

**Arthritis Foundation Aquatic Program
Participant Application and Release Form**

I. General Information

Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Type of arthritis, if known: _____

Session you wish to participate in: (check one) 3:45 - 4:45 P.M. 4:45 - 5:45 P.M. 5:45 - 6:45 P.M.

A fee of \$2.00 is charged for each session and is paid at the start of each session. Make check payable to: WCBDD

II. Participation Release Form

I understand and agree that there are risks, both foreseeable and unpredictable associated with any exercise program. I am aware of these risks and agree that my participation is at my own risk. If my application for the Arthritis Foundation Aquatics Program is accepted, I agree that neither the Arthritis Foundation nor the WCBDD no any co-sponsoring organization or facility, or their respective chapters, officers, director, employees, agents, members, or volunteers, shall assume or have any responsibility or liability for expenses or medical treatment or compensation for injury I may suffer during or resulting from my participation in this program. I do hereby, for myself, my heirs, executors and administrations, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me rising out of or represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitation to my participation.

Signature

Date

Please send your completed application to:
Washington County Board of Developmental Disabilities
1701 Colegate Drive
Marietta, Ohio 45750
Attention: Shelby Sams
Phone: 740-373-3781, Ext. 22