



Rappahannock Area YMCA, Inc.
Special Needs
Agreement of Assumption of Risk and Release of Liability

In consideration of being allowed to participate in the activities and programs of the Rappahannock Area YMCA, Inc. and to use its facilities, equipment and machines for the fees paid for these activities, I for myself, and my executors and administrators, do hereby **waive, release and forever discharge** the Rappahannock Area YMCA, Inc. and its Board of Directors, officers, volunteer workers, agents and employees (including fitness trainers) (hereinafter referred to collectively as "YMCA Personnel") or others acting on their behalf, from any and all responsibility, liability, demands and claims, arising from or connected with injuries or damages to myself or minor members of my family, resulting from my (or their) participation in any YMCA activities, or from my (or their) use of YMCA equipment or machinery in the above mentioned activities, including but not limited to injuries or damage caused by the negligent acts or omissions of YMCA Personnel.

I understand and am aware that participation in YMCA activities, including but not limited to strength, flexibility and aerobic exercise, use of equipment, use of the gym, courts, fields, pool, sauna, and steam room, all involve potentially hazardous activities, even under the supervision of YMCA Personnel. **I also understand that fitness activities involve a risk of injury and even death, and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the danger involved. I hereby agree to expressly assume and accept any and all risks of injury or death, regardless of the cause.**

YMCA Personnel are not trained in medicine, and make no determination of my fitness to participate in YMCA activities. I hereby declare myself to be physically sound. I have either had a physical examination and have been given my physician's permission to participate, or I have decided to participate in YMCA activities and to use YMCA equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities.

I have read the above conditions and accept them as shown by my signature.

Printed Name of Client

Date

Printed Name of Custodian

Custodian Signature



Medical Clearance

I authorize _____ to release
Name of Physician
 information necessary to the development of my fitness program to the
 YMCA Special Needs Manager.

Date: _____

Client Name: _____

Client Signature: _____

Physicians Approval:

I give medical approval to _____
Client Name

to participate in the fitness assessment and exercise program which will include progressive exercises (aerobics, flexibility, and resistance training) for conditioning the body. I certify that the person named above appears to have no reason why a progressive exercise program should not be undertaken with the recommendations I have indicated below. Please contact me if there are any concerns.

Note to Physician:

If the client is taking any form of medication which might affect their response to exercise, please indicate below the type of medication, possible effects and precautions when exercising:

 Name of Physician Phone Number

 Signature of Physician Date



Rappahannock Area YMCA, Inc.
Special Needs
Health Screen Form

Client Name: _____ Date: _____

Male

Age: _____

Female

Height: _____

Weight: _____

This form is intended to obtain relevant information about your health and will assist the staff in helping you with your program. Please answer to the best of your knowledge.

Blood Pressure

Do you have high blood pressure? Yes No

Have you had high blood pressure in the past? Yes No

Are you on medication for high blood pressure? Yes No

Which medications?

Smoking

Do you smoke? Yes No

Are you a former smoker? Yes No

If yes, please give the date you quit:

Diabetes

Do you have diabetes? Yes No

Are you on Insulin? Yes No

Heart

Have you ever had a heart attack? Yes No

Date: _____

Have you ever had heart surgery? Yes No

Date: _____

Have you ever had angina? Yes No

Have you ever had a stroke? Yes No

Are you on heart medication? Yes No
If yes, which medication(s)?

Do you have elevated blood cholesterol? Yes No

What is your current level of blood cholesterol? _____

Are you on medication for high cholesterol? Yes No
If yes, which medication(s)?

Orthopedic

Do you have any serious orthopedic problems that would prevent you from exercising?

Yes No

If yes, please explain

Other

Do you have any chronic illness or condition? Yes No

Do you or have you had seizures? Yes No

If yes, please explain

Are you pregnant? Yes No

Please list any medication you are currently taking

My doctor knows that I am exercising yes No