



16 Centennial Ave, 2nd Floor

Hanover, PA 17331

(717) 634-5445

Artistic Director: Lisamarie Marks

## INFORMED CONSENT FOR ADULT CLASSES

I desire to engage voluntarily in the adult classes in order to attempt to improve my physical fitness. I understand that the activities are designed to place a gradually increasing workload on the cardio respiratory system and to thereby attempt to improve its function. The reactions of the cardio respiratory to such activities can't be predicted with complete accuracy. There is a risk of certain changes that might occur during or following the exercise. These changes might include abnormalities of blood pressure or heart rate.

I understand that the purpose of this class is to develop and maintain cardio respiratory fitness, body composition, flexibility, and muscular strength and endurance. All classes include warm-up, exercise at target heart rate, and cool-down.

I understand that I am responsible of monitoring my own condition throughout the class and should any unusual symptoms occur, I will cease my participation and inform the instructor of the symptoms.

In signing this consent form, I affirm that I have read this form in its entirety and that I understand the nature of the class. I also affirm that my questions regarding the class have been answered to my satisfaction.

In the event that a medical clearance must be obtained prior to my participation in the class, I agree to consult my physician and obtain written permission from my physician prior to attending class.

Also, in consideration for being allowed to participate, I agree to assume the risk of such exercise, and further agree to hold harmless The Dance Academy and its staff members conducting the class from any and all claims, suits, losses, or related caused of action for damages, including, but not limited to such that may result from my injury or death, accidental or otherwise, during, or arising in any way from the class.

\_\_\_\_\_  
(Signature of Participant)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Class)

PLEASE PRINT CLEARLY

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

TELEPHONE \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_

TELEPHONE \_\_\_\_\_

LIMITATIONS/MEDICATIONS \_\_\_\_\_