

**Dr. Gertude A. Barber Center, Inc. d.b.a. Barber National Institute**

100 Barber Place, Erie, PA 16507

**AQUATIC PARTICIPANT DATA FORM and WAIVER**

LAST NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

FIRST NAME (of participant): \_\_\_\_\_ Age: \_\_\_\_\_ ☐ M ☐ F

IF PARTICIPANT IS UNDER 18 -

PARENT/LEGAL GUARDIAN: \_\_\_\_\_

EMAIL: \_\_\_\_\_ ☐ Check for mail through US parcel service.



*To send pool schedules, pool promotions and occasional Barber National Institute information only.*

ADDRESS: \_\_\_\_\_  
(street) (city) (state) (zip)

EMERGENCY CONTACT: \_\_\_\_\_  
(name) (phone#1) (phone #2)

**WHICH ACTIVITY ARE YOU PARTICIPATING IN?**

\_\_\_ Arthritis exercise class – *Arthritis Foundation Certified*

\_\_\_ Pool/Gym Rental

\_\_\_ Adult Open Swim

\_\_\_ Learn-To-Swim Lessons

**Anyone with a history of seizures IS REQUIRED TO wear a flotation aid during any swimming activity**

☐ Participant has known seizure activity

☐ I agree to provide adult supervision in lieu of flotation aid during swim lessons.

List any additional medical concerns:

\_\_\_\_\_  
\_\_\_\_\_

**HOW DID YOU HEAR ABOUT OUR AQUATIC PROGRAMS?**

\_\_\_ Friend

\_\_\_ Mailing

\_\_\_ Website

\_\_\_ Newspaper

\_\_\_ Health Care Provider

\_\_\_ Other

**Notice:** Pool temperature fluctuates between 89° and 91°

**WAVIER**

I understand and agree that there are risks, unforeseeable and unpredictable, associated with any exercise program. I am aware of these risks and agree that my participation is at my own risk. I hereby agree that the Dr. Gertrude A. Barber Center Inc., d.b.a. Barber National Institute shall not assume or have any responsibility or liability for expenses or medical treatment of for compensation for any injury I may suffer during or resulting from my participation on this program. Permission is granted to the Dr. Gertude A. Barber Center Inc., d.b.a. Barber National Institute staff to provide medical aid or assistance for my comfort until emergency personnel arrives, if required. I do hereby, for myself, my heirs, executors and administrators, waive, release and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or any future programs. I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

Signature \_\_\_\_\_

date: \_\_\_\_\_

(If under 18)

Parent Signature: \_\_\_\_\_

date: \_\_\_\_\_

**\*\*This waiver is valid for 1 year from the signature date\*\***