



# Autumn Escape Bike Trek

## Escape to the Cape

### CYCLIST REGISTRATION FORM

OCTOBER 2, 3, & 4, 2009

#### MINIMUM FUNDRAISING REQUIREMENTS FOR TREK 2009 - \$500

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Company/School Name: \_\_\_\_\_

Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  M  F T-shirt Size:  S  M  L  XL  XXL Cycling Jersey Size:  XS  S  M  L  XL  XXL

How did you hear about the Trek? \_\_\_\_\_

Please select which Trek Option you would like to participate in (choose one):  3 day trek  2 day trek

I will form a team; send me a Team Captain Guidebook

I am on a Team: \_\_\_\_\_ Team Captain: \_\_\_\_\_

Yes, I allow Team Alpha-1 volunteers to release my name and contact information to the rest of my team members.

I have participated in Autumn Escape Bike Trek: \_\_\_\_\_ years

My caregiver \_\_\_\_\_ will be joining us.

#### Available Accommodations

All Male Cabin  All Female Cabin

Co-Ed Cabin  Family Cabin

Other (I will make my own arrangements for accommodations & transportation) \* You must check in at camp each morning & afternoon \*

Roommate Request: \_\_\_\_\_  
(Must be a registered Trekker or Volunteer, will be Applicable for both nights if possible.)

#### Saturday Night Lobster Bake:

Order me ONE lobster

#### Available Transportation

I am a 3-day Trekker & will be taking the bus to my car in Plymouth.

I am a 2-day Trekker & will be taking the bus to my car in Sandwich.

I am a \_\_\_\_-day Trekker & will be making my own transportation plans for my return home.

#### Contact:

Susan Binnall  
sbinnall@comcast.net  
617-916-9805

Sheila Favazza  
sifavazza@yahoo.com  
978-468-7704

Note 1: If you wish to pay for your minimum pledge requirements to help support the team, you can mail your donation to Alpha-1 Foundation, 2937 SW 27 Avenue Suite 302 Miami, FL, 33133

Note 2: The Alpha-1 Foundation will write one (1) check to ALA for our registration fees and the \$500.00 pledge minimum per rider.

**Please complete both sides of this Registration Form**

## WAIVER FORM

I, the undersigned, agree as follows:

1. I understand fully that, as part of the Autumn Escape Bike Trek, an expedition will be undertaken, the nature and extent of which has been fully explained to me.
2. I acknowledge that the Trek will require strenuous physical activity and endurance.
3. I certify that, to the best of my knowledge, I have no physical condition which will be aggravated by the activity and endurance anticipated or which will impair my ability to participate in and withstand said activity and endurance.
4. I have neither suffered any illness, nor taken any prescription medication within the past thirty days, except as otherwise written on the Medical History form.
5. I understand there is NO SMOKING during the Bike Trek.
6. I agree to indemnify and hold free each of the American Lung Association of New England, all Autumn Escape Bike Trek sponsors, their agents and employees, individually and collectively, against any loss, cost, damage or expense of any kind arising out of or connected with participation in the Bike Trek.
7. I understand that I must conduct myself in a safe and responsible manner during the Bike Trek, for my personal safety as well as the safety of others. This includes, but is not limited to, obeying all traffic laws and observing common courtesy. I understand that I may be asked to leave the Trek entirely if my conduct is judged to be detrimental to the welfare of others.
8. I consent to use by the American Lung Association of New England or any one they authorize, for the purpose of publicity of themselves and their activities, of my likeness from participating in this event, without obligation or liability to me.

Signature of Participant: \_\_\_\_\_  
Date: \_\_\_\_\_

## MEDICAL HISTORY

(To be completed by applicant)

If you have had or are currently experiencing any of the following conditions, please circle the number and give details at the end of this section.

1. Any problems with hearing or vision - requiring hearing aids, glasses or contacts (hard or soft).
2. Dizzy spells, fainting, convulsions, persistent headaches.
3. Shortness of breath, or asthma on exertion.
4. Chest pains on exertion or deep breathing.
5. Palpitations of the heart, irregular heart beat, heart murmur, or poor circulation.
6. Jaundice or hepatitis.
7. Chronic pain in neck, back shoulders, arms or legs.
8. Reaction to extremes of temperature, frostbite, impaired circulation.
9. Hypoglycemia.
10. Episodes of depression, anxiety, hysteria, nervousness.
11. History of diabetes, thyroid trouble, bleeding problems.
12. Are you currently on an medications.
13. Allergies to food, drugs, or other.
14. What is your current level of physical activity?  
\_\_\_\_\_

If you circled any of the above items, please list details below according to number. Be specific (include dates, names of medications, history of condition, etc.) Use additional paper if necessary.

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

In Case of Emergency, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Contact Phone (1): \_\_\_\_\_ (2): \_\_\_\_\_  
Physician: \_\_\_\_\_ Physicians Phone: \_\_\_\_\_

### **MEDICAL INSURANCE COVERAGE** - For insurance records, answers to the following questions are required in detail.

Do you have hospitalization and medical care insurance coverage?  Yes  No

If yes, please indicate name and address of insurance company issuing such policy: \_\_\_\_\_

Indicate policy or certificate number: \_\_\_\_\_ Name on policy: \_\_\_\_\_