



2012 St. Jude  
Memphis to Peoria Run  
Waiver

NAME: \_\_\_\_\_ DOB \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
TELEPHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_  
CELL # \_\_\_\_\_ EMAIL \_\_\_\_\_

**\*Please print legibly**

SHIRT SIZE: (circle one) S M L XL XXL XXXL (Men's Sizes)  
S M L XL XXL (Women's Sizes)

1. Year 2012 will be my \_\_\_\_\_ year on the St. Jude Memphis to Peoria Run  
**1<sup>st</sup> year runners – Include \$50.00 Registration Fee** (to be applied to your pledged total)
2. My running speed is approx. \_\_\_\_\_ minutes per mile
3. If you anticipate driving a motor home, you must submit a copy of your DL, with this Waiver, to the Run Office prior to driving.

**Person to notify in case of emergency:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone Home: \_\_\_\_\_ Work: \_\_\_\_\_

**WAIVER:**

*In signing this release, I, for myself, heirs, executors, administrators, and assigns, do hereby waive any and all claims I may have for damages against the St. Jude Runners Association, the St. Jude Children's Research Hospital in Memphis, TN, and the St. Jude Midwest Affiliate in Peoria, IL, the sponsors, the cities in which I run, and any other parties connected with this event. I attest and verify that I have full knowledge of the risks involved in this event and that I am physically fit and trained to participate in this event.*

*The St. Jude Runs are committed to providing an environment that is free of discrimination. In keeping with this commitment, we maintain a strict policy prohibiting unlawful harassment, including sexual harassment. Our policy prohibits harassment in any form, including verbal, physical, and visual harassment. Any participant or volunteer who believes he or she has been a victim of such conduct should promptly report the facts of the incidents and the names of the individuals involved to any Run Leader, Run Coordinator, or Run Office employee.*

*I grant full permission for organizers to use photographs of me and quotations from me in legitimate accounts and promotions of this event.*

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

\*New runners - mail this Form & Medical Form (Page 2) to the St. Jude Run Office, 4722 N. Sheridan Rd., Peoria, IL 61614 & include your registration fee. Veteran runners may e-mail both forms to [Katie.aeschliman@stjude.org](mailto:Katie.aeschliman@stjude.org) or [Angie.wiebler@stjude.org](mailto:Angie.wiebler@stjude.org)

**St. Jude Run Medical History Form**

The following questionnaire is required in the unlikely event you require emergent medical care while participating in any of the St. Jude Runs. The information you provide may help health care providers assist you under such circumstances. Please answer the following as accurately as possible.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: M or F Date of Birth: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_

**Emergency Contacts:** Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Relation: \_\_\_\_\_ Work #: \_\_\_\_\_

**Medical Data:** Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

What medications are you presently taking or may you be taking during the run (include prescription medications, over-the-counter medications, dietary supplements and herbal remedies).

\_\_\_\_\_  
\_\_\_\_\_

Known food, drug or environmental allergies:

\_\_\_\_\_  
\_\_\_\_\_

Have you been treated or are you presently being treated for any of the following conditions. Please check all that apply and provide a detailed explanation for any checked responses in the area following.

Hypertension	_____	Epilepsy	_____	Lung Disease	_____	Thyroid Disease	_____
Diabetes	_____	Seizure Disorder	_____	Hypotension	_____	Liver Disease	_____
Heart Attack	_____	Brain Tumor	_____	Rheumatic Fever	_____	Anxiety	_____
Renal Disease	_____	Cancer	_____	Heart Failure	_____	Stroke	_____
Fainting	_____	Psychiatric Disease	_____	Myocarditis	_____	Anemia	_____
Loss of Consciousness	_____	Blood or Bleeding Disorder	_____	Circulatory Disorder	_____	Nervous System Disorder	_____
Gastrointestinal Disease	_____	Other Endocrine Disease	_____	Head, Eye, Ear, Nose, Throat Disorder	_____	Other	_____

**Special Conditions/Remarks:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I affirm that the above information is correct to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**ANY INFORMATION PROVIDED WILL BE KEPT COMPLETELY CONFIDENTIAL**