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

100 Barber Place, Erie, PA 16507

AQUATIC PARTICIPANT DATA FORM and WAIVER

FIRST NAME (of participant):	LAST NAME:	PHONE:	_ PHONE:		
PARENT/LEGAL GUARDIAN: EMAIL:	FIRST NAME (of participant):	Age:	M	F	
ADDRESS: (street) (city) (state) (phone#1) (phone #2) WHICH ACTIVITY ARE YOU PARTICIPATING IN? Arthritis exercise class — Arthritis Foundation Certified Adult Open Swim Anyone with a history of seizures IS REQUIRED TO wear a flotation aid during any swimming activity Participant has known seizure activity HOW DID YOU HEAR ABOUT OUR AQUATIC PROGRAMS? Friend Mailing Mebsite Moving 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. 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. Gertrude A. Barber Center Inc., d.b.a. Barber National Institute shall 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 or for 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 (if under 18) Parent Signature: date:					
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Parent Signature: date:		date:		_	
This waiver is valid for 1 year from the signature date	•	data			
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