Fitness @ Madison Women's Health LLP

Registration and Participant Waiver Form

Baby & Me Yoga 2023

Please check session(s) you wish to attend:

- ☐ 1: April 12 - May 17
- ☐ 2: May 31 - July 5
- ☐ 3: July 19 - August 23
- ☐ 4: September 6 - October 11
- ☐ 5: October 25 - November 29
- ☐ 6: December 13 - January 17, 2024

Please print:

Name: ____

Daytime phone: ______________________________ Email: ____

Preferred method of notification if cancelled or changed: _____________________________

I give permission to release my contact information to other class members: Yes____ No____Email____Phone____

The cost of each session is $85 (for a 6 week session)

Please return this form and payment. We accept checks and all major credit cards. Make checks payable to "Madison Women's Health" Forms can be mailed to: Madison Women's Health, 5801 Research Park Blvd, Suite 400, Madison WI 53719

If you wish to pay by credit card, please call us at 608-729-6341 and we will be able to take your payment over the phone.

Session fees are nonrefundable once session begins. You must complete the accompanying waiver form and have the Physician Release section completed prior to starting class.

Waiver of Liability and Physician Release

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 fetus(es) 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 or 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 Postpartum Yoga Class with out restrictions.

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Physician Signature Date