

MEDICAL ART CENTER ACTIVITY WAIVER

SECTION I: PERSONAL INFORMATION

*Name: _____

*Birth Date: ____/____/____

*Address: _____

*City: _____ *Zip: _____

*Phone: _____ *E-mail: _____

*Emergency Contact Name/ Number: _____

*Please list and explain any prior (Yoga /Workout/Zumba) experience and exercise history: _____

*Please list any medical conditions or physical limitations including injuries or surgeries sustained within the past two years: _____

*PLEASE NOTE: All information disclosed herein is solely for the use of Medical Art Center in better assessing and safely guiding your in-studio practice. The information will be retained confidentially and will be used only for providing professional instruction to the above practitioner.

SECTION II: AGREEMENT

I _____ (print name) understand that this activity consists of physical movements including relief of muscular tension. As in any case of physical activity, the risk of injury is always present. I assume full responsibility for any and all damages, which may incur through participation.

This activity is not a substitute for medical attention or diagnosis. This activity is not recommended or safe under certain medical conditions. If I am pregnant, become pregnant or I am post-natal or post-surgical, my signature verifies that I have my physician's approval to participate. I hereby agree to irrevocably waive any claims that I have now or may have hereafter against Medical Art Center and instructors.

I also understand that:

-I will notify instructors immediately of any pain and/or major discomfort felt during any activity.

-I am responsible for bringing my required equipment to class.

I have read and fully understand and agree to the above terms of this Liability Waiver Agreement. BY SIGNING BELOW, I accept and agree to the terms and provisions contained in this agreement.

Signature _____ Date _____

