ADULT WAIVER AND RELEASE

You agree that you are aware that you, person named below, will be engaging in physical exercise involving various sports, co-ordination events and fitness training which could cause injury. You agree that you are voluntarily participating in these activities and are assuming all risks of injury that might occur as a result of these activities. We will make no evaluation or recommendation whether you have any physical condition that may impair your ability to engage in these activities. It is your responsibility to obtain a physician's statement describing any limitations to participate in this activity. It is always advisable to consult your physician prior to undertaking any physical exercise program.

ADULT NAME_____DATE_____

SIGNATURE_____
Gymnastics In Motion, Inc

I HEREBY GIVE PERMISSION TO GYMNASTICS IN MOTION, INC. TO SECURE EMERGENCY MEDICAL AND / OR EMERGENCY SURGICAL TREATMENT FOR THE ABOVE NAMED ADULT WHILE IN OUR CARE.

Signature _____Date_____

Name of Physician or Health Clinic_____

Phone_____Health Insurance ID. Information_____

ADULT WAIVER AND RELEASE

You agree that you are aware that you, person named below will be engaging in physical exercise involving various sports, co-ordination events and fitness training which could cause injury to them. You agree that you are voluntarily participating in these activities and is assuming all risks of injury that might occur as a result of these activities. We will make no evaluation or recommendation whether you have any physical condition that may impair your ability to engage in these activities. It is your responsibility to obtain a physician's statement describing any limitations to participate in this program. It is always advisable to consult your physician prior to undertaking any physical exercise program.

ADULT NAME_____DATE_____

SIGNATURE_____
Gymnastics In Motion, Inc

I HEREBY GIVE PERMISSION TO GYMNASTICS IN MOTION TO SECURE EMERGENCY MEDICAL AND / OR EMERGENCY SURGICAL TREATMENT FOR THE ABOVE NAMED ADULT WHILE IN OUR CARE.

Signature _____Date_____

Name of Physician or Health Clinic_____

Phone_____Health Insurance ID. Information_____

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