



Take Control. We Can Help.™

Eastern Missouri Chapter

Date: \_\_\_\_\_

**PARTICIPANT APPLICATION AND RELEASE FORM**

Name \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

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

Phone # Day (\_\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Do you have arthritis? \_\_\_\_\_ YES \_\_\_\_\_ NO If yes, what type? \_\_\_\_\_

Emergency Contact: Name & Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Is this your first contact with an Arthritis Foundation Program? Yes \_\_\_\_\_ No \_\_\_\_\_

Race/Ethnicity/Age: (optional - for funding purposes only): Black/African American \_\_\_\_\_

Hispanic \_\_\_\_\_ White \_\_\_\_\_ Asian American \_\_\_\_\_ Native American \_\_\_\_\_ Other \_\_\_\_\_

Age: <18 \_\_\_\_\_ 18-24 \_\_\_\_\_ 25-34 \_\_\_\_\_ 35-44 \_\_\_\_\_ 45-54 \_\_\_\_\_ 55-64 \_\_\_\_\_ 65-74 \_\_\_\_\_ 75 & over \_\_\_\_\_

How did you find out about the Arthritis Foundation Program? \_\_\_\_\_

Registration fees: I would like to be considered for a full or partial scholarship. Yes \_\_\_\_\_ No \_\_\_\_\_

I would like to receive additional information about Arthritis Foundation programs, services and fundraising events. Yes \_\_\_\_\_ No \_\_\_\_\_

**PARTICIPANT RELEASE FORM (must be signed)**

I understand and agree that there are risks, foreseeable and unpredictable, associated with any program, including exercise. I am aware of these risks and agree that my participation is at my own risk. I hereby agree that neither the Arthritis Foundation, nor the facility or sponsoring organization, nor their respective chapters, officers, directors, employees, agents, members or volunteers, shall assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in the Arthritis Foundation Program and I further agree not to sue any of the foregoing parties with respect to same. I do hereby, for myself, my heirs, executors and administrators, waive, release and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or future programs.

I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date