Labor of Love | B.E. STRONG
B. = Beneficial
E. = Exercise

Body Work Waiver and Health History

Labor of Love B.E. STRONG, LLC disclaims any liability or loss in connection with the execution of the exercises or techniques administered or taught. **Labor of Love B.E. STRONG** expressly disclaims any and all liability relating to the practice or use of such techniques in any situation or their legality in any jurisdiction. **Labor of Love B.E. STRONG** strongly recommends that you consult your physician before beginning any fitness or exercise program. You should be in good condition and be able to participate in the program. You should understand that when participating in such a program, there is always the possibility of injury. If you engage in the exercises or techniques administered or taught, you agree that you do so at your own risk, are voluntarily participating in these activities, accept all risk of injury to yourself, and agree to release and discharge **Labor of Love B.E. STRONG** and its affiliates from any and all claims or causes of action, known or unknown, arising out of negligence. **Labor of Love B.E. STRONG** may use media taken for marketing purposes.

(PLEASE PRINT)

Have you had?	**No**	**Yes**	**Have you had?**	**No**	**Yes**
Recurrent Headache			Asthma		
Eye Problem			Epilepsy/Seizures		
Ear Problem			Dizziness/Fainting with Exercise		
Nose Problem			Head Injury/Concussion		
Throat Problem			Bone/Joint Injuries		
Thyroid Disorder			Stomach/Intestinal Problems		
Heart Murmur/Heart Disease			Diabetes		
Heart Palpitations			Eating Disorder		
High/Low Blood Pressure			ADD/ADHD		
Anemia/Sickle Cell			Chicken Pox/Immunization		
Bleeding Disorders: Hemophilia/Other			Mononucleosis		
Hepatitis			Alcohol Abuse		
Kidney/Bladder Disorders			Drug Abuse		
Pneumonia/Bronchitis			Sexual Assault/Violence		
Tuberculosis			Emotional Problems-Specify Below:		
Seasonal Allergies/Hay Fever					
Surgeries:					
Hospitalizations:					
Allergies:					
Medications Currently Taken:					

Any other disease, illness, past surgeries, permanent disabilities, or explanations of any marked concerns from the list above? _____

_____

Are you currently being treated by a health care professional? If yes, explain: _____

_____

By signing, you show that you agree with all the above statements.

_____ _____

PARTICIPANT'S PRINTED NAME **DATE**

_____ _____

PARTICIPANT'S SIGNATURE (OR PARENT/GUARDIAN OF MINOR) **DATE**

_____ _____

EMAIL **PHONE (Circle: Cell Home)**