Choose to Lose Summer Challenge
June 22 – September 11
AMH Wellness

**OFFICIAL REGISTRATION AND WAIVER**

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select a 4 digit number to be used as your event personal identification \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Male \_\_\_\_ Female \_\_\_\_ Age \_\_\_\_

Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check here if you would like this email to be added to the AMH Wellness mailing list for notification of future events. \_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Agreement to Participate**
In signing this form, I understand and acknowledge that Antelope Memorial Hospital and all sponsors bare no responsibility for any injury, harm, loss or inconvenience that may occur to me as a willing member of the activities associated with this event.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information**(Please check and sign one)

I would like my information kept private at all times \_\_\_\_
I am OK with my name and event results being displayed for recognition purposes \_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Be sure to add us on Facebook at AMH Wellness!
Please contact Katie in AMH Wellness with any questions or concerns.