Yoga & Pilates Waiver and Informed Consent

I _____ HEREBY AGREE TO THE FOLLOWING:

Client is aware that participation in Yoga or Pilates may result in an accident, or injury and Client assumes the risk connected with the participation in Yoga and Pilates and represents that Client is in good health and suffers from NO physical impairment that would limit their use of Serenity Yoga & Pilates Studio, LLC facilities. Client acknowledges that Marcie Evans and Justin Evans or any other Agent representing Serenity Yoga and Pilates Studio, LLC have not and will not render any medical services including medical diagnosis of Client's physical condition.

Client specifically agrees that Marcie and Justin Evans or any other agent of Serenity Yoga & Pilates Studio, LLC shall not be liable for any claim, demand, cause of action of any kind resulting from or related to Client's use of the facilities or participation in any sport, exercise, or activity within or without the studio premises, and buyer agrees to hold Marcie Evans, Justin Evans, or any other agent of Serenity Yoga & Pilates Studio, LLC harmless from same.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above. My signature below indicates my physician has cleared me to exercise.

_____

[SIGNATURE OF CLIENT]

The following conditions need pose/exercise modifications and adjustments. Client is responsible for talking to the instructor if he/she has any of the following conditions. In some cases, Client will be asked to have primary or specialty Physician or Therapist fill out a Medical Release Form prior to beginning any activity. Please check the boxes below if you experienced or sought treatment for any of the following:

- ❑ Arthritis
- ❑ Asthma
- ❑ Osteoporosis/Osteopenia
- ❑ Sciatica/Hip Pain/Hip Surgery
- ❑ Wrist Injury/Wrist Surgery
- ❑ Heart Condition/Heart Disease/Heart Attack
- ❑ Back OR Neck Injury/Surgery
- ❑ Knee Injury/Knee Surgery
- ❑ Shoulder Injury/Shoulder Surgery
- ❑ Glaucoma, Other Head or Eye Disorder
- ❑ Diabetes
- ❑ Hypotension (low blood pressure)
- ❑ Multiple Sclerosis, Fibromyalgia or other autoimmune disorder
- ❑ Pregnant Currently/Postpartum (list # weeks) _____
- ❑ Hypertension/ High Blood Pressure Please Circle (Medication or No Medication)
- ❑ Breast Cancer or Surgery If a Survivor, please circle: I HAVE/HAVE NOT been informed of the risks of lymphadema and HAVE/HAVE NOT been told to wear compressions during exercise