BRING YOUR CHILD TO WORK DAY
School Permission Form

I , _____,
(Print name of parent or guardian)

have given permission for _____to
(Print full name of student)

participate in the **BRING YOUR CHILD TO WORK** activities at the Northeast Ohio Medical University (NEOMED) in Rootstown, OH on April 27, 2017.

I understand that NEOMED will provide this student with a form verifying attendance in these activities and that it is my responsibility to have that form returned to the school by Monday, May 1, 2017 in order for this student to receive credit for attending a school-related activity for the day.

Parent/Guardian
Signature_____Date_____

Print Name of Child_____

Northeast Ohio
MEDICAL UNIVERSITY

Media Consent and Release

I authorize Northeast Ohio Medical University (NEOMED) to record my name, voice and likeness on videotapes, audiotapes, photographs, CDs, DVDs, video clips and/or web-based materials (media) at NEOMED's discretion. In addition, I give NEOMED permission to view, use, and edit such media. I waive all rights to inspect and/or approve the media and any copy that NEOMED may use in conjunction with the media and the uses to which they may be applied. I understand that NEOMED may use the media, in whole, in part, or in composite for educational, research, or promotional purposes, or for any other uses NEOMED deems fit.

I understand that NEOMED owns all rights to the aforementioned media and hereby release all claims against the University with respect to copyright ownership and publication. I understand I will not be compensated for the use of any media in which I am a part. I waive all rights in the media and release NEOMED from any loss, damage, and/or liability arising out of my appearance on such media.

_____ _____
Signature of Person Granting Consent Date

_____
Printed Name of Person Granting Consent

_____ _____
Address Telephone

_____ _____ _____
City State/Country Zip Code

_____ _____
Signature of Parent/Guardian of Minor. Date

If you have any questions, please contact the University's Office of Public Relations at 330.325.6618.

Guest Registration and Waiver Form

Today's Date:_____ Name:_____ Date of Birth: _____

Address:_____ City:_____ State:_____ Zip: _____

Primary Phone:_____ Secondary Phone:_____ Email:_____

Emergency Contact:_____ Emergency Contact Phone:_____

Exercise Readiness Questionnaire

Please read each question and circle either "Yes" or "No". If you answer "Yes" to any of the questions, you will re-quire a physician release form (see Member Services Associate at the Health and Wellness Desk) prior to participation within Health and Wellness Services.

Yes No 1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?

Yes No 2. Do you feel pain in your chest when you do physical activity?

Yes No 3. In the past month, have you had chest pain when you were not doing physical activity?

Yes No 4. Do you lose your balance because of dizziness or do you ever lose consciousness?

Yes No 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?

Yes No 6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

Yes No 7. Do you know of any other reason why you should not do physical activity?

I acknowledge that I have answered "Yes" to one or more of the above Exercise Readiness Questions (see above). Because of my increased medical risk factor(s), I acknowledge Sequoia Wellness requires a physician's clearance prior to participation. However, at this time I will NOT seek physical clearance and choose to continue to use Sequoia Wellness at my own medical risk. I release IWP-Rootstown (dba Sequoia Wellness), its employees and agents from any injury or illness that may occur as a result of this decision:

Signature:_____Date: _____
Failure to sign will preclude you from any activity or event inside Sequoia Wellness

Rules and Regulations

I understand and agree that I will be fully responsible for complying with all Rules and Regulations prescribed by the Wellness Center, which may be amended from time to time, and that I have been provided a copy of the Wellness Center's current Rules and Regulations.

Waiver of Claims and Assumption of Risk Form

This Waiver of Claims and Assumption of Risk Form (the "Waiver") executed on this day by the undersigned (the "Guest"), in favor of Northeast Ohio Medical University, IWP Rootstown, LLC, ERS Strategic Properties, Inc. and their respective subsidiaries, affiliates, directors, officers, owners, managers, employees, agents, successors and assigns (collectively, the "Operator") for his/her use of the Wellness Center. The Guest does hereby, voluntarily, and without duress execute this Waiver under the following terms:

Waiver of Claims and Assumption of Risk Form

This Waiver of Claims and Assumption of Risk Form (the "Waiver") executed on this ____ day of _____, 20__, by the undersigned (the "Guest"), in favor of Northeast Ohio Medical University, IWP Rootstown, LLC, ERS Strategic Properties, Inc. and their respective subsidiaries, affiliates, directors, officers, owners, managers, employees, agents, successors and assigns (collectively, the "Operator") for his/her use of the Wellness Center. The Guest does hereby, voluntarily, and without duress execute this Waiver under the following terms:

Release and Waiver: Guest does hereby release and forever discharge and hold harmless the Operator from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from Guest's use of the Wellness Center, including, but not limited to Guest's: (a) entry into or upon the facilities of the Wellness Center, (b) participation in any program or activity offered through the Wellness Center, (c) use of any equipment, machinery, or facilities of the Wellness Center, or (d) any exercise activities conducted outside the facilities of the Wellness Center. Guest understands that this Waiver discharges the Operator from any liability or claim that Guest, or any of Guest's heirs, executors, administrators, and assigns may have, against the Operator, with respect to bodily injury, personal injury, illness, death, or property loss or damage that may result from any of the above activities, whether caused by the negligence of the Operator or otherwise. Guest also understands that the Operator does not assume any responsibility for or obligation to provide financial assistance or other assistance, including but not limited to medical, health, or disability insurance in the event of injury or illness.

Medical Treatment: Guest does hereby release and forever discharge the Operator from any and all claims whatsoever which may arise on account of any first aid, treatment, or service rendered in connection with any of Guest's activities described herein.

Assumption of Risk: Guest understands that there are possible dangers associated with activities requiring physical exertion, including, without limitation, transient dizziness, fainting, nausea, muscle cramping, musculoskeletal injury, sprains and strains, heart attack, stroke or death, and that the Wellness Center will **NOT** be monitoring Guest's use of the equipment, machinery or facilities of the Wellness Center. Guest hereby assumes full responsibility for any and all injuries or damages arising from those risks.

Representations: Guest understands that strength, flexibility, sports and aerobic exercises, including the use of exercise equipment involves risk of injury. Guest represents that Guest is physically able to participate in the activities and programs offered through the Wellness Center and that Guest will not extend himself/herself beyond his/her abilities, or if Guest does so, it will be at his/her own risk. Guest has been informed by the Operator that he/she should consult with a physician concerning his/her current physical condition, and should periodically update his/her physical condition with a physician. Guest has either obtained his/her physician's approval or has decided to participate in physical activities without obtaining the advice of a physician.

By signing below, Guest acknowledges that he/she has read this Waiver and understands the rights he/she is waiving by signing it.

Guest:_____ Guest: _____ Date:_____
(Print) (Signature)

If Guest is under the age of 18:

_____ _____ Date: _____
Parent or Authorized Representative (Print) Parent or Authorized Representative (Signature)