



American Turners of Louisville, Inc
 3125 River Road 3rd Floor Gym Louisville, KY 40207 (502) 895-7501 ph
 Turners Circus & Gymnastics
Permission to Participate, Waiver and Release of Liability



Initial each item below when you have read and fully understand what you are initialing

____ I hereby acknowledge and accept the risks and dangers of gymnastics, acrobatics, Trapeze, Silks, Lyra, Spanish Webs, , fire entertainment (18 and older), and other circus activities. I accept the conditions and enrollment and give permission for myself / my child to participate in circus training.

____ I also understand in the event medical treatment is required, I give my permission to the staff to secure the services of a licensed physician to provide the necessary treatment, including anesthesia, for my child's/children's well being. In the event of immediate attention,

____ I give my permission to American Red Cross certified Turners Circus staff to assist my child/children until Emergency Medical Technicians or licensed medical practitioners arrive. Turners Circus will make every attempt to contact the person I have listed on the emergency form.

____ I agree to comply with all program regulations, gym rules, and Turner Park rules and regulations.

____ American Turners of Louisville, Inc. DBA Turners Circus or Louisville Turners retains the rights to any photographs, videos, or media of participants to be used for publicity, social media, or advertising and I give permission for myself / my child to be photographed or videoed.

____ I fully understand and acknowledge that (a) risks and dangers exist in participation in acrobatics, aerial arts, aerial performance, fire entertainment (18 and older), other circus activities, gymnastics. (b) participation in such activities and / or use of circus equipment being used in these activities may result in injury, illness or death, or damage to personal property (c) these risks and dangers may be caused by other participants by accident and risks and dangers may arise from foreseeable or unforeseeable causes that are integral to recreational activities; (d) I hereby accept and assume these risks and dangers.

____ I acknowledge that I/my child am/is in good health and understand that I/my child will be experiencing some strenuous physical exertion while participating in these activities. I am aware of no physical disabilities or health problems which would present any risk to me/my child or instructors and/or volunteers of Turners by me/my child engaging in the activities.

____ In addition, in consideration for being allowed to participate in one or more of the above activities or observe others who are participating, the undersigned acknowledges and agrees that he or she, for and on behalf, or his or her heirs, executor, administration, agents/or assigns does hereby forever exonerate, release, acquit or discharge American Turners of Louisville DBA Turners Circus or Louisville Turners their officers, employees, agents, and/or assigns from any and all fines, claims, demands, damages, action, suit, judgment, debts, liabilities, injuries, and causes of action of every nature, including death which the undersigned has, or, may have, or which the undersigned may have against American Turners of Louisville, Turners Circus, and Louisville Turners, its officers, agents, employees, volunteers, and/or assigns resulting from injuries or death suffered by the undersigned's participation in circus activities.

____ I understand it is Turners policy that current medical insurance is necessary in order to participate in any gymnastics, acrobatic, aerial, fire entertainment (18 and older) and circus activities. I have current medical insurance and agree to provide Turners with a copy of the insurance card before I can participate.

Health Questionnaire:

Turners recommends all participants have a health physical by a medical professional before starting any gymnastics, martial arts, acrobatic, aerial, or circus training. This questionnaire is designed to help you determine the need to obtain a physical or consultation from your doctor. It is always advisable to seek the opinion of your physician prior to starting any exercise program. This questionnaire is especially helpful if you feel that you are de-conditioned or if it has been a long time since you started a regular exercise program.

- Yes or No 1. Are any participants listed above currently taking medication for high blood pressure?
- Yes or No 2. Do any participants listed above have any history of heart disease?
- Yes or No 3. Have any participants listed above experienced dizziness, fainting spells, syncope, blackouts, or loss of time in the last year?
- Yes or No 4. Do any participants listed above have any muscle, joint, back, or neck problems that may be aggravated by certain types of exercise?
- Yes or No 5. Do any participants listed above have any behavioral issues, depression, or suicidal thoughts that the instructors should be made aware?
- Yes or No 6. Can you think of any physical problems that may prohibit or limit the participants listed above participation?

If yes to any of the above questions, please explain AND describe to instructors: _____

If you answered yes to any of the above questions, it is important that you seek the advice of your physician prior to starting any exercise program. The question of your physical fitness is ultimately left up to you. As with any exercise program, it is best to take your time and slowly build up the level of intensity that you desire. By understanding your body's limitations, you will safely achieve your fitness goals.

Signature _____

I HAVE READ THE ABOVE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO ASSUME AND ACCEPT ALL RISKS ASSOCIATED THEREWITH.

PLEASE FILL OUT BOTH SIDES



Permission to Participate, Waiver and Release of Liability, Class Registration and Contact Information



Adult's First Name: _____ Last Name: _____

(Circle one)M / F Member - Yes / No Occupation: _____ Age _____

Address: _____

Phone: _____ Email: _____

2nd Adult's First Name: _____ Last Name: _____

(Circle one)M / F Member - Yes / No Occupation: _____ Age _____

Address: _____

Phone: _____ Email: _____

**Please list all participants whom may be using our facilities,
the above are financially, medically, and legally responsible for:**

Child's First Name: _____ Last Name _____

Birthday _____ Age _____ M / F Member - Yes / No

Child's First Name: _____ Last Name _____

Birthday _____ Age _____ M / F Member - Yes / No

Child's First Name: _____ Last Name _____

Birthday _____ Age _____ M / F Member - Yes / No

Child's First Name: _____ Last Name _____

Birthday _____ Age _____ M / F Member - Yes / No

Emergency:

Emergency Contact: _____ Phone: _____ Other: _____

Preferred Hospital or Doctor: _____ Phone: _____ Other: _____

Please provide us with a copy of your medical insurance, if a copy is not available, you must provide your insurance information below. Due to the medical and health dangers involved with gymnastics, acrobatics, aerial, and circus training you must have current medical insurance to participate.

Medical Insurance: _____ Group: _____ Policy: _____

Other:

How did you hear about Turners? _____

What is your goal? _____

Any similar background / training / interest / hobbies / professions:

PLEASE FILL OUT BOTH SIDES