



## Informed Voluntary Consent and General Release

In consideration of participation in the University of Dayton Faculty/Staff Wellness Program as described herein, and having actual knowledge and appreciation of the particulars of the program and those risks involved in this type of activity/program, I, voluntarily consent to use of the facilities and participation in the activities/programs at this site, and assume all the risks arising therefrom.

I hereby declare that I am in good health and have no mental or physical condition or symptoms that could interfere with my safety or the safety of others while participating in any activity using any equipment or facilities of the University of Dayton. Furthermore, I certify that I have adequate health insurance to cover any injury or damage that I may suffer while participating, or alternatively, agree to bear all costs associated with any such injury or damages.

I understand that my participation in this Wellness program or activity is completely voluntary and is not part of my job responsibilities and falls clearly outside the course and scope of my employment. As such, any injury or damage that I may suffer while participating will not be covered by Workers Compensation coverage.

I, the undersigned, do hereby release, hold harmless, indemnify, waive, and discharge the University of Dayton and all its officers, agents, and employees from and against any and all claims, demands, actions or causes of action arising from any injuries or damages I may suffer or sustain from her/his participation in, or use of, any facility, equipment, and/or programs. Furthermore, in full recognition and appreciation of the potential dangers and hazards inherent in athletic and other activities, I do hereby agree to assume any and all risks, liabilities, and responsibilities for all accidents, injuries, damages, or property losses arising from my participation.

In the event of a medical emergency requiring more than basic first aid, I authorize University of Dayton to secure from any licensed hospital, physician, and/or medical personnel any treatment deemed necessary for my immediate care and agree that I will be responsible for payment of any and all medical services rendered.

**I have read and fully understand the above statements.**

---

Print Name of Participant

---

Signature of Participant

---

Date

List Wellness Class(es) enrolled in:

---