

Okay to photocopy. One person per form. Waivers must be signed. Payment in full must accompany sign-up form.

Register online at [www.inmotionfit.com](http://www.inmotionfit.com)

## Program Sign-up Fee: \$60

How did you learn about this program? \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

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

Email Address \_\_\_\_\_

M F Age D.O.B. (MM/DD/YY) Day Phone No. W/Area Code T-shirt Size (circle one - adult sized, technical fabric, short-sleeve T-shirt)

\_\_\_\_\_ S M L XL XXL

OCCUPATION EMPLOYER

\_\_\_\_\_

### RELEASE AND WAIVER: MUST BE SIGNED

In consideration of the acceptance by In Motion, Inc. and In Motion Fit for entry to the America's Finest City Half Marathon Training Program of In Motion, Inc. and In Motion Fit and other good and valuable consideration relating to the training program, the sufficiency of which I hereby acknowledge, I hereby agree as follows:

**1. Acknowledgment.** I acknowledge and agree that In Motion Fit and In Motion, Inc., its employees, independent contractors, agents, representatives, volunteers and sponsors can not assume my safety during participation in the training program. I acknowledge and agree that participation in the training program exposes me to risks including, but not limited to, running-related injury, traffic and detrimental effects of heat and pollution.

**2. RELEASE OF CLAIMS.** I, FOR MYSELF, MY HEIRS, EXECUTORS, ADMINISTRATORS, SUCCESSORS AND ASSIGNEES HEREBY RELEASE, WAIVE AND FOREVER DISCHARGE AND HOLD HARMLESS IN MOTION FIT AND IN MOTION, INC., AND THEIR EMPLOYEES, INDEPENDENT CONTRACTORS, AGENTS, REPRESENTATIVES, VOLUNTEERS, SPONSORS, SUCCESSORS AND ASSIGNS ("THE IN MOTION, INC. AND IN MOTION FIT PARTIES") OF AND FROM ALL CLAIMS, DEMANDS, DAMAGES, COSTS, EXPENSES, ACTIONS, AND CAUSES OF ACTIONS, WHETHER IN LAW OR EQUITY, IN RESPECT OF DEATH, INJURY, LOSS OR DAMAGE TO MY PERSON OR PROPERTY, HOWSOEVER CAUSED, ARISING OUT OF, BY REASON OF, OR DURING MY ATTENDANCE AT OR PARTICIPATION IN THE TRAINING PROGRAM, WHETHER AS A SPECTATOR, PARTICIPANT, OR OTHERWISE (ALL OF THE FOREGOING REFERRED TO HEREAFTER AS THE "CLAIMS"), WHETHER OR NOT THE CLAIMS RESULT FROM MY FOLLOWING ANY PROGRAM OF DIET AND/OR EXERCISE ON THE RECOMMENDATION OF ANY OF THE PARTIES, WHETHER SUCH CLAIM ARISES OUT OF EVENTS PRIOR TO, DURING, OR SUBSEQUENT TO SAID ATTENDANCE OR PARTICIPATION, EVEN IF SUCH CLAIMS WERE CAUSED BY, CONTRIBUTED TO, OR OCCASIONED BY THE NEGLIGENCE, FAULT OR OTHER CONDUCT OF THE IN MOTION, INC. AND IN MOTION FIT PARTIES.

### CERTIFICATION REGARDING MEDICAL CONDITION

**All participants must read and sign.**

Anyone beginning an exercise program for the first time, or restarting an exercise program after a period of inactivity, must consult a doctor before starting the training program.

Furthermore, anyone who conforms to any of the following criteria must consult a doctor before training:

- You are over the age of 60 and not accustomed to vigorous exercise.
- You have a family history of premature (i.e., under age 55) coronary artery disease.
- You frequently have pains or pressure in the left or midchest area, neck, shoulder, or arm during or immediately after exercise.
- You often feel faint or have spells of severe dizziness, or you experience extreme breathlessness after mild exertion.
- Your doctor has said your blood pressure is too high and is not under control, or you do not know if your blood pressure is normal.
- Your doctor has said you have heart trouble, that you have a heart murmur, or that you have had a heart attack.
- Your doctor has said you have bone or joint problems.
- You have a medical condition not mentioned here that needs special attention during an exercise program (i.e., insulin-dependent diabetes).

By my signature I certify that I have read and understand the above, I have doctor's approval, or will consult with one before beginning the training program, if the above information indicates that I should.

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

IF APPLICANT IS UNDER AGE 18: I am the parent or legal guardian of the Applicant, a minor, who has signed this form. I have READ, and AGREE to, the RELEASE AND WAIVER, AND THE CERTIFICATION REGARDING MEDICAL CONDITION. I hereby further certify, acknowledge, and agree that, in conjunction with the Training Program, I will directly supervise the Applicant during his or her participation in the Training Program.

Parent or Guardian Signature (If applicant under age 18) \_\_\_\_\_ Date \_\_\_\_\_

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Official Use Only**

AMOUNT PAID: \$

PAYMENT METHOD: CASH  CHECK  CREDIT CARD