




Public Health
Prevent. Promote. Protect.



Tuscarawas County
Health Department


Release and Waiver of Liability

Full Name	
Address	
Phone Number	
Email (if applicable)	
Emergency Contact Name	
Emergency Contact Phone	

1. In consideration for voluntary participation, I hereby accept full responsibility for and assume the risk of any injuries sustained because of my participation in practice or lessons involving *Bingocize*, *Walking with Ease*, *Tai Chi for Arthritis*, and/or *A Matter of Balance*, and I hereby release and hold harmless, Tuscarawas County Health Department, affiliated hosting agencies, and all persons, and Coaches in association with the practice of *Bingocize*, *Walking with Ease*, *Tai Chi for Arthritis*, and/or *A Matter of Balance* (herein known as Classes) and waive any claim I may have against any and all interested parties.
2. I recognize and understand that I must be in adequate physical and mental health to participate in the Classes and that the Classes may require some physical exertion. I represent and warrant that I have no medical conditions which would prevent my active participation in the Classes, and I recognize that participation in the Classes may cause or aggravate a physical injury or medical condition. I understand that it is my responsibility to follow any instruction from my physician and to refrain from exerting my body or mind past my physical and mental limits. I understand that, at the discretion of my Coach and for my personal wellbeing, I may be required to notify my physician of my participation in the Classes. I understand that the Coaches reserve the right to refuse my participation in the Classes.
3. I am aware that my participation in the Classes could result in high blood pressure, fainting, fatigue, heartbeat disorders, heart attack, stroke, physical injury, death, and/or may aggravate pre-existing medical condition. I understand that I could experience muscle, back, joint, neck, or other injuries as part of my participation in the Classes. I understand my physical and mental limitations and I am self-aware enough to stop or modify my participation in the Classes to prevent injury, death, or aggravate a pre-existing medical condition.

 897 E. Iron Ave.
Dover, OH 44622

 (330) 343-5555
 (330) 343-1601

 www.tchdnow.org
 director@tchdnow.org



4. I acknowledged that my participation in the Classes is completely voluntary and that I may withdraw from the Classes at any time during the program, regardless of the reason.
5. This agreement shall be construed in accordance with, and governed by, the laws of the State of Ohio and that all actions, suits, claims, and proceedings relating to this agreement shall be brought in a court of competent jurisdiction located in Tuscarawas County Ohio. In case any provision of this agreement shall be held invalid, illegal, or unenforceable, it shall not affect any other provision of this agreement and this agreement shall be construed as if the provision had never been contained herein.

I acknowledge that I have carefully read and understand this agreement in its entirety. I voluntarily and knowingly agree to the terms and conditions stated herein. I am aware that by signing this agreement, I am waiving any rights of mine, my heirs, executors, or any assigned to those positions, to any legal repercussions against any and all interested parties.

Participant Signature: _____ Date: _____

Class Name: _____

This form must be completed for each balance and mobility program attended by each participant. Thank you for your cooperation
This program is funded by a grant from the Ohio Department of Health utilizing federal funds from the United States Department of Health and Human Services (HHS) Preventive Health and Health Services Block Grant (93.991).