

Office Use Only
Class applied for: _____
Day/Time of Class: _____
Member Service Initials: _____

Non-Member Class Waiver

Please Print:

Name: _____ Ph: _____ Date: _____

Date of Birth: _____ Primary Physician: _____

Mailing Address: _____ Town/zip: _____

The Bond Wellness Center at Monadnock Community Hospital is committed to providing safe and appropriate exercise programs to all who use our facilities. As a medically based exercise facility, we require a doctor's approval prior to exercise for people with high-risk medical conditions. Please complete this page before you participate.

Please Check All Appropriate Boxes:

- | | |
|---|---|
| <input type="checkbox"/> Age over 80 | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart surgery or angioplasty/stent placement |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Abnormal heart rhythm requiring medication or previous hospitalization |
| <input type="checkbox"/> Currently Pregnant | |

If any ONE of the boxes above is checked, we require your physician's signature on the reverse of this form prior to participating in classes.

Please Check All Appropriate Boxes:

- | | |
|--|--|
| <input type="checkbox"/> Age Over 60 | <input type="checkbox"/> Current Smoker |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Age Over 70 (Counts As 2... see below) |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes / Do you currently take insulin? Y N (Please circle) |

If any THREE of the boxes above are checked, we require your physician's signature on the reverse of this form prior to participating in classes.

Please check this box if you are currently, or have recently participated in physical therapy here at MCH.

I acknowledge that I've carefully read the above health criteria and answered honestly and completely.

(Signature)

(Date)

Liability Waiver & Release

You acknowledge that your attendance at or use of The Wellness Center at Monadnock Community Hospital, including without limitation your participation in any of the Wellness Center's programs or activities and your use of The Wellness Center's equipment and facilities and transportation provided by The Wellness Center, could cause injury to you. In consideration of your visit to The Wellness Center, you hereby assume all risks of injury which may result from or arise out of your attendance at or use of The Wellness Center or its equipment, activities, facilities, or transportation; and you agree on behalf of yourself and heirs, executors, administrators and assigns, to fully and forever waive, indemnify, hold harmless, release and discharge The Wellness Center at Monadnock Community Hospital, its affiliates, including but not limited to all of their respective officers, directors, employees, agents, successors and assigns, and (collectively, the "Releases") from any and all claims, damages, demands, rights resulting from or arising out of your attendance at or use of The Wellness Center or its equipment, activities, facilities, or transportation. Further, you hereby agree to waive any and all such claims, damages, demands, rights of action or causes of action. Further, you hereby agree to release and discharge the Releases from any and all liability for any loss or theft or, or damage to, personal property. You acknowledge that you have carefully read this waiver and release and fully understand that it is a waiver and release of any and all liability.

Do you now have or have you had any of the following? (Please check)

<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	Foot Pain L/R	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	Tight shoulders
<input type="checkbox"/>	Mid back pain	<input type="checkbox"/>	Chronic Fatigue	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	Cerebral aneurysm	<input type="checkbox"/>	Sciatica pain	<input type="checkbox"/>	TMJ pain	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Bleeding w/in the head	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	Stiff neck	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Fibroid disease	<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Fibromyalgia

If any of the above are checked, please explain:

Reimbursement Schedule for Cancelled Participation:

<u>Your Cancellation Date</u>	<u>% of Class Reimbursement</u>
Prior to First Class.....	Entire Cost, less 20% processing fee
After 1st Class, Prior to 3 rd Class.....	½ Class Costs Reimbursed
After Third Class.....	Unable to Reimburse

Physician Approval (If Required from Other Side)

I approve this patient's participation in exercise classes at The Wellness Center.

_____ Able to participate without limitation

_____ Able to participate while adhering to the following restrictions:

Physician's Name: _____ Office Phone () _____

Physician's Signature: _____ Date: _____

Please call 603-924-4650 with any questions.