

MINISTRY OF HEALTH
CARIBBEAN WELLNESS WEEK

THEME: "A BRIGHTER FUTURE FOR OUR YOUTH"
 Saturday 4th & Sunday 5th November, 2017 @ 6:am

REGISTRATION FORM – FUN RUN-WALK-CYCLE

Registration is Free

INFORMATION:

Last Name: _____ First Name: _____

Email Address: _____

Telephone Contact: (H): _____ (W): _____ (C): _____

Wear your own comfortable clothing: T-shirt and shorts or sweat pants.

ROUTE: Clifford Park to Cable Beach Post Office and back to Clifford Park, West Bay Street

DIVISION:

Male: _____ Female: _____ Team: _____

Walk: _____ Run: _____ Cycle: _____

Age Group: _____ under 12 _____ under 20 _____ under 30
 _____ under 50 _____ 50 & over

Team Name: _____

EMERGENCY CONTACT:

Name: _____

Telephone Contact: _____

Waiver:

I understand that I am participating in an event that is potentially hazardous and I should not enter or participate unless I am physically able to do so. In consideration of the acceptance of my entry, I hereby assume full responsibility for any risks, injuries or accidents that may result from my participation. Recognizing the potential for serious physical trauma, injury or death, I elect to voluntarily participate in this event knowing such risks. I hereby, for myself, my heirs, executors, representatives and administrators, waive and release any and all rights and claims for damages I may have against the Ministry of Health, sponsors, volunteers, participants, their representative, successors and assigns for any and all injuries suffered by me in said events. I grant to the Ministry of Health and the Ministry of Health sponsors and licensees the right to the free use of my name, my voice and/or my picture in any broadcast, telecast, advertising, promotion or any other account of this event. I further attest and certify that I am physically fit.

IF THE PARTICIPANT IS UNDER THE AGE OF 18 YEARS, I as the parent or guardian for the above named minor give permission for my child or ward to participate in the event, and further agree individually on behalf of my child or ward, to the terms above. I further certify that my child/ward is in good physical condition and is able to safely participate in the event. I hereby authorize medical treatment for him/her and grant access to my child/ward's medical records as necessary.

Signature of Applicant

**Signature of Parent/Legal Guardian
 (If under 18)**

Date

