**White Cloud Pilates West**

New Client Release Form

1414 Riverside Dr.

Lakewood, OH 44107

**CLIENT INFORMATION**

 **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Last

 **Home address:** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Apt. #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City ST Zip

**Contact Info:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mobile # Email

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Phone # Relationship

**How did you hear of us? \_\_\_\_ Building Sign \_\_\_\_ Internet \_\_\_\_ Clients referrals Name of referring client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL INFORMATION**

Please discuss, with your Pilates instructor, any of the following, as they apply to you:

* Protruding/degenerative disks, scoliosis, sciatica, bone spurs or other spinal problems
* Previous surgeries, especially to the neck, shoulders, abdomen, hips, spine, knees, and/or feet
* Conditions which may require surgery in the future
* Chronic conditions such as bursitis, tendentious, arthritis or muscular dystrophy
* Pregnancy, heart disease, high blood pressure, or osteoporosis

**Disclaimer:** Although I understand that Pilates exercise is usually safe, and I recognize that any physical
activity holds some risk of injury. I fully acknowledge and accept this potential risk, and I am willingly participating. In consideration of my participation in White Cloud Pilates West (WCPW’s) Pilates program,

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Print Full Name) for myself and my family, release WCPW (its employees and owners), from any claims, demands and causes of actions arising from my participation in the exercise program, and

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (Print Full Name) hereby release WCPW, from any liability now or in the future including, but not limited to, muscle strains, pulls, tears, broken bones, heart attacks, knee, lower back, or foot injuries and any other illness, soreness or injury, however caused, occurring during or after my participation in this program.

I have read and fully understand the above.

***X* Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Participant or Guardian)**

**WHITE CLOUD PILATES WEST POLICIES**

Someone has explained the following policies to me, and I understand that these polices apply to any WCPW session.

* We request a **6 -Hour cancellation notice** for cancellations of any class or appointment.
* Clients who attend classes are responsible for managing his/her own schedules, both into and out of classes.
* A **“no show”** for any type of session, be it a private or a group class, **will result in a charge**.
* There are **NO** **REFUNDS** on package purchases, although packages may be transferred.
* **Full Payment** must be received prior to attending any type of session at White Cloud Pilates West.

***X* Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **(Participant or Guardian)**

**White Cloud Pilates West**

**Covid-19 Waiver**

By entering this facility and participating in Pilates classes or sessions with White Cloud Pilates West, you are aware that you agree to fully accept all known and unknown risks, including the potential risk of exposure to respiratory illnesses such as the “coronavirus” (“2019-nCoV”, “SARS-CoV-2”, “COVID-19”). COVID-19 is primarily transmitted via exhaled respiratory droplets most often through coughing and sneezing. However, you are aware of and accept responsibility for the possible risk of exposure through breathing techniques used during your Pilates practice, as well as potential exposure through either equipment contact or exposure to other clientele.

You further understand that, although White Cloud Pilates West is increasing cleaning procedures and has rearranged equipment according to social distancing regulations, you may be exposed, through no fault of your own, to COVID-19. You understand and agree that you will not hold owners and/or instructors of White Cloud Pilates West liable for any real or perceived symptoms of COVID-19 or any other disease, illness, or condition, nor for exacerbating any existing symptoms. Finally, you fully agree to accept all risks of entering the facility, the White Cloud Pilates West studio, using the equipment, working with instructors, attending classes or private sessions, and/or interacting with or being exposed to other members.

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Signature

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Printed Name Date