

GROUP EXERCISE CLASSES - INDEMNITY FORM

Name : _____ Company: _____

Email: _____ PH (Work): _____

Date range of Class: _____

Who referred you to this class:

CLASS YOU ARE PARTICIPATING IN

- | | | | | | |
|-----------------------------|--------------------------|---------------|--------------------------|-----------------|--------------------------|
| Yoga | <input type="checkbox"/> | Boxing | <input type="checkbox"/> | Hip Hop | <input type="checkbox"/> |
| Pilates | <input type="checkbox"/> | Bootcamp | <input type="checkbox"/> | Belly Dance | <input type="checkbox"/> |
| Circuit | <input type="checkbox"/> | Tai Chi | <input type="checkbox"/> | Bollywood Dance | <input type="checkbox"/> |
| Flexibility & Core Strength | <input type="checkbox"/> | Running Group | <input type="checkbox"/> | Latin Dance | <input type="checkbox"/> |

YOUR PAST EXPERIENCE

Is this your first experience with this class? (Y/N)

If no, summarise your past experience:

PLEASE ANSWER THESE FOLLOWING HEALTH QUESTIONS TO ASSIST THE INSTRUCTOR

Your instructor can tailor your class as long as we know if there are any medical problems that we should be aware of

Are you aware that you have any of the following? (tick all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> epilepsy | <input type="checkbox"/> knee problems | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> asthma | <input type="checkbox"/> headache, migraine | <input type="checkbox"/> menstrual complaints | <input type="checkbox"/> skin conditions |
| <input type="checkbox"/> back problems | <input type="checkbox"/> heart problems | <input type="checkbox"/> muscular complaints | <input type="checkbox"/> thyroid conditions |
| <input type="checkbox"/> constipation | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> neck problems | <input type="checkbox"/> wrist problems |
| <input type="checkbox"/> diabetes | | | |

If you have ticked any of the above boxes, please provide us with further details:

Are you currently taking any prescribed medication? No Yes – please specify

Do you have any condition not mentioned in the list? No Yes – please specify

Please indicate your current level of stress, where 0 is no stress and 10 is extreme stress: 0 _____ 10

DISCLAIMER AND LIMITATION OF LIABILITY

The Group Exercise Class, and all information and products provided, are designed to assist with your general wellbeing. Such information and products are not intended as a substitute for professional medical advice, diagnosis or treatment. Calastica accepts NO liability of any kind to you or anyone else for any personal injury, damages or loss whatsoever (including direct, indirect, incidental, special or consequential damages) arising out of any reliance upon or use of the information or products provided during the Class. You acknowledge that your participation in the Class and the use of the information and products provided during the Class is at your sole discretion and risk. Calastica expressly disclaims all express and implied warranties to the maximum extent permitted by law. It is advisable to consult your medical practitioner before undertaking any complementary therapies. You should consult your medical practitioner for all required medical advice, diagnosis or treatment. You warrant that the information provided by you on this form is true, complete and correct.

I have read and understand this disclaimer and limitation of liability statement:

Signed : _____ Date : _____

Witness : _____ Date : _____