

Agreement and Release of Liability

1. In consideration of being allowed to participate in the activities and programs of Progressive Fitness Omaha, Inc. personal training and to use its facilities, equipment and machinery in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Progressive Fitness Omaha, Inc. and its directors, officers, agents, employees, representatives, successors and assigns, administrators, executors, and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned activities. I do also hereby release all of those mentioned and any others action upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission or any way arising out of or connected with my participation in any activities of Progressive Fitness Omaha, Inc. or the use of any equipment at Progressive Fitness Omaha, Inc. .

2. I understand and am aware that strength, flexibility and aerobic exercises, including the use of equipment are a potential hazardous activity. I also understand that fitness activities involve the risk of injury and even death, and that I am voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.

3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, infirmity or other illness that would prevent my participation or use of equipment or machinery except as hereinafter stated. I do hereby acknowledge that I have been informed of the need for a physician's approval for my participation in an exercise/fitness activity or in the use of exercise equipment and machinery. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise and the use of exercise and training equipment so that I might have his/her recommendations concerning these fitness activities and equipment use. I acknowledge that I have either had a physical examination and have been given my physician's permission to participate, or that I have decided to participate in activity and use of equipment and machinery without the approval of my physician and do hereby assume all responsibility for my participation and activities, and utilization of equipment and machinery in my activities.

4. I understand that the fitness assessments, exercise prescriptions, and lifestyle recommendations are NOT treatment, diagnosis, or cures for diseases, ailments, or chronic medical conditions. They serve only as an awareness and possible preventative measure in the management of such conditions.

DATE

PRINTED NAME

SIGNATURE

Client must sign for each session at the time of service, including sessions canceled without 24-hour notification. The Fitness Service Agreement terminates six months from the date of purchase and all sessions must be completed on or before the agreement expiration date. Training sessions and trainers are not available at all times. Standard sessions are up to a maximum of 50 minutes in duration.

Letter of Agreement

This Agreement made and entered into this _____ day of _____, 20___, by and between _____ (“Client”) and Progressive Fitness Omaha Incorporated.

In consideration of the mutual promises exchanged herein and other good and valuable consideration, the parties agree as follows:

1. Client and Trainer have agreed that Trainer will conduct _____ one-hour workout sessions. Each session will begin at a mutually convenient, agreed-upon time and shall be subject to the policies attached hereto as “Exhibit A.”

2. Client will pay Trainer, in advance, the sum of \$_____ for these workout sessions or \$_____ monthly. Client acknowledges and agrees that no credit or refund shall be due for sessions cancelled by Client, except as provided in the Policies attached hereto as Exhibit A.

3. Concurrently with the execution of this Agreement, Client has executed and delivered to Trainer a Waiver and Assumption of Risk Agreement and a Waiver for Home Workouts Agreement (if applicable) (these agreements herein collectively referred to as the “Waiver Agreements”), in which Client assumes the risk of participating in an exercise program and agrees that Trainer and his or her agents, employees, or contractors, if any, shall have no liability for any injury, illness, or similar difficulty that Client may suffer arising out of or connected with Client’s participation in Trainer’s program. Client hereby acknowledges and agrees that the execution and delivery of the Waiver Agreements are material inducements to Trainer’s permitting Client to participate in Trainer’s program and agrees to be bound by same.

IN WITNESS WHEREOF, Client and Trainer have caused this Agreement to be executed on the day and year first above written.

By: _____
Trainer

Trainer, please print name

By: _____
Client’s signature

Client, please print name

By: _____
Client’s signature

Client, please print name

By: _____
Client’s signature

Client, please print name

Emergency Medical Authorization

I/We hereby give consent for (1) the administration of any treatment deemed necessary by:

My preferred physician Dr. _____ or any of his/her associates.

My preferred dentist Dr. _____, or any of his/her associates, or in the event the appropriate preferred practitioner is not available, by another licensed, qualified physician or dentist; and (2) the transfer to:

_____ Hospital, the preferred hospital, or any hospital reasonably accessible.

Major Surgery

This authorization does not cover non-emergency major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery, defining such period for non-emergency surgery as 24 hours.

Medical Data

The following is needed by any hospital or practitioner not having access to my medical history:

Allergies: _____

Medication being taken: _____

Physical impairments: _____

Other pertinent facts to which physician should be alerted: _____

Medical insurance coverage: _____

Emergency contact name and phone: _____ Relationship: _____

In the event the above emergency contact cannot be reached, please contact: _____

DATE

PRINTED NAME

SIGNATURE

Medical/Health History

Name: _____	Age: _____	Date: _____	Physician: _____
Address: _____		Physician Phone: _____	
Day Phone: _____	E-mail: _____	Physician Fax: _____	

Present and Past History

Do you now have, have you recently experienced, or have you ever had: (check in front of those questions to which you answer yes, leave others blank)

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart attack, bypass, or other cardiac surgery
<input type="checkbox"/> Peripheral vascular disease
<input type="checkbox"/> High Blood Pressure (above 140/90)
<input type="checkbox"/> High LDL or Low HDL cholesterol levels
<input type="checkbox"/> Unusual shortness of breath
<input type="checkbox"/> Light headedness or fainting
<input type="checkbox"/> A chronic recurrent cough
<input type="checkbox"/> Stomach or intestinal problems
<input type="checkbox"/> Migraine or recurrent headaches
<input type="checkbox"/> Limited range of motion in joints
<input type="checkbox"/> Fatigue, lack of energy
<input type="checkbox"/> Swollen, stiff, or painful joints
<input type="checkbox"/> Increased anxiety or depression
<input type="checkbox"/> Extra, skipped or rapid heartbeats/palpitations
<input type="checkbox"/> Do you now or have you in the past 6 months, smoked
If yes, how much? | <input type="checkbox"/> Diabetes
<input type="checkbox"/> Phlebitis, emboli
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Heart murmurs
<input type="checkbox"/> Ankle swelling
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Knee problems
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cold hands or feet
<input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke
<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Chest discomfort
<input type="checkbox"/> Bursitis
<input type="checkbox"/> Epilepsy, seizures
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Shoulder problems
<input type="checkbox"/> Foot problems
<input type="checkbox"/> Broken bones
<input type="checkbox"/> Back problems
<input type="checkbox"/> Hernia
<input type="checkbox"/> Neck problems
<input type="checkbox"/> Emotional Disorders |
|--|--|--|

IF YES TO ANY OF THE ABOVE, PLEASE EXPLAIN

1. Please list any prescribed medications you are now taking:

2. Please list any over the counter medications or dietary supplements you are now taking:

3. Please list any illnesses, hospitalizations, or surgical procedures within the past two years:

4. Please list any drug allergies:

FAMILY MEDICAL HISTORY

Have any of your blood relatives had any of the following?

(Please check if yes) Include grandparents, parents, aunts, uncles and siblings.

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | Heart attack |
| <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | Coronary disease |
| <input type="checkbox"/> | Congenital heart disease |
| <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | Coronary operations |
| <input type="checkbox"/> | Elevated cholesterol |

IF YES TO ANY OF THE ABOVE PLEASE LIST RELATIVE AND AGE OF OCCURANCE:

Informed Consent for Exercise Participation

I desire to engage voluntarily in an exercise program in order to attempt to improve my physical fitness. I understand that the activities are designed to place a gradually increasing workload on the cardiorespiratory and/or muscular system to thereby attempt to improve its function. The reaction of the cardiorespiratory system to such activities can't be predicted with complete accuracy. There is a risk of certain changes that might occur during or following the exercise. These changes might include abnormalities of blood pressure or heart rate.

I understand that the purpose of the exercise program is to develop and maintain cardiorespiratory fitness, body composition, flexibility and muscular strength and endurance. A specific exercise plan will be given to me, based on my needs and interests and my doctor's recommendations. All exercise programs include warm-up, exercise at target heart rate and cool-down. The programs may involve walking, jogging or cycling; participation in exercise fitness, rhythmic aerobic exercise or choreographed fitness classes; or calisthenics or strength training. All programs are designed to place a gradually increasing workload on the body in order to improve overall fitness. The rate of progression is regulated by exercise target heart rate and perceived effort of exercise.

I understand that I am responsible for monitoring my own condition throughout the exercise program and should any unusual symptoms occur, I will cease my participation and inform the instructor of the symptoms.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the exercise program, I also affirm that my questions regarding the exercise program have been answered to my satisfaction.

Also, in consideration for being allowed to participate in an exercise program, I agree to assume the risk of such exercise and further agree to hold harmless Progressive Fitness Omaha, Inc. and its staff members conducting the exercise program from any and all claims, suits, losses or related causes of action for damages, including, but not limited to, such claims that may result from my injury or death, accidental or otherwise, during, or arising in any way from, the exercise program.

I understand that I am responsible for my children and/or any other minors, and the actions of said children/minors, who I bring with me on the premises. I do hereby waive, release and forever discharge Progressive Fitness Omaha, Inc. and its directors, officers, agents, employees, representatives, successors and assigns, administrators, executors, and all others from any and all responsibilities or liability from injuries or damages resulting from said children/minors participation in any activities or their use of equipment or machinery in the above mentioned activities. I do also hereby release Progressive Fitness Omaha Incorporated, those already mentioned and any others acting on behalf from any responsibility or liability for any injury or damage to said children/minors, including those caused by the negligent act or omission in any way arising out of or connected with said children/minors participation in any activities of Progressive Fitness Omaha, Inc. or the use of any equipment at Progressive Fitness Omaha, Inc.

DATE

PRINTED NAME

SIGNATURE