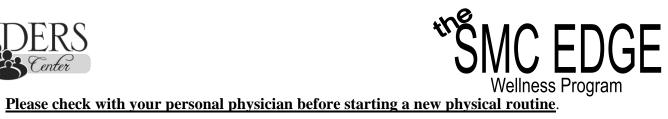


Parent/Guardian Signature:



Fitness Training Registration											
Participant's Name:			Occupation:			Preferred Training times:					
Address:			City:				Morning State:	Evening Sat Morning Zip:			
Address.		City.					-				
Age: Date of Birth:		Height:		Weight:		M 1 (circle gend	T-Shirt Size:		irt Size:		
Email Address:			P		Phone #:		(circie gem	<i>xcr)</i>			
Employee Control November		Work:			Cell:						
Emergency Contact Name:					Emergency Contact Phone #:						
Physician's Name:		Rate your fitness level:			Excellent Good		☐ Fair		☐ Poor		
Medical Conditions and/or Surgical History:											
Describe your fitness goals:											
W O D. I											
Waiver & Release of Liability											
BY SIGNING THIS DOCUMENT, YOU ARE WAIVING CERTAIN LEGAL RIGHTS.											
PLEASE READ THIS DOCUMENT CAREFULLY BEFORE SIGNING.											
I understand that by participating in <i>The SMC Edge</i> , I hereby release and agree to hold harmless Saunders Medical Center, including its affiliated companies or schools, if any, and its and their directors, officers, employees, and agents, from any and all liability arising from or relating to my participation in <i>The SMC Edge</i> , including, without limitation, any damage to or loss of property, any injury to me, or my death. I understand and agree that if I engage in any physical exercise, evaluations, screenings, or other activity on the premises of Saunders Medical Center, or any other location as part of my participation in <i>The SMC Edge</i> , I do so at my own risk.											
This waiver and release of all liability includes, but is not limited to, injuries or death which may result from improper use of equipment, my use of equipment which may malfunction, or any other unspecified injury, WHETHER OR NOT SUCH CLAIM FOR DAMAGE, LOSS, INJURY, OR DEATH IS CAUSED, IN FULL OR IN PART, BY THE NEGLIGENCE, OMISSION, OR FAULT OF SAUNDERS MEDICAL CENTER.											
I acknowledge that I am participating in <i>The SMC Edge</i> voluntarily and understand that I may experience pain, soreness, and possible injury while participating in the normal course of this program. I further understand that IT IS MY RESPONSIBILITY TO INFORM A CLINICIAN IMMEDIATELY should I experience any of these symptoms.											
BY SIGNING BELOW, I WARRANT THAT I HAVE CAREFULLY READ THIS DOCUMENT, and that I execute this document fully intending to be bound by its terms.											
Participant's Signature:					Age: Date:						
If the parti	_										
As the parent/guardian of the above-named participant, I agree to be bound by each of the terms and conditions set out above, and further consent to the participant's participation in <i>The SMC Edge</i> program.											

Date: