SAUNDERS Medical Center

the SMC EDGE Wellness Program

Please check with your personal physician before starting a new physical routine.

Fitness Training Registration

Participant's Name:		Occupation:		Preferred Training times: Morning Evening Sat Morning	
Address:		City:		State:	Zip:
Age:	Date of Birth:	Height:	Weight:	M F *(circle gender)*	T-Shirt Size:
Email Address:		Phone #: 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: _____

_____

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 *The SMC Edge*, 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 *The SMC Edge*, 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 *The SMC Edge*, 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 *The SMC Edge* 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 participant is under the age of 19, a parent or legal guardian must sign below.

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 *The SMC Edge* program.

Parent/Guardian Signature:	Date: