



Down Syndrome Achievement Centers  
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**GiGi's Playhouse  
Purposeful Programming  
Waiver & Physician Approval for Physical Activity**

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Parent/Guardian Please read and initial:**

**Photo Release**

I agree to allow the Released parties, and their contractors, agencies and sponsors, the use of my name and likeness in connection with the Program for any purposes related to advertising or promotion of the Program, worldwide in perpetuity in all forms of media now and forever known. **Parent/Guardian Initials** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Please read and sign:**

**GiGi's Playhouse Participation Waiver**

1. I understand that my execution of this Waiver is a prerequisite for participation in the GiGi's Playhouse GiGiFIT and/or other fitness based programs at GiGi's Playhouse.
2. I understand that in order to be allowed to participate in the Program, I agree to assume all risks and to release and hold harmless GiGi's Playhouse and their affiliates, divisions, assigns, successors in interest, agents servants, employees, officers, trustees and directors, past and present and each of them, its officers, agents, employees, assigns, successors in interest, contractors, agencies, sponsors, officials, and volunteers, including program leaders, participating communities, clubs, and all government and public entities including but not limited to the State, County, and local municipalities where the program takes place (collectively the "Released Parties").
3. I understand and agree that this release will have the effect of releasing, discharging, waiving, and forever relinquishing any and all actions or causes of action that I may have or have had on my own behalf of my survivors, heirs and estate, whether past, present or future, whether known or unknown, and whether anticipated or unanticipated by me, arising out of my participation in the Program. This release constitutes a complete release, discharge and waiver of any and all actions or causes of action against the Released Parties.
4. I understand and agree that this release applies to personal injury, property damage, or wrongful death that I may suffer, even if caused by negligent actions or omissions of others. I understand that by agreeing to this release that I am assuming full responsibility for any and all risk of death or injury or property damage suffered by me while participating in the Program, including training prior to the Program. I understand and agree that this release will be binding on my heirs, my personal representatives, and my assigns.
5. I understand that I am solely responsible for my health and safety, and I acknowledge that I am physically capable of participating in and completing this program. I understand that I must have valid health insurance at the time of the program.
6. Should any portion of this Waiver be judicially determined invalid, voidable or unenforceable, for any reason, such portion of this Waiver shall be severable from the remaining portions herein and the invalidity, voidability, or unenforceability thereof shall not affect the validity, effect, enforceability, or interpretation of the remaining provisions of this Waiver. I have carefully read this Waiver and fully understand its content. I am aware that this is a release of liability and I agree of my own free will.

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Waiver valid for 1 year from date of signature.



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## Physician Approval for Physical Activity

Participant's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

GiGi's Playhouse- Down Syndrome Achievement Centers is a non-profit organization which provides free educational and therapeutic programs for individuals with Down syndrome, their families and the community. The individual mentioned above is interested in participating in a program for individuals with Down syndrome, within our fitness programs. GiGi's Playhouse provides instructional fitness programs, focused on development of health, confidence and the whole self. All of the GiGi's Playhouse fitness-related programs promote a healthy lifestyle through nutrition education, physical activity and safety. During participation in the GiGi's Playhouse GiGiFIT and/or other fitness based programs, at GiGi's Playhouse, all participants are encouraged to exercise for **45-60 minutes, 4 times a week** to prepare their bodies for the demands of life. Due to the nature of this program, it is imperative that each participant is in a state of health that is conducive to participation in physical activity. As the physician overseeing the health care of the abovementioned individual, your approval for participation in physical activity is requested. For more information, please contact your local GiGi's Playhouse. Thank you!

### Proposed Physical Activities include:

Upon review, please indicate whether you approve your patient to participate in the preceding activities:

- GiGiFIT
  - GiGiFIT Foundational Movements
  - GiGiFIT Hip Strengthening Movements
  - GiGiFIT Vestibular and Balance Movements
  - GiGiFIT Warm-up and Cool Down
  - GiGiFIT Plyometric Movements (advanced progressions only)
- Program specific skills and goals
- Brisk Walk Outdoors/Running
- Safe Stretching
- Aerobic Exercise
- Resistance Training
- Treadmill
- Dance
- Circuit Training
- Yoga

- I approve my patient participating in the proposed physical activities
- I do not approve my patient participating in any of the proposed physical activities
- I approve my patient participating in the proposed physical activities with the following modifications:

This individual has (or had surgical correction of) cervical subluxation/atlando-axial instability and should not participate in activities likely to result in a blow to the head or straining of the neck such as wrestling, diving, gymnastics, tumbling, butterfly stroke, or contact sports.

Physician's Name (printed or stamped): \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This Physician Approval Form expires 1 year from the signed physician's date.