Bourne Council on Aging
BOURNE VETERANS MEMORIAL COMMUNITY CENTER
239 Main Street, Buzzards Bay, Massachusetts 02532
Phone: 508-759-0600 Ext. 5300 Fax: 508-759-0655

Town of Bourne Council on Aging Exercise Programs Medical Authorization, Indemnification and Hold Harmless Agreement

For and in consideration of permitting me to enroll and participate in Town of Bourne exercise Programs, I, the undersigned, shall to the maximum extent permitted by law, indemnify and hold harmless the Town of Bourne, its officers', agents, volunteers, and employees, from and against any and all damages, liabilities, actions, suits, proceedings, claims, demands, losses, costs, and expenses (including reasonable attorneys' fees) that may arise out of or in connection with my participation in any and all Town of Bourne exercise programs, unless any damage is cause by the Town of Bourne's gross negligence or willful misconduct.

It is my intention to expressly assume all risk of personal injury, death, or property damage upon myself, to the exclusion of the Town of Bourne, and to exempt and relieve the Town of Bourne from liability for personal injury, property damage or wrongful death.

I further agree that my spouse, assignees, heirs, guardians, and legal representatives shall not make any claim against, sue, or attach the Town of Bourne for any loss or damage resulting from my participation in Town of Bourne exercise programs.

I understand that Town of Bourne exercise programs are physical activities which may be strenuous and/or require physical exertion. I understand that my participation in Town of Bourne exercise program activities is voluntary and I accept fill responsibility for my actions and any and all consequences resulting from said participation.

I further agree that I am in good health and medically authorized by my medical provider to participate in said exercise programs.

*Print Participant Name:*_____ *DOB:*_____

*Signature of Participant:*_____

*Date:*_____

*Print Physician Name:*_____ *FAX:*_____

*Signature of Physician:*_____

*Date:*_____

Exercise Programs: ☐ ***Yoga*** ☐ ***Bal & Cond.*** ☐ ***Sen Fit*** ☐ ***Other:***_____