Fitness@ Madison Women's Health

Registration and Participant Waiver Form

Name of Class: Post-Partum Exercise Class

Date you will start class: _____

Please print:

Name: _____

Daytime Phone: _(_____)_____-_____.

Email: _____

Please return this form and a check made payable to "Madison Women's Health" in the amount of $60 per session. Session fees are nonrefundable once you begin classes. You must complete the accompanying waiver form and have the Physician Release section completed prior to starting class. Mail this form and payments to Madison Women's Health, LLP, 5801 Research Park Blvd, Ste. 400, Madison WI 53719.

Waiver of Liability and Physician Release

I intend to use or participate in the Post-Partum Exercise Class and some or all of the facilities and services at Madison Women's Health, LLP, located at 5801 Research Park Blvd, Ste. 400, Madison WI 53719.

I understand that physical and recreational activities, such as those offered at Madison Women's Health, LLP can be strenuous and hazardous. I understand that I may experience bodily injury and potential health risks to myself or my newborn that could lead to possible death. These risks include, but are not limited to the following: injuries to the body including muscles, ligaments, tendons and joints; momentary lightheadedness; fainting; abnormal blood pressure; disorders of heart rhythm; chest discomfort; leg cramps, nausea; stroke, heart attack.

Understanding these risks, I fully accept and assume all such risks, whether known to me or reasonably foreseeable, and I fully accept and assume full responsibility for all losses, costs or damages arising from or in any way related to my use of the facilities at Madison Women's Health, LLP.

I HAVE READ THIS WAIVER AND FULLY UNDERSTAND ITS TERMS, AND I AGREE TO FULLY ADHERE TO ITS TERMS

_____
Participant's Name (Print)

_____ _____
Participant's Signature Date

_____ _____
Parent/Guardian Signature (if participant under 18) Date

PHYSICIAN RELEASE (must be completed before session begins)

I release _____ to participate in the Post-Partum Exercise Class without restrictions.

_____ _____
Physician Signature Date