

Physical Activity, Waiver, Release and Indemnity Agreement

Waivers must be completed annually for each physical activity class one attends

1. I understand that my participation in this exercise program may increase my personal risk of injury.
2. I understand that the level of my participation in the exercise program and which exercises to perform must be determined by me in consultation with my physician, and that Inova Health System, the Life with Cancer Program and the instructor(s) are not responsible for the intensity of my participation.
3. I understand that the instructor(s) is not a physician, nurse, or emergency medical technician and that, by offering this exercise program, Inova Health System, the Life with Cancer Program, and instructors are not assuming any responsibility for my medical condition. If my medical status should change, I will immediately consult my physician about continuing or discontinuing my participation.
4. I have read the advisory and have consulted with my physician for approval to participate in this exercise program. I hereby personally assume any and all risks associated with my participation.
5. I hereby release, indemnify and hold harmless the Life with Cancer Program, Inova Health System and its trustees, officers, subsidiaries, affiliates, employees, agents and the instructor(s) of the exercise program I have chosen to attend, from any and all damages, claims, citations, liability and expenses (including costs of judgments, settlements, court costs and attorney's fees), regardless of the outcome of such claims or actions arising out of or relating in any way to my participation in the exercise program.
6. Should a provision of this agreement or portion thereof be found invalid or void as against public policy by any court of competent jurisdiction, the remainder of this agreement shall nonetheless remain in full force and effect.
7. I acknowledge that I have read and agree to the terms of this Waiver, Release and Indemnity Agreement and have been given the opportunity to ask questions and in turn have received and understand all of the information provided.

Class Name _____

Participant's Signature _____ Date _____

Participant's Name (printed): _____

E-Mail: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Diagnosis _____ Date of diagnosis: _____

Date treatment began: _____ Date treatment completed: _____