



We are pleased to invite you to participate in the FitChurch Challenge. The program and associated health screenings can give you a snapshot of your health but do not serve as a substitute for professional medical care and evaluation. We encourage you to consult with your treating physician or other healthcare professional in connection with your decision to participate in this program.

IN ORDER TO PARTICIPATE IN THE LAKELAND REGIONAL HEALTH (LRH) FITCHURCH CHALLENGE HEALTH AND WELLNESS PROGRAM (THE “PROGRAM”), I HEREBY ACKNOWLEDGE THE FOLLOWING:

I HEREBY CERTIFY THAT I am eighteen (18) years or older, that I have read this release and voluntarily agree to its terms and conditions.

or

I HEREBY CERTIFY THAT I am eighteen (18) years or older, I am the legal guardian for the registered participant under age eighteen (18) years, that I have read this release and voluntarily agree to its terms and conditions.

I HEREBY CERTIFY THAT I request and grant permission to the volunteers, employees and organizations participating in the Program to perform certain health screenings for me, if requested, as part of the Program. I acknowledge and agree that I understand that these health screenings are to be used solely for screening purposes, that the results are in no way to be considered conclusive, nor do these assessments constitute medical advice. I further acknowledge and agree that for conclusive measurements and for any medical advice and treatment, it is my responsibility to contact my own personal healthcare provider.

I HEREBY WAIVE, RELEASE, and FOREVER DISCHARGE LRH, and its affiliates, the YMCA of West Central Florida, all Program sponsors, Program producers, Program staff, administrators, officials, contractors, vendors, and organizers, volunteers, all other persons or entities involved with the Program, congregations, states, cities, towns, and other governmental bodies and locations in which the Program or portions of the Program take place, and the officers, directors, members, employees, agents, insurers, and representatives of all of the above (collectively, the “Released Parties”), from any and all claims, causes of action, damages, losses (economic and noneconomic), and liabilities of every kind (collectively “claims”), for death, personal injury, or property damage, which may arise out of, result from, or relate to my participation in, the Program, including but not limited to any claims for theft, damage to any equipment, negligence, partial or permanent disability, claims relating to the provision of first aid, medical care, medical treatment, or medical decisions (at Program sites or elsewhere), and any claims for medical or hospital expenses.

I acknowledge and ASSUME ALL OF THE RISKS of participating in all aspects of the Program in which I decide to participate (collectively, “risks”).

HEALTH SCREENINGS

I understand that, for the purposes of these health screenings, I am acting as a participant and not a patient of LRH.

I understand it is my responsibility to follow-up with my own healthcare provider to discuss these results.

I understand that my personal health information collected as part of this health screening will be treated as confidential and that only I and Lakeland Regional Health program administrators will have access to the information located in the online Challenge platform, Challenge Runner. In addition to any specific personal health information I voluntarily add to the Challenge Runner platform, I specifically authorize the release and use of my weight, blood pressure, and blood glucose results during my participation in the Challenge. I understand this information will be used by Lakeland Regional Health for the sole purposes of monitoring my Challenge progress and determining Challenge winners and awards.

I understand that the screenings and their results are for informational purposes only and do not constitute a diagnosis of any disease or any other illness or health condition, which can only be made by a qualified healthcare provider. It is solely my responsibility to have a follow-up examination performed by my personal healthcare provider to assess the screening results and obtain advice or treatment, if applicable.

I understand that any education is for informational purposes only and is not intended as medical advice or a substitute for the professional opinion of a physician or other healthcare provider involved in my treatment.

I have read and understand this information and hereby release the Released Parties from any and all liability in any way connected with my health screening and participation in this program.

CONSENT TO PHOTOGRAPHY/VIDEOTAPE/FILM/INTERVIEW

Purpose of Disclosure:

- LRH marketing, advertising, and fundraising, including but not limited to, media publications and advertisement, web site, social media, and LRH publications.
- Health Promotion by LRH of community health issues, including but not limited to, general health and wellness, flu prevention, immunizations, prenatal care, senior care.

I hereby give consent to LRH to take and use images (photographs or videotape) or sounds recordings of me and/or the minor named below for whom I am giving consent, and disclose confidential patient information about me and/or the minor, to or in any public media, including radio, television, Internet or print, or in a LRH publication.

I understand that the intended use of such images and confidential information is for advertising, marketing, fundraising or promotional purposes of LRH. I understand that confidential information to be disclosed may include information about participation in the program obtained from interviews of the family, physicians and hospital personnel, or from the participant's results, including photographs, videotapes and results of diagnostic studies, and I hereby waive the right to or interest in the confidentiality of this information or images taken and disclosed to the public, as contemplated in this release.

I acknowledge that this consent and authorization for release of confidential information is being made solely for the benefit of LRH and without any expectation of compensation or other benefit to the minor or person or the family thereof. To the extent that any benefit accrues or might accrue to LRH from the use of images or disclosure of information, I hereby and forever waive any interest in or claim to such benefits.

- I hereby grant permission to LRH to take and use photographs and/or digital images of me for use in news releases, educational materials, and/or for promotional purposes.
- I DO NOT grant permission to LRH to take and use photographs and/or digital images of me.

RELEASE AND WAIVER OF LIABILITY FOR MINORS

I have carefully considered my decision, the benefits and risks involved and hereby give my informed consent, on behalf of the minor child listed below, for him/her to participate in the Program, as set forth in this Release of Liability, and such terms are incorporated herein.

Printed Name of Participant under 18 Years Old

Date of Birth

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Date

RELEASE AND WAIVER OF LIABILITY FOR PARTICIPANTS

I have carefully considered my decision, the benefits and risks involved with participating in the Program and knowingly agree to the terms of this Release of Liability.

Printed Name of Participant

Signature of Participant

Date