



# HealthHike

## Mallwalkers Release and Agreement

Please fill out this form completely. Please print.

I \_\_\_\_\_ (name) of \_\_\_\_\_ (street

address, city, state, zip code), in consideration of the license to use certain portions of the enclosed Shopping Center known as Bridgewater Commons Mall (Premises) for the physical activity commonly referred to as "walking" do hereby release and forever discharge Bridgewater Commons Mall, Robert Wood Johnson University Hospital Somerset, Robert Wood Johnson Healthcare Corporation, its owners and managing agents and their affiliates, representatives, employees, agents, successors and assigns, from any liability for all claims, demands, actions, causes of action, damages and costs for any and all personal injuries, loss of time, pain and suffering and any other loss, damages and expense arising out of my use of the Premises.

I \_\_\_\_\_, further agree to defend, indemnify and save free and harmless Bridgewater Commons Mall, Robert Wood Johnson University Hospital Somerset, Robert Wood Johnson Healthcare Corporation, its owners and managing agents and their affiliates, representatives, employees, agents, successors and assigns, from and against any and all claims, demands, fines, suit actions, proceedings, orders, decrees and judgments of any kind or nature and from and against any and from and against any and all costs and expenses, including reasonable attorney's fees, resulting from or in connection with loss of life, bodily injury or property damage arising, directly or indirectly, or of, from or on account of my use of the Premises.

I further agree to abide by all the rules and regulations as hereinafter amended or supplemented, established by the managing agent, its representatives, employees, agents, successors and assigns, applicable to the authorized use of the Premises and agree that my license to use the Premises may be canceled at any time, without prior notice or warning and that I disclaim any recourse in the event of such cancellation and agree to immediately vacate the Premises upon request.

I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT. I AM AWARE OF THE FACT THAT I AM RELEASING AND WAIVING CERTAIN POTENTIAL RIGHTS, AND VOLUNTARILY AND FREELY AGREE TO THE TERMS AND CONDITIONS AS SET FORTH.

Signed and dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signature \_\_\_\_\_

Witnessed by \_\_\_\_\_

## Emergency Health Information

Date of Birth \_\_\_\_\_

Phone # (Hm.) \_\_\_\_\_ (Wk.) \_\_\_\_\_

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

Emergency Contact \_\_\_\_\_

Phone # (Hm.) \_\_\_\_\_ (Wk.) \_\_\_\_\_

Relationship to Emergency Contact \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

Please list any pre-existing health conditions and/or medications which may be necessary should you need emergency care: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**The information provided here will be kept confidential to this program and will not be shared.**

**NOTE:** Please consult your doctor before beginning this or any exercise program.

Robert Wood Johnson University Hospital is committed to keeping you healthy and well informed. In the future, we may send you useful health news or information on health programs that may be of interest to you. If you do not wish to receive this information via mail or email, please check here \_\_\_\_\_.