LIVING A HEALTHY LIFE (CDSMP)
A CHRONIC DISEASE SELF MANAGEMENT WORKSHOP
PARTICIPANT APPLICATION AND RELEASE FORM

Name: _____ Birthdate: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Email: _____

☐ Please contact me for future class opportunities or chronic disease information

Gender (Circle One): M F Do you live alone? (Circle One) Y N

In case of emergency, please call _____

I understand and agree that there are risks, both foreseeable and unpredictable, associated with any program including exercise. I am aware of these risks and agree that my participation is at my own risk. I hereby agree that neither the Missouri Department of Health and Senior Services-Heart Disease and Stroke Prevention Program, nor the Missouri Arthritis & Osteoporosis Program - Regional Arthritis Centers, nor the facility hosting the class, nor sponsoring organizations, nor their respective chapters, officers, directors, employees, agents, members or volunteers, shall assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in the Living a Healthy Life (CDSMP) workshop. I further covenant not to sue any of the foregoing parties with respect to same. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or any future programs.
I further understand and agree that my name, address, and attendance record of this program is released to DHSS for the purpose of statistics or program participation. I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in exercises described in this program, and whether there are precautions or limitations to my participation.

_____ _____
Signature Date