WATER FITNESS at the WILLARD POOL

WATER AEROBICS

MONDAY through FRIDAY

11:00 AM—12 NOON

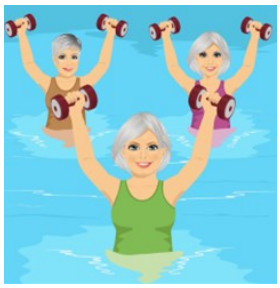
- People of all ages looking for a low-impact exercise
- Water Walking
- Strength
- Flexibility
- All in shallow water—participants do not need to know how to swim

Aquafit

MONDAYS, TUESDAYS, THURSDAYS

(THURS DEEP WATER)

6:15 PM—7:15 PM



- Increase Muscle Strength
- Build Endurance
- Increase Flexibility
- Cooling Exercise
- Burns Calories
- Alleviates Pressure on Joints
- The instructor's class design of 20—30 minutes cardio exercise combined with 30 minutes of body toning will help to sculpt & stretch your muscles

Starting June 20th!

Cost: $40 for all Sessions Each or $2 per Session

Or **FREE** for Season Pool Pass Holders

Willard City Pool—561 W. Laurel Street

www.willardohio.us

SIGN-UP SHEET ON BACK INCLUDING THE EMERGENCY MEDICAL FORM REQUIRED FOR ALL PARTICIPANTS

*No Lifeguard on duty during class

Water Fitness Sign-up Sheet

FULL NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TELEPHONE: _____ EMAIL: _____

BIRTH DATE (MM/DD/YYYY): _____

FAMILY PHYSICIAN: _____

PHYSICIAN TELEPHONE NUMBER: _____

WATER AEROBICS AQUAFIT BOTH (circle one)

EMERGENCY CONTACT INFORMATION

NAME & RELATIONSHIP: _____

TELPHONE NUMBER: _____

ANY OTHER INFO OR COMMENTS (medication,allergies,etc.): _____

PART 1: GRANT TO CONSENT

I hereby give consent for the following medical care providers and hospitals to be called:

Physician: _____ Phone: _____

Hospital: _____ Phone: _____

Medical Specialist: _____ Phone: _____

In the event that reasonable attempts to contact listed have been unsuccessful, I hereby give my consent for:

(1) The administration of any treatment deemed necessary by the named doctors, or, in the event the designated preferred practioner is not available, by another licensed physician; and

(2) The transfer of myself to my preferred hospital or any hospital reasonably accessible

This authorization does not cover major medical surgery unless the medical options of two other licensed physicians, concurring with the necessity for such surgery,are obtained prior to performance of such surgery.

Facts concerning my medical history, including allergies, medications being taken, and any other physical impairment to which a physician should be alerted:

SIGNATURE: _____ DATE: _____

PART 2: REFUSAL TO CONSENT

I DO NOT give permission for emergency medical treatment for myself. In the event of illness or injury requiring emergency treatment, I wish the program authrties to take the following action: _____

_____

SIGNATURE: _____ DATE: _____