Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/St/Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(Allergies/Medications)*

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

 *(Name-Relationship-Phone No.)*

WAIVER AND RELEASE

I will not enter the walk unless I am medically able. I agree to abide by all directives of the walk relative to my ability to safely complete the walk. I assume all risk associated with walking in this event including, but not limited to, falls, contact with other participants, the effects of the weather, conditions of the walking surface, all such risks being known and understood by me.

Upon acceptance of my entry, I release the Lutheran Women’s Missionary League, the cities of Fremont/Newark, their representatives, and successors, from all claims or liabilities of any kind arising out of my participation.

I grant permission to the LWML to use any photographs, motion pictures, recordings or any other record of this activity for any legitimate purpose. In consideration of all participants, I agree that baby joggers, baby strollers, headphones, animals on leashes, skateboards, skates, and roller blades are prohibited.

I acknowledge and agree that LWML is a service agency of the Lutheran Church-Missouri Synod and cannot and does not accept any responsibility for my safety and well-being related to my participation in the walk.

Furthermore, I consent to such medical treatment as LWML (or any of its authorized representatives) deems necessary or appropriate in the event of my illness, accident, or other medical emergency and I accept full financial responsibility for any fees and expenses relating to such treatment.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_