

PRENATAL CONSENT FORM



I request enrollment in HeartCore exercise classes at Heartcore Fitness Ltd.

I certify that I have given my treating physician the written information about this class and have obtained the approval of my treating physician to participate.

I understand that I will not be able to enroll or to continue in this class without the prior written permission of my treating physician.

I agree to keep my physician informed of the effects of this class on my body and to consult him/her whenever necessary. I further understand that there is no requirement to perform all the class exercises and that I can withdraw from this class at any time.

During class, I agree to limit my activity to that which is comfortable for me and to stop all activity immediately if I feel uncomfortable. Upon experiencing any discomfort at any time either during or after class, I will immediately contact my treating physician to inform him/her and seek medical advice.

I understand that all forms of exercise involve some risk of injury. I accept complete sole responsibility for my health and well being in this voluntary program.

In consideration of my participation in HeartCore classes at Heartcore Fitness Ltd., I, for myself, my heirs and assigns, hereby release and discharge Heartcore Fitness Ltd. from any and all liability now or in the future except insofar as permitted by law.

This release includes, but is not limited to, heart attacks, muscle strains, fractures, shin splints, musculoskeletal injuries, heat prostration, or any injury to myself and my unborn child unless caused by the negligence of Heartcore Fitness Ltd.

Save as otherwise stated, I hereby knowingly and voluntarily waive any and all claims against Heartcore Fitness Ltd. and its staff, agents and/or officers.

Information regarding my health status will be treated as confidential and will not be released to any person other than program staff without consent.

Printed Name of Participant

Signature of Participant

Date

PHYSICIAN CERTIFICATION

I approve of my patient's participation in this class. The health status of this patient will permit her to participate in the program subject to restrictions listed below.

List any exercises or precautions that this patient should not perform:

Signature of Treating Physician

Date

Printed Name

Office Telephone