

THE BEAUTY OF HOPE PROGRAM PARTICIPATION AGREEMENT, RELEASE OF LIABILITY AND WAIVER

Name _____

Address _____

Phone __Cell_____Home_____Work_____

Emergency contact name_____ Phone _____

By signing this Release of Liability and Waiver, I am confirming that I have voluntarily signed up for The Beauty of Hope Program and recognize that there may be inherent risks associated with using certain equipment, utilizing transportation provided, utilizing the Spa facilities, participating in programs and/or receiving Spa treatments/services.

I acknowledge and agree that I am responsible for my own health; that the Service providers, Spa associates and/or technicians are not health care practitioners and cannot be expected to diagnose and/or treat individual health problems.

I understand that I am responsible for discussing any questions that I may have concerning my health conditions (if any) throughout any program or treatment at the Spa and, should health-related symptoms occur, I will cease my participation and inform Spa personnel of the symptoms.

In the event that I have reason to believe that medical clearance must be obtained prior to participation in any Spa treatments, therapies, steam, pools, exercise or facility equipment, I agree to first consult a physician and obtain written permission from a physician prior to the commencement of any program, treatment or activity.

By voluntarily choosing to receive Spa-related treatments and/or participate in Spa-related activities and programs, I warrant that to the best of my knowledge, I have no disability, impairment or ailment that prevents me from receiving such treatments and/or engaging in such participation.

Consequently, in light of the foregoing, I hereby release the Lump to Laughter organization, all participating Spas and Service Providers of The Beauty of Hope Program (and its parent corporation(s), subsidiaries, affiliated corporations, and their respective officers, directors, shareholders and employees and waive any and all claims, liabilities, or damages for personal injuries that I may experience directly or indirectly from receiving Spa related treatments, utilizing the Spa facilities and/or participating in the programs or activities offered by the Spa or through any services provided through The Beauty of Hope Program.

Signature _____Date _____

Witness Signature _____Relationship to Participant _____

Any person under 18 years of age must have a parent or legal guardian sign the above acknowledgment pertaining to the release of liability and waiver.

Name of Minor(s)