

IOWA STATE UNIVERSITY
RELEASE AND WAIVER OF LIABILITY

PLEASE READ THIS CAREFULLY.

It affects any rights you may have if you are injured or otherwise suffer damages while participating in the 5K "Pi Mile Run" on October 20, 2007 sponsored by Tau Beta Pi.

I, _____ (participant) hereby release, waive, discharge and covenant not to sue Tau Beta Pi, the State of Iowa, the Board of Regents of the State of Iowa, Iowa State University, and any of the officers, servants, agents and employees of the above-mentioned entities (hereinafter referred to as RELEASEES) for any liability, claim and/or cause of action arising out of or related to any loss, damage or injury, including death, that occurs as a result of my participation in the above-described activities.

I agree to indemnify and hold harmless the RELEASEES whether injury is caused by my negligence, the negligence of the RELEASEES or the negligence of any third party. I further agree that this Release and Waiver of Liability shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representatives, if I am deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND COVENANT NOT TO SUE the above-named RELEASEES. I hereby further agree that this Release and Waiver of Liability shall be construed in accordance with the laws of the State of Iowa.

By signing this Release and Waiver of Liability, I state that I have read and understand the conditions set forth in this Release and that I agree to all conditions set forth herein, and that I sign this voluntarily.

Date

Name (please print)

Signature

Signature of Parent or Guardian (if under 18)

Iowa State University

Medical Information/Release Form

Note: The Release and Waiver of Liability must be signed by the participant's legal guardian if the participant is not of legal age.

PARTICIPANT INFORMATION

Participant's Name _____ Social Security # _____
Permanent Address _____ Date of Birth _____ Sex _____
City, State, Zip _____ Home Phone () _____

MEDICAL EMERGENCY CONTACT INFORMATION

| | |
|-------------------------------|--------------------------------------|
| Person to Contact First: | Backup Contact (Relative or Friend): |
| Name _____ | Name _____ |
| Relation to Participant _____ | Relation to Participant _____ |
| Daytime Phone () _____ | Daytime Phone () _____ |
| Evening Phone () _____ | Evening Phone () _____ |

Is the participant allergic to any medications? _____

List current prescriptions/medications _____

Is the participant currently under a doctor's care? Please explain. _____

INSURANCE POLICY INFORMATION

Yes No The above-named participant is covered by health insurance.

If yes, provide the following information which is required by Iowa State University to expedite treatment and to facilitate the billing process.

Policy Holder's (P.H.) Name _____ P.H.'s Date of Birth _____
Address _____ Relation to Participant _____
City, State, Zip _____ Occupation _____
P.H.'s Employer's Name _____
Employer Address _____
Insurance Company Name _____
Insurance Company Address _____
Policy # _____ Plan # _____