Health Nexus Orthopedics & Wellness

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VO2 MAX TESTING MEDICAL WAIVER AND ASSUMPTION OF RISK AGREEMENT

Participant Name: _____

Date of Birth: _____ Phone Number: _____

Email: _____

Emergency Contact Name & Phone: _____

1. Acknowledgment of Services

I acknowledge that I am voluntarily participating in VO2 Max testing utilizing the PNOE metabolic system. This test is designed to evaluate my cardiorespiratory fitness and metabolic performance through a graded exercise protocol under observation.

2. Medical Clearance

I affirm that I am in good health and have no known medical conditions or history of:

- Untreated cardiovascular or pulmonary disease

- Uncontrolled hypertension

- Chest pain during exertion

- Fainting or dizziness during or after exercise

- Any other condition that would make participation in a maximal exercise test unsafe

If I am unsure about my health status, I understand it is my responsibility to consult with a licensed medical provider before participating in this assessment.

Initials: _____

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3. Voluntary Participation & Assumption of Risk:

I understand that VO2 Max testing involves maximal physical exertion, which may place stress on the cardiovascular and respiratory systems. I accept and assume all risks, including but not limited to:

- Elevated heart rate or blood pressure

- Dizziness or fainting

- Musculoskeletal injury

- Cardiac events (including rare but serious complications such as arrhythmia or heart attack)

I voluntarily agree to undergo this testing and release the organizers, test administrators, HealthNexus Orthopedics & Wellness, Athletes Edge, and any affiliated personnel or location from any liability, claim, or cause of action that may arise from my participation.

Initial here: _____

4. No Medical Treatment or Diagnosis:

I understand that this assessment is not a substitute for medical diagnosis or treatment. Unless otherwise specified, the individuals administering this test may not be acting as my healthcare provider, and no medical diagnosis, treatment, or emergency care will be provided. Additionally, I understand that no doctor-patient relationship is being established or implied.

5. Photography and Data Use (Optional):

☐ I give permission for anonymized data and/or photos to be used for educational or promotional purposes.

☐ I do not give permission for my data or image to be used.

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6. Consent and Release:

I hereby release and discharge HealthNexus Orthopedics & Wellness, the testing personnel, and the host location (bike shop) from all claims, demands, and causes of action related to injury, illness, or other issues arising from participation. I certify that I have read this document and fully understand its contents.

Signature of Participant: _____

Date: _____

If under 18, signature of parent/guardian:

Name: _____

Signature: _____

Date: _____