**The MHS Sports Medicine Club is presenting the**

**Retro Run 5K**

**March 11, 2017**

proceeds go towards sending the MHS Sports Medicine students to

the Sports Medicine State Competition

**Prizes for best costumes**, as well as **top finishers**

Date: Saturday, March 11th

Location: Lake Tye, Monroe WA. 98272

Start Time: 9:00am (arrive about 30 minutes early to check in)

Fee: $15 donation by March 1st to guarantee t-shirt

Please make checks payable to: MHS

Mail Entry To: Monroe High School

Attn: Heather Sevier

17001 Tester Rd

Monroe WA. 98272

**Retro Run 5k** Entry Form

Last Name First Name MI Date of Birth

Mailing Address City State Zip

Phone Email

Shirt Size (circle) These are adult sizes

S M L XL XXL

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian if under 18.

Please sign the “Assumption of Risk Form” on the back as well.

**ASSUMPTION** **OF RISK / PARENTAL PERMISSION TO PARTICIPATE**

As a participant requesting to voluntarily participate in The Retro Run 5K, I hereby acknowledge that I have read, understood and agreed to the following:

1. I acknowledge that The Retro Run 5K entails known and unanticipated risks which could result in physical or emotional injury, paralysis or death, as well as damage to property, or to third parties.  I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.  The risks include, among other things: sprains, strains, broken bones, fatigue, dehydration, traffic collisions, contact with other participants, and exposure to cold/rain or other environmental conditions.  The course will close at 12:00 p.m. (Participant/Parent/Guardian Initial)\_\_\_\_\_\_\_\_\_\_\_\_
2. I certify that I have adequate insurance to cover any injury that may be sustained by my child/myself to cover any injuries or damages that may be caused by my child/myself, or else I agree to bear the costs of such injury or damage myself.  (Participant/Parent/Guardian Initial)\_\_\_\_\_\_\_\_\_\_\_\_\_
3. I further certify that my child/myself has no medical or physical conditions which could interfere with his/her/my safety in this activity, or else I am willing to assume and bear the costs of all risks that may be created, directly or indirectly, by any such condition.  (Participant/Parent/Guardian Initial)\_\_\_\_\_\_\_\_\_\_\_\_\_
4. I understand that transportation to/from this activity is NOT being provided by the Monroe School District, and that I, the parent/guardian am fully, completely, and solely responsible for ensuring that my child arrives and returns home safely. The school district cannot be held responsible for the decisions I or my child make regarding the mode of transportation we choose to use for this event. (Participant/Parent/Guardian Initial)\_\_\_\_\_\_\_\_\_\_\_\_\_
5. The undersigned further grants full permission to the MHS Sports Medicine Club and/or any person or entity authorized by it to use my name, age, birth date, city, finish place, and finish time, in the public domain. I further grant full permission for the MHS Sports Medicine Club to use any photographs, videotapes, motion pictures, recordings and or any record of the event for any purpose. (Participant/Parent/Guardian Initial)\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents/Guardian needs to complete if student is under 18 years of age:

I hereby give my permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who attends

(Student’s name)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate on 3/11/17 for the purpose of The Retro Run 5K

(School)

Student’s address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s home phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical conditions, medication information or allergies district should be made aware of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event of an emergency, I wish the following person to be notified in case I cannot be contacted:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize a qualified physician/surgeon to examine and in the event of injury or serious illness administer emergency care to the above named student/myself. I understand every effort will be made to contact me to explain the nature of the problem prior to any involved treatment.

In the event it becomes necessary for the school district staff-in-charge to obtain emergency care for my student/myself, neither she/he nor the district assumes financial liability for expenses incurred because of the accident, injury, illness and/or unforeseen circumstances.

**Signature of Participant/Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**