PERSONAL HEALTH AND FITNESS, LLC

WAIVER AND RELEASE

I do hereby assume full responsibility for any and all damages, injuries, or losses that I may sustain or incur, if any, while attending or participating in exercise sessions supervised by _____ or any other trainer contracted by Personal Health And Fitness, LLC. I hereby waive all claims against Personal Health And Fitness, LLC. I also waive all claims against _____. These waived claims are for any injuries or damages that I could sustain.

I understand that there is a risk of injury or death associated with participating in any exercise program, exercise session, or sports activity and I certify that I am in good physical condition and have no known disabilities that might otherwise be detrimental to my health or well-being. I certify that all of the information provided on the Personal Health And Fitness, LLC., paperwork is correct and true.

PARTICIPANT SIGNATURE _____

DATE _____

****Parents must sign if participant is under 18 years of age.

Prohibited Medical Conditions

If you have been diagnosed by your physician as have any of the following medical conditions, you will not be allowed to participate in **Personal Health and Fitness, Inc**. personal training sessions until we receive written approval from your Physician.

1. Previous Heart Attack (within the last five years)
2. Previous Cardiac Bypass Surgery (within the last two years)
3. Known Cardiac Heart Disease
4. Congestive Heart Failure
5. Mitral Valve Prolapse
6. Uncontrolled Coronary Arrhythmia's
7. Recent Embolism, Systemic or Pulmonary
8. Unexplained Inappropriate Bradycardia
9. Known or Suspected Dissecting Aneurysm
10. Known or Suspected Thrombophlebitis
11. Pacemaker (fixed rate)
12. Uncontrolled Blood Pressure (without medication)
13. Controlled Blood Pressure (with medication)
14. Acute Systemic or Infectious Illness (i.e., mono, hepatitis, fever, viral infection)
15. Uncontrolled Metabolic Disease (i.e., diabetes, thyrotoxicosis)
16. Pregnancy
17. Terminal disease
18. Pulmonary Disease (i.e., asthma, emphysema)
19. Orthopedic Limitations
20. Degenerative Neuromuscular Disease
21. Please list explain and any changes in your medical history in the past twelve months or medications that you are currently taking.

_____

_____

_____

Physician's Name, Address and Phone Number:

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I HEREBY ACKNOWLEDGE THAT I HAVE READ THE ABOVE INFORMATION PRIOR TO SIGNING AND HAVE **NOT** HAD ANY OF THE ABOVE STATED CONDITIONS.

SIGNATURE_____DATE_____