



**CATAWBA COUNTY PUBLIC HEALTH  
FAMILIES FIT FOR LIFE  
ADULT PROGRAM RELEASE**



I, \_\_\_\_\_, understand and agree that Catawba County Public Health shall not be liable for any claims, demands, actions, or cause of action, whatsoever, to my person or property, arising out of, or connected with, my participation in this weight-management program. I further agree that I have been strongly encouraged to consult my medical healthcare provider before enrolling in this program. I do hereby forever release and discharge Catawba County, its employees, agents, or servants from all such claims, demands, injuries, damages or cause of action of any kind on behalf of myself.

With this program having been explained to me and all of my questions answered to my satisfaction, I consent to participate in this weight-management program fully aware of the procedures and any risks that may be involved.

This the \_\_\_\_\_ day of \_\_\_\_\_, 2008

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Witness

**PHYSICIAN APPROVAL / WAIVER OF MEDICAL EXAM  
Catawba County Public Health Families Fit For Life Program**

This is a weight-management program consisting of healthy eating and physical activity, with an emphasis on individual capabilities. There exists the possibility of certain biological changes occurring during your participation in the program. These changes include, but are not limited to: risk of gallstones with rapid weight loss, risk of fractures if you have osteoporosis, abnormal blood pressure, fainting, disorder of the heartbeat and, in rare instances, heart attack or death. Thus, prior to participating in this program it is advisable that you consult a physician. If you choose not to consult a physician, the waiver form (Part B) below must be executed.

**A. Physician Approval**

I hereby stipulate that I am physically sound and that I have medical approval from my healthcare provider to proceed with a normal routine of physical activity and healthy eating in this weight-management program.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date

**B. Waiver of Medication Examination**

I hereby make a knowing and informed waiver of the suggested medical exam and certify that I am physically sound and can proceed with this weight-management program.

\_\_\_\_\_  
Signature of Participant

\_\_\_\_\_  
Date