



REGISTRATION TYPE

Adult \$25 Youth \$10

Bib # _____

CONTACT INFORMATION

Last name _____ First name _____

Gender M F Birthdate _____ Phone _____

Email _____

Address _____

Church Attending _____

Team Options Team Captain Team Member No Team

Team name _____

T-Shirt size (included in price)

Adult ___XS ___S ___M ___L ___XL ___XXL Youth ___XS ___S ___M ___L

Would you like to purchase additional t-shirts? (\$8 per shirt, if available)

Adult ___XS ___S ___M ___L ___XL ___XXL Youth ___XS ___S ___M ___L

Payment Information payment via Cash Check Card

Card # _____ Exp _____ Sec _____

Name on card _____ Total \$ _____

WAIVER

I hereby release Hope Pregnancy Clinic or any individuals or organizations who assist or support the Hope Run from any liability from illness or injuries I may suffer as a result of my participation in this event. I know that running in an organized race such as this is a potentially hazardous activity. I should not enter unless I am medically able and properly trained. I certify that I am physically fit to participate in this race.

I consent to be treated by licensed medical personnel if an emergency occurs, although Hope Pregnancy Clinic will not have any liability for payment of any costs of such treatment.

I understand that my photographed image may be included in Hope Pregnancy Clinic publications.

I have read and agree to this waiver. Signature _____