



## Parent Informed Consent/Release to Exercise

In consideration of the Graham Academy's acceptance of my minor child, as listed below, for participation in the Graham Academy's fitness program, including use of the school's equipment and facilities, I, on behalf of said minor child and myself, my heirs, personal representative(s) and assigns hereby represent and agree as follows:

1. I understand that utilizing the Graham Academy's fitness equipment is not part of the academic curriculum and is completely voluntary on my minor child's part.
2. I fully recognize and understand that there are risks and hazards associated with both cardiovascular exercise and resistance training that may result in property damage and/or personal injury, including but not limited to: cuts, scrapes, bruises, broken bones, muscle strains, pulls or tears, other bodily injuries, heat prostration, blindness, deafness, heart attacks, temporary or permanent disabilities, paralysis, and, even, death.
3. I understand that engaging in cardiovascular exercise and/or resistance training at the Graham Academy, as well as use of its equipment, requires a minimum level of fitness for safe participation. I also understand that the Graham Academy requires participants to have a physical examination to determine their fitness or participation. **I further understand that the Graham Academy does not provide medical, health, or other insurance for students who utilize the fitness equipment or engage in cardiovascular exercise and/or resistance training.**
4. Knowing the dangers, hazards, and risks associated with cardiovascular exercise and resistance training, as well as use of the Graham Academy's fitness equipment, and with sufficient knowledge of my child's physical condition(s) and limitations, if any, I voluntarily assume all responsibility and risks of loss, damage, illness and/or injury to person or property which my child may, in any way, sustain in connection with his/her participation in cardiovascular exercise and/or resistance training at the Graham Academy.
5. I agree that my child must abide by all rules and regulations applicable to participation in cardiovascular exercise and/or resistance training at the Graham Academy. Should my child require first aid or emergency medical treatment as a result of illness or injury associated with cardiovascular exercise and/or resistance training at the Graham Academy, I consent to first aid or treatments.
6. To the fullest extent permitted by law, I hereby release and forever discharge, and agree not to sue and to indemnify and hold harmless, the Graham Academy and their officers, agents, employees, and volunteers from and against any and all liabilities, claims, demands, and causes of actions of any kind on account of any loss, damage, illness, or injury to person or property in any way arising out of or relating to my child's participation in cardiovascular exercise and/or resistance training at the Graham Academy or use of the Graham Academy's fitness equipment or facilities, whether due to negligence default, or other action or inaction of any person or entity.

I CERTIFY THAT I AM 18 YEARS OF AGE OR OLDER AND THAT I HAVE READ AND FULLY UNDERSTAND THIS RELEASE AND INFORMED CONSENT FORM, AND I SIGN IT VOLUNTARILY WITH FULL KNOWLEDGE OF ITS SIGNIFICANCE.

\_\_\_\_\_  
Name of Student (please print)

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

\_\_\_\_\_  
Name of Student's Parent/Guardian (please print)

\_\_\_\_\_  
Signature of Student's Parent/Guardian

\_\_\_\_\_  
Date



# THE GRAHAM ACADEMY

*a journey of discovery*

## Medical Clearance Form

Date:	Student Name:
D.O.B:	

Dear Doctor,

Your patient, the student listed above, wishes to begin exercising in our gym. The student would engage in low to moderate intensity cardiovascular exercise, involving a recumbent bike, rowing machine, and treadmill. As time passes, the student may progress to bodyweight exercises (push-ups, sit-ups, etc) and then weights.

If your patient is taking any medications that will affect his or her exercise capacity, or heart rate response to exercise, please indicate the manner of the effect (raises, lowers, or has no effect on exercise capacity or heart rate response).

Type of medication	Effects

Please identify any restrictions or contraindications to exercise for your patient in the space below:

Please check the appropriate box to indicate your evaluation:

<input type="checkbox"/>	The patient has my approval to begin exercising with the restrictions listed above.
<input type="checkbox"/>	The patient <b>does not</b> have my approval to begin exercising at this time.

Signed \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_