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 3, 2009 sponsered 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:

Name ______________________________________

Relation to Participant _________________________

Daytime Phone ( ) _______________________

Evening Phone ( ) _______________________

Backup Contact (Relative or Friend):

Name ____

Relation to Participant __________________________

Daytime 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 # _____________________________________