Light Walk Mite Walk

# 2024 LWML CONVENTION

## Mission Walk Medical Release Form

Name: _____

Address: _____

_____ State_____Zip_____

Phone Number: _____

Email Address: _____

### MEDICAL INFORMATION

Name:_____

Allergies:_____

Medications:_____

_____

Emergency Contact:_____

Relationship:_____

Phone Number:_____

Note: *Please read the waiver and release information on the back of this sheet. If you agree with all terms of the release, please sign below. Bring this form to convention and hand in at the registration table.*

### AUTHORIZATION SIGNATURE

Printed Name:_____

Signature:_____

Date:_____

### WAIVER AND RELEASE

I will not enter the walk unless I am medically stable. I agree to abide by all the directives of the walk director relative to my ability to safely complete the walk. I assume all risks associated with walking in this event including, but not limited to falls, contact with other participants, the effects of the weather, conditions of the walking surface, all such risks being known and understood by me.

Upon acceptance of my entry, I release Lutheran Women's Missionary League, the city of Brainerd, Minnesota, Cragun's Resort, the sponsors: their representatives and successors, from all claims or liabilities of any kind arising out of my own participation in this event.

I grant permission to the LWML to use any photographs, motion pictures, recordings, or any other record of this activity for any legitimate purpose. In consideration of the safety of all participants, I agree that baby joggers, baby strollers, headphones, animals on leashes, skateboarders, skaters, and other roller blades are all prohibited. I acknowledge and agree that LWML is a service agency of The Lutheran Church—Missouri Synod and cannot and does not accept any responsibility for my safety and well-being related to my participation in the walk. Furthermore, by signing this waiver, I consent to such medical treatment as LWML (or any of its authorized representatives) deems necessary or appropriate in the event of my illness, accident, or other medical emergency and I accept full financial responsibility for any fees or expenses relating to such treatment.

**Please Sign the front of this form.**

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