CANADA

VON SMART (SENIORS MAINTAINING ACTIVE ROLES TOGETHER)®
INFORMED CONSENTAND WAIVER

THIS FORM MUST BE READ AND SIGNED BY EVERY PERSON WHO WISHES TO PARTICIPATE IN THE VON SMART IN-HOME EXERCISE PROGRAM AND/OR GROUP PROGRAM
PLEASE READ CAREFULLY

TO: **SMART (SENIORS MAINTAINING ACTIVE ROLES TOGETHER)® ("SMART")**

FROM: _____
Name of participant (the "Participant")

_____
Address and telephone number

I. ASSUMPTION OF RISKS AND RESPONSIBILITY

(1) I realize that there are potential risks inherent in my participation in the VON SMART In-Home Exercise Program and/or Group Program including, without limitation, slips and falls, an increased load on the heart, bone and muscular skeletal injury such as sprains and strains and episodes of light headedness, fainting, chest discomfort, leg cramps and nausea. The risk of sustaining these types of injuries results from the nature of the activity and can occur without any fault. By choosing to take part in this activity, I am accepting the risk that I may be injured. I freely and voluntarily accept and assume all such risks and dangers.

(2) I acknowledge that VON SMART offers no medical assessment or treatment and that SMART makes no determination as to whether or not I am physically fit to participate in VON SMART's In-Home Exercise Program and/or Group Program. I hereby warrant that I am physically fit to participate in VON SMART's In-Home Exercise Program and/or Group Program.

(3) I accept my responsibility to carefully follow instructions at all times while participating in VON SMART's In-Home Exercise Program and/or Group Program and to abide by all the rules set out by VON SMART.

(4) I am aware that at any time I may decline to participate in part of, or in the entire In-Home Exercise Program and/or Group Program. I accept full responsibility for my level of participation. I acknowledge my obligation to immediately inform the facilitator of any pain, discomfort, fatigue or any other symptoms that I may suffer during and immediately after my participation. I understand that I am encouraged to ask questions or request further explanation about the VON SMART In-Home Exercise Program and/or Group Program at any time.

II. LIABILITY WAIVER

In consideration of the acceptance of my application and permission to participate in VON SMART's In-Home Exercise Program and/or Group Program, I for myself, my heirs, executors, administrators, successors and assigns hereby agree that SMART, Victorian Order of Nurses for Canada, the SMART funders and sponsors and their respective subsidiaries, affiliates, associates, officers, directors, employees and agents shall not be liable for any injury to my person or loss or damage to my personal property arising from or in any way connected to my participation in VON SMART's In-Home Exercise Program and/or Group Program.

III. ACKNOWLEDGEMENT:

I ACKNOWLEDGE THAT I HAVE READ THE ABOVE, I UNDERSTAND THAT IN PARTICIPATING IN THE ACTIVITY DESCRIBED ABOVE I AM ASSUMING THE RISKS ASSOCIATED WITH DOING SO.

IN WITNESS WHEREOF, I am signing this INFORMED CONSENT AND LIABILITY WAIVER at _____.
City/town

SIGNED, SEALED AND)
DELIVERED)
In the presence of)
)
_____)

_____
Name, Address and Occupation of Witness

_____
Signature of Participant
Date:

Date Effective: January 2007 Date Revised/Reviewed: May 2010

CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, _____, have received and reviewed VON Canada's Statement of Information Practices.

I understand that VON Canada is seeking my consent to collect, use and/or disclose my personal health information in order to provide me with health care or assist in the provision of health care to me. I had an opportunity to have my questions answered regarding these practices. I understand that VON Canada will only collect, use and disclose my personal health information with my consent, unless a particular collection, use or disclosure is permitted or required by law without my consent.

I hereby authorize VON Canada to collect, use and disclose my personal health information for the purposes set out above.

OR

I hereby authorize VON Canada to collect, use and disclose the personal health information of: _____ for the purposes set out above.
(Name of the person for whom you are the Substitute Decision Maker (SDM))

I understand the purpose for which my personal health information is being collected, used and disclosed. I understand that I can refuse to sign this consent form or later withdraw my consent.

Name: _____

Mailing Address: _____ Date of Birth: _____

City, Province _____ Postal Code: _____

Home Phone: _____ Cell / Work Phone: _____

_____ _____
Signature Date

If Applicable

Relationship of SDM to Client: _____

Identification/Evidence Provided by SDM: _____

_____

_____ _____
Printed Name of Witness *Signature of Witness*

_____
Date