LiveWell
FITNESS CENTER

Home School PE

Participant First Name/Team Name | Middle Initial | Last Name

Age:_____ Grades 1-4: _____ OR Grades 5-8: _____ OR Grades 9-12: _____

Printed Parent/Legal Guardian Name (if applicable) | Email Address

Mailing Address | City | State | Zip Code

Home Phone | Work Phone | Participant Date of Birth

Emergency Contact Name and Phone number

Release, Waiver, & Assumption of Risk Agreement (Adult and Minor)

I hereby apply for permission to use the facilities and services of the National Training Center and the LiveWell Fitness Center (the "Centers"), divisions of South Lake Hospital, Inc. ("SLH"), a Florida not for profit corporation. I understand that this application is subject to the review and approval of the program's management and that this Release, Waiver and Assumption of Risk Agreement ("this Agreement") is a condition to such use.

I understand that participation may be suspended or terminated by SLH and the Centers if I am in violation of the Centers' rules, regulations and policies, if I conduct myself in a manner which management deems inappropriate or disruptive or if I make false representation of information contained in this application. I will not be entitled to any refund of program fees. I am responsible for any outstanding balance due.

I understand that the training dates, times and services as scheduled are subject to approval by the Centers and subject to change at any time by discretion of the Centers. This Agreement shall apply regardless of any such changes.

I grant SLH, the Centers and all sponsors the right to photograph and/or videotape me and further to use my name, face, likeness, voice and appearance in connection with exhibitions, publicity, advertising and promotional materials without reservation or limitation. I further agree I will not seek remuneration for such photos and publicity. SLH, the Centers and all sponsors are, however, under no obligation to exercise said rights herein granted.

Release and Waiver: In consideration of permission to enter upon and use, today and all future dates, the property, facilities, staff, equipment, and services of the Centers, I hereby release, waive, discharge, and covenant not to sue South Lake Hospital, Inc. (SLH) and the LiveWell Training Center and National Training Center (the Centers) and their owners, officers, employees, and agents, (the "Releasees,") from any and all liability, claims, demands, actions, and causes of action whatsoever, arising out of or related to any loss, damage, accidents, or injuries, including loss of life, which may happen to me, or to any of my property and personal belongings, whether caused by the Releasees' negligence or otherwise, including but not limited to those causes which result from the my negligence or negligence of my group's coaches, agents, servants, and employees, while in or at the Centers and/or any location where the Centers' services are provided.

Assumption of Risk: I am aware that there are certain inherent risks associated with engaging in physical activities that can result in serious personal injury or loss of life. I hereby voluntarily assume full responsibility for any risk of bodily injury, death, or property damage due to such risks and due to negligence or otherwise by the Releasees and/or while competing, observing, or for any purpose participating in any event, practice or training. I expressly acknowledge and agree that this assumption of risk includes environmental and contagion risks, in addition to risks associated with use of the Centers' equipment and facilities, and includes any location where Centers' services are provided.

I expressly agree that this Agreement is intended to be as broad and inclusive as is permitted by the laws of the State of Florida. If any portion hereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

Alterations to this Agreement will not be accepted and are not permitted unless expressly authorized by a manager of SLH and the Centers. SLH and the Centers' staff are not authorized to make any changes to this Agreement.

I hereby certify that I am at least 18 years of age and am legally competent to sign this Agreement. If I am under the age of 18, I have had my parent/legal guardian sign this Agreement along with myself. It is my express intent that this release shall bind me, the members of my family and spouse, if any, and my heirs, assigns and personal representatives, and shall be governed by the laws of the State of Florida.

NOTICE TO THE MINOR CHILD'S NATURAL GUARDIAN
F.S. 744.301(3)(b)

READ THIS FORM COMPLETELY AND CAREFULLY.
YOU ARE AGREEING TO LET YOUR MINOR CHILD ENGAGE IN A POTENTIALLY DANGEROUS ACTIVITY. YOU ARE AGREEING THAT, EVEN IF SLH AND THE CENTERS USE REASONABLE CARE IN PROVIDING THIS ACTIVITY, THERE IS A CHANCE YOUR CHILD MAY BE SERIOUSLY INJURED OR KILLED BY PARTICIPATING IN THIS ACTIVITY BECAUSE THERE ARE CERTAIN DANGERS INHERENT IN THE ACTIVITY WHICH CANNOT BE AVOIDED OR ELIMINATED. BY SIGNING THIS FORM, YOU ARE GIVING UP YOUR CHILD'S RIGHT AND YOUR RIGHT TO RECOVER FROM SLH AND THE CENTERS IN A LAWSUIT FOR ANY PERSONAL INJURY, INCLUDING DEATH, TO YOUR CHILD OR ANY PROPERTY DAMAGE THAT RESULTS FROM THE RISKS THAT ARE A NATURAL PART OF THE ACTIVITY. YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS FORM, AND SLH AND THE CENTERS HAVE THE RIGHT TO REFUSE TO LET YOUR CHILD PARTICIPATE IF YOU DO NOT SIGN THIS FORM.

I have read the Release, Waiver, & Assumption of Risk Agreement in its entirety and understand all of the terms and conditions it contains, and I understand that I am giving up substantial rights, including my right to sue, by signing it. I acknowledge that I am signing it freely and voluntarily and further agree that no oral representations, statements, or inducements apart from the foregoing written agreement have been made

PAYMENT

Non-Refundable Program Fee: $_____ Account: Dept#/Line: (WEDNESDAYS) 5506/64540 all 4 quarters fitness

(FRIDAYS)**5513/64540-1st quarter (Swim)** **5511/64540-2nd quarter (Track/Fitness);**

5514/64540-3rd quarter (Soccer); **5513/64540-4th quarter (Swim/ Fitness)**

PAYMENT IN FULL: ❑ Cash _____ ❑ Check #:_____ ❑ Credit Card _____

_____

Participant Signature Date Staff Signature Date

For office use only:	Pmt 1 Date _____	Pmt 2 Date _____	Pmt 3 Date _____

DAY/QUARTER ATTENDING:

WEDNESDAY HOMESCHOOL PE SESSIONS/QUARTERS

- ☐ I. Sept. 2– Oct. 28 $68
- ☐ **Late registration (after Aug 28) $75**
- ☐ II. Nov. 4—Jan. 20 $68
- ☐ **Late registration (after Oct 30) $75**
- ☐ III. Jan. 27-March 23 $68
- ☐ **Late registration (after Jan 22) $75**
- ☐ IV. March 30-May 25 $68
- ☐ **Late registration (after March 25)$75**
- ☐ All Wednesday Sessions $231.20

15% DISCOUNT ON **FULL YEAR FOR PRE-REGISTRATION ONLY**

FRIDAY HOMESCHOOL PE SESSIONS/QUARTERS

- ☐ I. Sept. 4– Oct. 30 $68
- ☐ **Late registration (after Aug 28) $75**
- ☐ II. Nov. 6—Jan. 22 $68
- ☐ **Late registration (after Oct 30) $75**
- ☐ III. Jan. 29-March 25 $68
- ☐ **Late registration (after Jan 22) $75**
- ☐ IV. April 1-May 27 $68
- ☐ **Late registration (after March 25)$75**
- ☐ All Friday Sessions $231.20

15% DISCOUNT ON **FULL YEAR FOR PRE-REGISTRATION ONLY**

Medical Release and History

Health Statement

(To be completed by Parent/Guardian and/or Medical Doctor).

	NO	YES	YES responses will require an explanation.
Respiratory problems - Asthma, persistent cough, etc.			
Heart Problems - High/low blood pressure, chest pain, etc.			
Kidney, Stomach, Gall Bladder, or Liver problems			
Diabetes, Hypoglycemia			
Recent fractures, illness, exposure to contagious diseases, etc.			
Eye, ear, nose, or throat problems - Skin disease			
Allergies - Bee stings, ant bites, plants, sun, food, penicillin, etc.			
Nervous disorders - Epilepsy, convulsions, dizziness, etc.			
Emotional disorders - Frequent anxiety, excessive fears, etc.			
Any hospitalization in the last two years?			
Any physically limiting conditions?			
Currently taking any medications?			
Participant WILL be bringing medication to programs and activities.			

***Emergency Medical Treatment*: I understand that every effort will be made to contact the Parent/Guardians of participants. If this is not possible, I hereby authorize the South Lake Hospital and NTC to obtain medical treatment.**

Parent/Guardian Signature: _____ Daytime Phone: _____

Family Physician/Clinic:

_____

Location: _____ Phone: _____

Insurance Company: _____ ID # _____ Group # _____