HAWAII PACIFIC HEALTH GREAT ALOHA RUN

IN TRAINING WORKSHOP REGISTRATION/ WAIVER

Name: _____Gender (circle one): F M Age: _____
Best contact number: _____ E-mail: _____
My goal finishing time for the GAR is: _____ Hour(s) _____ Min(s)
I am a: Slow walker _____ Fast walker_____ Walk/jogger_____ Jogger_____ Slow runner_____ Runner_____

In case of an emergency, please contact the following:
Name: _____ Contact number: _____

I understand that not all exercises are suitable for everyone and therefore this or any other exercise program may result in injury including, but not limited to, falls or contact with other participants.
I further acknowledge that the activity will be conducted over public roads and in/on facilities open to the public during the activity and upon which hazards of traveling and use are expected. I further agree and warrant that if I believe at any time that conditions are to be unsafe or I experience physical distress of any sort, I will immediately discontinue further participation in the activity.
To reduce the risk of injury, I am advised to consult my personal physician before selecting equipment and/or beginning this program and that the instruction and advice presented are in no way intended as a substitute for medical counseling and that this program is not intended to diagnose, treat or cure any condition. Despite the fact that a complete account of all risks is not possible, it is still my desire to participate.
Having read this waiver and knowing these facts, I, for myself and anyone entitled to act on my behalf, assume all risks in this program and waive and release The Hawaii Pacific Health Great Aloha Run, Steering Committee, Carole Kai Charities, all sponsors, Nicole McDermott, staff, pace setters, instructors, trainers, volunteers, participants, landlords, City & County of Honolulu, and their representatives and successors of all claims or any liability or loss from or in connection with this program, activities, the exercises and advice herein. I give permission to use any and all images taken of me.

Signature: _____ Date: _____20____

MEDICAL INFORMATION

Do you have or ever had pain/discomfort in the following areas (Check all that apply)
Head_____ Neck_____ Shoulder(s)_____ Upper Back_____ Mid Back_____ Lower Back_____
Hip(s)_____ Knee(s)_____ Shin(s)_____ Ankle(s)_____ Elbow(s)_____ Wrist(s)_____
Finger(s)_____ Toe(s)_____ Fore Arm(s)_____
If yes to any of the above, please explain.
_____
_____

Do you currently have or had any of the following (Check all that apply)
Diabetes_____ High blood pressure_____ Heart disease_____ Pace maker_____
Headaches_____ Arthritis_____ Seizures_____ Surgeries_____ Kidney disease_____
Cancer_____ Numbness_____ Anemia_____ Dizziness_____ Asthma_____
Hernia_____ Allergies_____ Dermatitis_____
If yes to any of the above, please include date and explain
_____
_____

Current medications (Type and dosage)
_____
_____