	___ Arm/elbow	___ Knee/thigh injury
___ Calcium deposits	___ Nerve damage	___ Back injury
___ Head/neck injury	___ Bone fracture	___ Wrist/hand injury
___ Hip/pelvis injury	___ Tennis elbow	

If you marked any above please clarify: _____

_____

5. Do you smoke? ____No ____ Yes

6. Please list any medication(s), both over-the-counter and prescription drugs, you are currently taking: _____

_____ _____ _____ _____

Thank you for your cooperation in maintaining a safe environment for all participants.

Revised 2/17/14

Hartland Senior Activity Center will use your email address to send updates and reminders about center happenings as well as notifications about the center being closed for holidays and snow days.

You can choose to receive your monthly newsletter via email to help with cost savings at the center. We appreciate your assistance in helping HSAC be fiscally sound.

I would like to receive my newsletter via Email Yes No

Office Use Only:

Membership Dues Paid:

Year: _____	*Date Paid:* _____	*Year:* _____	*Date Paid:* _____
Year: _____	*Date Paid:* _____	*Year:* _____	*Date Paid:* _____
Year: _____	*Date Paid:* _____	*Year:* _____	*Date Paid:* _____
Year: _____	*Date Paid:* _____	*Year:* _____	*Date Paid:* _____
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Year: _____	*Date Paid:* _____	*Year:* _____	*Date Paid:* _____
Year: _____	*Date Paid:* _____	*Year:* _____	*Date Paid:* _____
Year: _____	*Date Paid:* _____	*Year:* _____	*Date Paid:* _____
Year: _____	*Date Paid:* _____	*Year:* _____	*Date Paid:* _____
Year: _____	*Date Paid:* _____	*Year:* _____	*Date Paid:* _____

Last Name First Name Date of Birth

Spouse's Last Name *Spouse's* First Name Date of Birth

Address or P.O. Box City State Zip Code

Home Phone Cell Phone Township

Emergency Contact Name Relationship Telephone Number

Email Address: _____
(Please Print Clearly)

☐ I agree that I have read, understood and will abide by the HSAC Code of Conduct at all times while at the Center and off site when involved in Center related activities.

☐ I have read, understood and signed the Waiver and Medical Information Form. I assume all risks related to my voluntary participation in programs offered by the HSAC.

In the event of an emergency, I give HSAC permission to call 911 and/or my family.

My signature _____ Spouse's signature_____

Last Name First Name Date of Birth

Spouse Last Name Spouse First Name Date of Birth

Address or P.O. Box City State Zip Code

Home Phone Cell Phone Township

Emergency Contact Name Relationship Telephone Number

Email Address: _____
(Please Print Clearly)

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