



In Partnership With



## WalkStrong 5k/10k Training for ALL Bodies

**PLEASE PRINT LEGIBLY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State Zip \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

T-SHIRT SIZE (circle One)    SM    M    L    XL    2XL    3XL    4XL

### **WAIVER AND RELEASE OF LIABILITY -- READ BEFORE SIGNING**

In consideration of being allowed to participate in any way in a Synergy Health and Wellness or FootZone related event (To include but not limited to training programs, social runs, fun runs, clinics, etc.) and any of its related events and activities, I, the undersigned, acknowledge, and agree that:

- The risk of injury from the activities involved in this program is significant, and while particular skills, equipment, and personal discipline may reduce this risk, the risk of serious injury or death does exist. I knowingly and freely assume all such risks, both known and unknown, even if arising from the negligence of the releases or others, and assume full responsibility for my participation.
- I willingly agree to comply with the stated and customary terms and conditions for participation. If, however, I observe any unusual significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the Company immediately.
- I understand that Synergy Health and Wellness is an independent LLC and independently operates this training program which I am willingly choosing to participate in and take full responsibility and risk for my involvement and anything that may occur during the event or activity.
- I understand that FootZone independently operates and take full responsibility and risk for my involvement and anything that may occur during the event or activity.
- I also understand that Synergy is not directly affiliated in any way other than good faith partnership with FootZone.
- I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, hereby release, indemnify, and hold harmless Synergy Health and Wellness, FootZone of Bend, their agents, employees, coaches, volunteers, officers, directors, franchisers, successors and assigns, and any and all sponsors, their representatives and successors ("Release's"), with respect to any and all injury, disability, death, or loss or damage to person or property associated with my presence or participation, whether arising from the negligence of the releases or otherwise, to the fullest extent permitted by law.
- I attest that I am in good health and physically capable and voluntarily participating in this activity or event, **and my medical care provider has approved my participation.**

- Further, I hereby release, consent to, and authorize, in advance, any such use of my name, photograph, voice or likeness by the foregoing parties in any manner they deem appropriate and necessary without remuneration to me.
- Refunds will only be issued in the case that a physician denies medical clearance for participation at the beginning of the program.

I HAVE CAREFULLY READ THIS WAIVER AND RELEASE AND FULLY UNDERSTAND ITS CONTENTS.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent or Guardian if under 18** \_\_\_\_\_

**Refunds will be issued only in the event that the participant’s physician does not agree to the clearance for activity below, prior to start of the program.**

**Participant Agreement (initial next to each pledge)**

- \_\_\_\_ I will obtain and provide physician’s clearance no later than the first group session.  
(this may be faxed to 541-323-3488)
- \_\_\_\_ I promise to attend as many WalkStrong group sessions as possible.
- \_\_\_\_ I pledge to commit the time and energy to complete my mid-week workouts.
- \_\_\_\_ I agree to contact my WalkStrong coach when I have questions or concerns.
- \_\_\_\_ I will set realistic expectations and goals for myself.
- \_\_\_\_ I promise to go my own pace and honor what my body can do that day.
- \_\_\_\_ I guarantee to take ownership of my participation in the WalkStrong program.
- \_\_\_\_ I pledge to honor all bodies, including my own, and will honor everyone’s right to enjoy movement in a weight inclusive environment. I will refrain from any talk about weight loss, dieting, or judgment of body sizes during my time with the group.
- \_\_\_\_ I will communicate with coaching and medical staff anytime I am not feeling well during a workout.



Synergy Health and Wellness, LLC ®  
 361 NE Franklin Ave. Bldg C  
 Bend, OR 97701  
 541.323.3488  
**FAX: 541-323-3483**

Dear Doctor \_\_\_\_\_:

Your patient (Name) \_\_\_\_\_ (Date of Birth) \_\_\_\_\_ wishes to take part in an exercise program called WalkStrong. This program has been specifically designed for people who are new to exercise, living in larger bodies, and/or are differently-abled, but of course all bodies are welcome! Our minimum requirement is the ability to walk or roll for 5 minutes upon starting. The program may include progressive resistance training, flexibility exercises, and a cardiovascular program increasing in duration and intensity over time. Our program will slowly progress over the course of 12 weeks and will result in the ability to walk a 5k or 10k event as a group. Our supervised trainings include staff who will be able to monitor symptoms and call for emergency medical assistance if needed.

We seek your advice in setting any limitations to their program. By completing this form, you are not assuming any responsibility for our exercise and assessment program. Please identify any recommendations or restrictions for your patient's fitness program below (Physician's Recommendations).

### Patient's Consent and Authorization

I consent to and authorize (Physician Name) \_\_\_\_\_ to release to Synergy Health and Wellness, health information concerning my ability to participate in a movement program. I understand this consent is revocable except to the extent action has already been taken. Authorization is not valid beyond one year from date of signature. Further disclosure or release of my health information is prohibited without specific written consent of the person to whom it pertains.

Participant/Patient signature	Date
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### Physician's Recommendations

Initial One	
	I am not aware of any contraindications toward participation in a fitness program.
	I believe the applicant can participate, but urge caution because:
	The applicant should not engage in the following activities:
	I recommend the applicant <b>not</b> participate in the above fitness program.

Physician's signature	Date	
Physician's name (print)	Phone	Fax