WAIVER

Our program is a comprehensive program of Fall Prevention, which includes assessment and specific interventional exercises both of which may contain risks, although rare. They include, but are not limited to: muscle/tissue soreness, strains/sprains and possible fractures. Please note that in an emergency situation our staff will follow all lifesaving procedures, including calling 911, and the administering of CPR.

After your initial assessment, you may notice some stiffness or soreness. This is because the staff member may be placing your body through some movements in order to determine your baselines. Please keep our staff informed about changes in your symptoms during the course of our program so that they can respond accordingly. We ask that you follow the staffs' instructions so that you perform the activities in a safe manner to avoid any risk of injury. You may discontinue our program at any time, however, we ask that you extend the courtesy of informing our staff or administration at Hudson Valley Cerebral Palsy Association of your decision, as well as your reasons for doing so. If you have any further questions, you are encouraged to ask our staff.

Consent

As a participant in the Fall Prevention Program, I have received permission from my physician to participate in an exercise program to improve my gait and balance a Hudson Valley Cerebral Palsy Association. In signing this waiver, you agree that you are unaware of any medical condition that would prevent you from participating in either the assessment and/or the interventional exercises of our program, or have documented clearance from the physician to participate.

Clinic Liability Waiver

As a participant in the Fall Prevention program, conducted by the staff of HVC PA, including all assessment protocols and interventional protocols, I, for myself, my executor, administrators, heirs, devises, and assigns, hereby discharge Hudson Valley Cerebral Palsy Association, its staff, their management, their officers, board member, employees, members, organizers or their representatives, or their successors, and all cooperating businesses and organizations from all claims of damages, demands, actions, illnesses, injuries, death and causes whatsoever in any matter arising from or growing out of my participation in the Fall Prevention Program at HVC PA. I attest and verify that I am medically able to participate and assume all risks of participation in the Fall Prevention Program. I understand that I may be photographed, filmed, or videotaped at the event.

I state that I am physically fit and able to participate in the Fall Prevention Program. I also give my full permission for such first aid as deemed necessary to be provided to me on the premises or prior to transport to a hospital for further treatment.

Participant Name: _____ Date: _____
Participant Signature: _____
Parent or Guardian Signature (if under 18): _____

☐ Yes, I give Hudson Valley Cerebral Palsy Association the absolute right and permission to post photographs, gait analysis, and/or written description of my gait analysis on their Facebook page.

☐ No, I do not give Hudson Valley Cerebral Palsy Association the absolute right and permission to post photographs, gait analysis, and/or written description of my gait analysis on their Facebook page.