
General Waiver of Liability and Indemnification

Member or Applicant:

I understand that although the facilities, equipment, services and programs of the YWCA *Therapeutic Recreation* program are designed to provide a safe level of beneficial exercise and enjoyment, there is an inherent risk that use of such facilities, equipment, services and programs may result in injury to me. The risks include, but are not limited to:

1. Injuries arising from any exercise equipment and machines.
2. Injuries arising from participation in supervised or unsupervised activities and programs in the swimming pool, the exercise rooms, or any other areas of the YWCA building.
3. Injuries or medical discords resulting from exercising at the facility including but not limited to, heart attacks, strokes, heat stress, sprains, broken bones and torn muscles or ligaments.
4. Accidental injuries within the facilities, including but not limited to, the locker rooms, whirlpool, sauna, showers and dressing rooms.

I also acknowledge the existence and the need for Rules and Regulations including those governing the use of the **Therapeutic Recreation** program's equipment and facilities and participation in various YWCA programs and services. I hereby agree to comply with those Rules and Regulations and to amendments or additions to them as the YWCA deems necessary.

I understand that my membership may be cancelled if the YWCA determines this is in the best interest of the organization and/or its clientele.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND I SPECIFICALLY AGREE TO ASSUME ALL RISK OF INJURY TO ME WHILE USING ANY OF THE YWCA EQUIPMENT, SERVICES OR PROGRAMS. I HEREBY WAIVE ANY AND ALL CLAIMS OR ACTIONS I OR ANY OF MY MINOR CHILDREN MAY HAVE AGAINST THE YWCA OR ITS BOARD MEMBERS AND TO HOLD THE YWCA EMPLOYEES OR BOARD MEMBERS HARMLESS FROM ANY AND ALL CLAIMS RESULTING FROM SUCH INJURY TO ME OR TO MY MINOR CHILDREN.

Member Signature

Date

Member Printed Name

Brief Personal Health History

Member/Applicant Name *(Please Print)* _____

All information in this section is maintained in strictest confidence and will not be released to anyone unless Member/Applicant grants permission in writing.

Please help us determine what your personal needs are. If you have any special needs of which you would like our instructors to be aware of, please indicate: _____

Do you have, have you had, or have you been treated in the last year for any of the following?
(For information purposes only and will not affect eligibility to participate in the program.)

	YES	NO	COMMENTS		YES	NO	COMMENTS
Arthritis				Epilepsy			
Asthma				Heart Attack			
Bleeding Tendency				High Blood Pressure			
Congenital Heart Disease				Stroke			
Diabetes				Chest Pain			
Emphysema				Heart Palpitations			
Visual Problems				Neck Injury			
Hearing Problems				Back Injury			
Severe Dizziness				Muscle/Tendon Injury			
Fainting/Blackouts				Shortness of Breath			
Severe Headaches				Recent Surgery			
Head Injury				Hernia			

Are you currently under a doctor's care for any of the above? Yes No

If so, please explain: _____

Name of Doctor: _____

Telephone Number: () _____

DO YOU...	YES	NO	CONSUMPTION:	WEEK	DAY
Smoke?			Packs per		
Drink Coffee/Tea?			Cups/Glasses per		
Drink Alcohol/Beer?			Ounces per		

I consider myself...	YES	NO
Overweight		
Underweight		
The right weight		
Basically in shape		
Somewhat in shape		
Totally out of shape		

I currently exercise ...	YES	NO
Once a Week		
Twice a Week		
Three times a Week		
Three + times a Week		
None		
Occasionally		

Person to contact in Emergency: _____

Relationship: _____ Phone #: _____