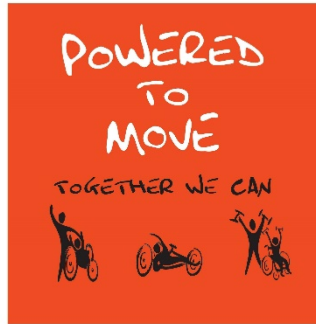


Adapted Fitness Program
Participation Form

PARTICIPANT INFORMATION

Name of Participant____Date:____________________________

Address:____City:_________________________Zip: _______________

Phone Number:____________________________________Alternate Phone Number: __________________________

Date of Birth:______/_____/_______ Current Age: ____________ Gender (circle): M F

Email: ______________________________________

Primary Disability/Diagnosis: ____

EMERGENCY CONTACT INFORMATION

Names of parent(s), home provider, or primary contact: ____ Home

Phone Number:_______________________________(Work)___________________________(Cell)_______________

Address:____City:________________________Zip: ________________

Relationship to participant: ____

Participant is able to give consent for medical treatment in the event of an emergency: **Yes** **No**

HEALTH & SAFETY INFORMATION

Current Medications: ____

____

Seizures: Yes No If yes describe type and frequency: _________

Do you have any medical implants (i.e., VNS or pacemaker)? Yes No

Allergies: Check any allergies below and provide specific allergy

___Food: ____

___Medication: ____

___Environmental (seasonal, dust, etc.): ____

___Other: ____

___No Known Allergies

Physical Activity Readiness Questionnaire (PARQ)

Name of Program Participant:____

Name of individual filling out this form:____

Age:______________________ Gender: ______________________

Height:______________________ Weight:______________________

Please read the following questions carefully and check (X) the appropriate answer. Answer all questions honestly and to the best of your ability.

YES/ NO

_______1. Has your doctor ever said that you have a heart condition (had a stroke, heart attack, or heart surgery) and/or that you should only do physical activity recommended by a doctor?

_______2. Do you feel pain in your chest when you do physical activity?

_______3. In the past month, have you had chest pain when you were not doing physical activity?

_______4. Do you lose your balance because of dizziness or do you ever lose consciousness?

_______5. Have you ever been told by a doctor that you have bone, joint, or muscle problems that could be made worse by physical activity?

_______6. Do you have a diagnosed illness that could be made worse by physical activity?

_______7. Is your doctor currently prescribing medication for your blood pressure or heart condition?

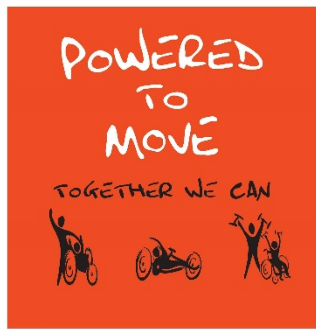
_______8. Do you know of any other reason why you should not do physical activity?

Fitness Participation Agreement

I have voluntarily chosen to participate in *Adapted Fitness Program* offered by *Powered to Move*. I have answered the questions above to the best of my ability and affirm that my physical condition is good and I have no known conditions that would prevent me from participation. I acknowledge that participation is at my own pace and comfort level and that I may discontinue my participation at any time. Furthermore, I agree to self-determine my exertion through good judgment and to discontinue any activity that exceeds my personal limitations. I understand that by signing this agreement that I hereby waive and release *Powered to Move*, its Board Members++, staff, and all relevant employees in any way from liabilities or demands as a result of injury, loss, or adverse health conditions as a result of my participation. I affirm that I have read and understand this document and I wish to participate in fitness activities.

Signature of Participant:______________________________ Date:__________________

Signature of Parent/Caregiver: ______________________________ Date:__________________



PARTICIPANT INDEMNIFICATION, RELEASE OF LIABILITY, AND HOLD HARMLESS AGREEMENT

This form must be signed by each person who will participate (Participant) in or otherwise be involved with Powered to Move's – Adapted Fitness Program.

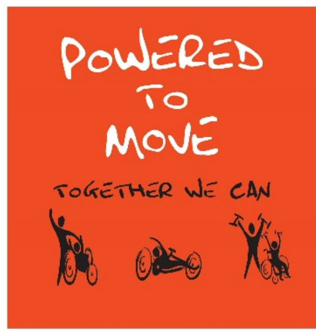
Please read this form carefully and be aware that by registering for and/or participating in a fitness workout, or by registering yourself in the program(s), (collectively herein referred to as the "programs") you will be waiving your rights to all claims for injuries you might sustain arising out of this program(s), and you will be required to indemnify, hold harmless and defend the Epilepsy Foundation for any claims arising out of your participation in the program(s).

RISK OF INJURY: AS A PARTICIPANT IN THE PROGRAM, I RECOGNIZE AND ACKNOWLEDGE THAT THERE ARE CERTAIN RISKS OF PHYSICAL INJURY, AND I AGREE TO ASSUME THE FULL RISK OF ALL INJURIES, INCLUDING DEATH, DAMAGES, OR LOSS, WHICH I MAY SUSTAIN AS A RESULT OF PARTICIPATING IN ANY ACTIVITY ASSOCIATED WITH THIS PROGRAM.

RELEASE FROM LIABILITY: I HEREBY RELEASE, REMISE, ACQUIT, SATISFY, AND FOREVER DISCHARGE AND AGREE TO INDEMNIFY AND HOLD HARMLESS POWERED TO MOVE AND ITS CONTRACTORS OFFICERS, AGENTS, AND EMPLOYEES OF AND FROM ALL MANNER OF ACTIONS, DISPUTES, CAUSES OF ACTION, SUITS, CLAIMS, COUNTER-CLAIMS, CROSS CLAIMS, DEBTS, ACCOUNTS, BILLS, INTEREST, COSTS, AGREEMENTS, JUDGMENTS, EXECUTIONS, LIABILITIES, LOSSES, OBLIGATIONS, AND DEMANDS OF ANY CHARACTER, TYPE, OR DESCRIPTION, IN LAW OR IN EQUITY, AT COMMON LAW, STATUTORY OR OTHERWISE, INCLUDING, BUT NOT LIMITED TO, NEGLIGENCE, GROSS NEGLIGENCE, AND/OR WILLFUL AND MALICIOUS CONDUCT FOR ANY DAMAGES ARISING OUT OF OR IN ANY WAY CONNECTED WITH MY PARTICIPATION IN THE PROGRAM, INCLUDING, BUT NOT LIMITED TO, ATTORNEY'S FEES, LOST WAGES, EXPENSES FOR MEDICAL TREATMENT, LOSS OF CONSORTIUM, AND MENTAL ANGUISH DAMAGES RESULTING FROM PROPERTY DAMAGE, PERSONAL INJURY, OR DEATH. THIS INDEMNITY AND RELEASE IS BINDING ON ME, MY ESTATE, HEIRS, AND ASSIGNS.

CONSENT TO TREATMENT: IF, IN THE CASE OF AN EMERGENCY, I (OR MY EMERGENCY CONTACT) CANNOT BE REACHED, I AUTHORIZE POWRED TO MOVE STAFF OR CONTRACTORS TO OBTAIN WHATEVER MEDICAL TREATMENT THEY REASONABLY DEEM NECESSARY FOR THE WELFARE OF ME OR MY CHILD. I FURTHER UNDERSTAND AND AGREE THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES AND FEES INCURRED FOR THE PROVISION OF SUCH MEDICAL TREATMENT.

______________________________	______________________________	__________________
Signature of Participant	Printed Name of Participant	Date
______________________________	______________________________	__________________
Signature of Parent/Caregiver	Printed Name of Parent/Caregiver	Date



Internet and Photo Release form

I do hereby consent and agree that Powered to Move, and all other affiliates/programs, its employees and agents have the right to take photographs, videotape, or digital recordings of me during my participation in their Adapted Fitness Program to use in any and all media forms including; advertising, publications, website, internet and social media. This (these) photograph(s) may be used indefinitely as part of the above mentioned program and may also be used to promote to educational or health professionals, referral sources, and/or the general public in print and/or e l e c t r o n i c format. I do hereby release to Powered to Move, and all other affiliates/programs, its employees and agents, all rights to exhibit this work of myself in print and electronic form for publicity or privately. ____________________ Initial

I further consent that my name and identity may be revealed therein or by descriptive text or commentary. I understand that I can withdraw my permission for future publication and that upon my written request, the photograph(s) will not be re-published for future circulation. This will not affect my relationship with Powered to Move or staff in any way. I understand that I will receive no financial or other reimbursement for recording, photographing or videotaping me, either for initial or subsequent transmission or play back. ____________________ Initial

If I want more information about the photograph(s), or if I have questions or concerns at any time, I can call or e-mail Powered to Move.

Signing my name below means that I have read and understand this form; and that I am giving consent to be photographed during my participation in the Adapted Fitness Program, thereby granting permission for the use of my photograph in any publication or advertising material (printed or electronic) of Powered to Move, its employees and agents. This consent also serves to waive all rights of privacy and compensation which I may have in connection with the use of my photograph. ____________________ Initial

I represent that I am at least 18 years of age, and have read and understand the above statements, and will execute this agreement. ____________________ Initial

____________________	____________________	____________________
(Name of Participant)	**(Signature of Participant)**	**(Date)**
____________________	____________________	____________________
(Name of Legal Guardian)	**(Signature of Legal Guardian)**	**(Date)**
____________________	____________________	____________________
(Name of Company Representative)	**(Signature of Company Representative)**	**(Date)**