Participant Release Form

I represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

I also understand and agree that there are risks, foreseeable and unpredictable, associated with any exercise program. I am aware of these risks and agree that my participation is at my own risk. If my application for the Aquafit Physical Therapy Fitness Program is accepted and I am permitted to participate in this program, I understand and agree that Aquafit Physical Therapy as a facility, nor their respective officers, directors, employees or volunteers shall assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury that I may suffer during or resulting from my participation in this program. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or any future programs.

_____ _____

Date *Signature*

I give permission to:

_____

Name of physician

_____

Address

_____

City

_____

State *Zip* *Phone*

to complete the Diagnosis Verification Form (optional, depending on chapter's requirements)

_____ _____

Date *Signature of participant*