PARTICIPANT FITNESS WAIVER

South Brunswick Office on Aging / Senior Center, 540 Ridge Rd, Monmouth Jct., NJ 08852

Print Name: _____Date of Birth___/___/___
Address: _____ Zip_____
Phone #: Home_____Cell_____

Emergency Contact Information
Name _____ Relationship_____
Phone _____
Cell _____

PARTICIPANT WAIVER STATEMENT

Users of the South Brunswick facilities and participants in the Fitness & Recreational activities should recognize that:

A. Conditions in and around the recreation facilities and
B. The nature of certain activities all present certain reasonable and foreseeable risk or injury.

Exercise, dance, and other athletic programs are potentially strenuous activities. It is required that you check with your physician prior to registering for the gym or any fitness, dance, or athletic program sponsored by the Township of South Brunswick. Also required prior to participation is the completed Physician's Medical Clearance form. I understand a personal trainer will not always be available in the gym and I assume all risks.

I hereby assume the risk of all conditions or occurrences which may be encountered, and waive all claims for damages, injury or loss to my person and/or property which may be caused, by my participation in the Fitness and/or Recreational activity for which I am a participant. I waive any and all specific notice of the existence of any adverse conditions or occurrences and waive all claims I may have as a result of any act or omission of the Township of South Brunswick, its agents, employees or volunteers. I hereby covenant not to sue the Township of South Brunswick, its agents, employees or volunteers, for any claim arising out of my participation or for any act, omission or condition occurring during my participation.

In completing this form, I claim, to the best of my knowledge, that I do not have a disability (medical or physical), that would preclude safe participation in this program. I will update my registration form and notify the staff and or instructor if any of my medical information should change and I will supply a physician's medical clearance form.

_____ _____

Participant's Signature ***Date***

MEDICAL INFORMATION

Please indicate by a check ( ) if any of the following apply to you:

- ☐ Heart Condition, heart disease, (including rheumatic)
- ☐ Vascular disease or problems
- ☐ Neurological conditions, epilepsy, convulsive disorders
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Pacemaker / Internal Defibrilator
- ☐ Arthritis
- ☐ Back problems
- ☐ Insulin dependant
- ☐ Repiratory problems including asthma, chronic asthma or chronic lung disease

☐ Other_____