**WAIVER OF LIABILITY AND INFORMED CONSENT RELEASE (2011)**

This release, Waiver of Liability and Informed Consent Release and Agreement, is made by and between the undersigned client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (client name) and Vital Lifestyles, Inc. and entered into on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(date) in connection with certain fitness and/or wellness programs to be provided by Vital Lifestyles, Inc., including, but not limited to, Pilates Training, Yoga, Tai Chi, Personal Training and Group fitness classes.

I acknowledge that Vital Lifestyles, Inc. is not associated with Legacy Shops or Bear Properties, in any way.

I recognize that Vital Lifestyles, Inc. will not provide the program to me without the execution of this instrument. I understand that Vital Lifestyles, Inc. specifically disclaims any liability for client’s individual use or application of information or techniques provided by Vital Lifestyles, Inc. I assert that my participation in physical activity facilitated by Vital Lifestyles, Inc. whether in sessions, on the grounds, in transportation to or from the sessions, or at any other location is voluntary.

I further understand that there are serious inherent risks involved with all physical activity and that when performing exercise I may suffer minor injury, serious injury or even death. I understand these inherent risks and I assume all such inherent risks associated with participation in any activities with Vital Lifestyles, Inc. In consideration for participation in any session conducted by Vital Lifestyles, Inc., I, my heirs and assigns hereby release, discharge and waive, any and all claims, demands, losses or damages caused in whole or in part by Vital Lifestyles, Inc., its officers, directors, agents and employees, for any and all negligence by the Releases or otherwise. I will indemnify, save and hold harmless each of the Releases from any litigation expenses, attorney fees, loss, liability, damage, or cost which they may incur as a result of such claim.

I further represent that I am in good health and physical condition and that I am not disabled in any way, taking medication or suffering from any condition that would prevent my from safely engaging in such activities or that would make such participation potentially dangerous or harmful for me. I affirmatively assert that should I become disabled, begin taking medication or acquire any medical condition that could cause such participation to be dangerous or harmful to me, I will notify Vital Lifestyles, Inc. immediately, and cease all participation immediately. Should this occur, I agree that I will not return to participation in such potentially harmful activity without clearance from my physician.

I acknowledge that Vital Lifestyles, Inc. has not and will not render any medical services including medical diagnosis of my physical condition. I acknowledge that I either have no restrictions from my physician or that I have permission from my physician to participate in the fitness sessions with Vital Lifestyles, Inc.

**I HAVE CAREFULLY READ, UNDERSTAND AND ACKNOWLEDGE ALL OF THE ABOVE STATEMENTS.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Name (please print) Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Signature Cell Phone Number Home Phone Number Work Phone No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address Email Address**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip Code Date of Birth**

**Physical Problems, Surgeries or limitations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Emergency Contact Name and Phone Number Physician Contact (if required or under Dr’s care)**

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**FOR MINORS ONLY (Under 18 years old)**

The undersigned is a parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(client name) and on his/her behalf, hereby agrees to all the conditions set forth above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature Date**

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**Witness Date**