



# Fit Mamas Prenatal Exercise Consent Form

## Participant Section

I request enrollment in prenatal exercise class. I certify that I have given my treating physician the written information about this class and have obtained the approval of my treating physician to participate. I understand that I will not be able to enroll or to continue in this class without written permission of my treating physician. I agree to keep my physician informed of the effects of this class on my body. I further understand that there is no requirement to perform all the class exercises and that I can withdraw from this class at any time.

During class, I agree to limit my activity to that which is comfortable for me and to stop all activity if I feel uncomfortable. Upon experiencing any discomfort at any time either during or after this class, I will immediately contact my treating physician to inform him/her and seek medical advice. I understand that all forms of exercise involve some risk of injury. I accept complete responsibility for my health and well being in this voluntary program. In consideration of my participation in the Fit Mamas exercise program, I, for myself, my heirs and assigns, hereby release and discharge from any and all liability now or in the future. This release includes, but is not limited to, heart attacks, muscle strains, fractures, shin splints, musculoskeletal injuries, heat prostration, or any injury to myself and my unborn child. I hereby knowingly and voluntarily waive any and all claims against Fit Mamas prenatal exercise and its constituents.

Information regarding my health status will be treated as confidential and will not be released to any person other than program staff without consent. The information obtained may be used for statistical purposes.

\_\_\_\_\_  
Printed Name of Participant

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

## Physician Certification

I approve of my patient's participation in this class. The health status of this patient will permit her to participate in the program subject to restrictions listed below.

List any exercises or precautions that this patient should not perform:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Treating Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Office Telephone