Sans Souci Massage & Wellness Center LLC

Katherine E Schimmel LMT, CFT

I, (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my consent to participate in the exercise therapy conducted by Katie Schimmel at Sans Souci Massage & Wellness Center LLC.

**BENEFITS**

Participation in a regular program of physical activity has been shown to produce positive changes in a number of organ systems. These changes include increased work capacity, improved cardiovascular efficiency, and increased muscular strength, flexibility, power and endurance.

**RISKS**

I recognize that exercise carries some risk to the musculoskeletal system (sprains, strains) and the cardiorespiratory system (dizziness, discomfort in breathing, heart attack). I hereby certify that I know of no medical problem (except those noted on PAR Q+ form) that would increase my risk of illness and injury as a result of participation in a regular

exercise program.

**TESTING AND EVALUATION RESULTS**

I understand that I will undergo an initial assessment to determine my current physical fitness status. The assessment will consist of video recording of movements (walking, picking up items, and reaching for a shelf), completing health inventory including PAR Q+, LEFS, UEFI. I further understand that such screening is intended to provide Katie Schimmel with essential information used in the development of an individualized exercise therapy program. I understand that my individual results will be made available only to me. I also understand that the testing is not intended to replace any other medical test or the services of my physician. I will be provided a copy of all results if requested. I may share the results with whomever I please, including my personal physician. By signing this consent form, I understand that I am personally responsible for my actions during my training at Sans Souci Massage & Wellness Center LLC, and that I waive the responsibility of this center and trainer (Katie Schimmel) if I should incur any injury not limited to, physical or phycological injury, pain, suffering, illness disfigurement, temporary or permanent disability, economic or emotional loss, or death as a result of participating in the exercise therapy plan.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PARENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

or GUARDIAN (for participants under the age of majority)

InformedConsent