ENTRY FORM

FLYING PIG KIDS' MARATHON 26TH-MILE AND 5K EVENTS — MAY 6, 2017

OFFICIAL USE ONLY

#

AMT REC'D _____

CHECK/M.O. # _____

DATE REC'D

Cincinnati Children's Heart Institute
School or Group Affiliation

First Name | M.I. | Last Name

☐ Male ☐ Female
Gender (check one)

MONTH | DAY | YEAR
Date of Birth

Age on race day

Email Address

Daytime Phone

Evening Phone

Street Address/Apartment Number

City | State

ZIP Code/Postal Code

Country (leave blank if USA)

☐ SM ☐ MED ☐ LG ☐ XL ☐ XXL
Adult T-shirt Size

or

☐ XS ☐ SM ☐ MED ☐ LG
Youth T-shirt Size

XS (2–4) MED (10–12)
SM (6–8) LG (14—16)

(We will do our best, but we cannot guarantee size)

Waiver and Signature

LIABILITY WAIVER AND RACE AGREEMENT. I hereby certify that I have carefully read, understand and agree to the Entry Form and the Terms and Conditions published by the Marathon, including but not limited to information about risk, preparation, medical condition, authorization for assistance, the rules concerning the race, and the waiver and release of all claims. In consideration of the acceptance of my entry and my participation in the Marathon, I, for myself, my heirs and assigns do hereby release The Cincinnati Marathon, Inc., Flying Pig Marathon, the Cities of Cincinnati, Covington and Newport, all sponsors, volunteers, Marathon staff, directors and officers, together with their subsidiaries, successors, heirs, contractors, subcontractors, directors, officers, agents, attorneys, and representatives from all claims of liabilities of any kind and character whatsoever arising from my participation in the Marathon or any of its allied or accompanying events. I consent to the use of my image in photos, video and audio recording, and film, of my participation in all Marathon events. I understand the Terms and Conditions (available on request or at www.flyingpigmarathon.com). I will not enter and run unless I am medically able and properly trained to do so.

_____ _____
Signature of Applicant | Date

_____ _____
Emergency Contact | Phone Number

_____ _____
Parent/Guardian Signature for all participants under 18 years of age | Date

Fit Hearts Training Program Registration
To be completed by participant, parent or guardian. Please print legibly.
All information will be used by staff only and will be kept confidential.

Participants name (Last): _____ (First): _____
Sex (circle): M F Birthdate (MM/DD/YYYY): _____ Age at training:_____
Address: _____
City: _____ ST: _____ Zip: _____
Primary Phone #: _____ Type: Home Mobile
Email address:_____
Child's T-shirt size (circle): Youth sizes: S M L Adult sizes: S M L XL XXL

Participants/ Parent/Legal Guardian Information

If participant is a minor:
Primary parent/legal guardian name (Last name, First name):_____
Address: _____
City: _____ ST: _____ Zip: _____
Primary Phone #: _____ Type: Home Mobile
Email address:_____

Emergency Contacts

Please list a contact that can be reached in case of emergency.

Emergency Contact #1 Name:_____
Relationship to participant:_____
Primary Phone #: _____ Type: Home Mobile Work

Medical Information

Participant's Cardiac Diagnosis:_____
Cardiologist: _____ Phone:_____
Pediatrician: _____ Phone:_____
Medical problems other than cardiac problems (please describe):

- _____
  _____
  _____
  _____

Does your child (circle yes or no, and explain as needed):

Yes No partake is a school physical education program:_____
Yes No get short of breath with activity:_____
Yes No become more "blue" when playing or running:_____
Yes No ever require oxygen:_____
Yes No keep playing when he/she should stop to rest:_____
Yes No get out of breath walking up a flight of stairs:_____
Yes No need help getting around - ie, wheelchair or scooter:_____
Yes No has the participant's cardiologist limited your activity in any way? If so, please list:__
_____
Yes No Are all immunizations up to date?

I have, to the best of my knowledge, accurately stated all information herein correctly.

_____ _____

Participant/ Parent/legal guardian signature **Date**

Cincinnati Children's Hospital Medical Center
♥♥ Fit Hearts Training Program ♥♥

The Heart Institute has developed a progressive marathon training program designed for HealthWorks! and Congenital Heart Disease patients minimal age of 5. This 7-week training program will allow participants to complete a progressive full marathon beginning on Saturday, March 12, 2016 and ending on Saturday, April 30, 2016. Participants will have the opportunity to complete 3.6 miles through wheeling, walking and/or running each week.

Staff volunteers including Registered Nurses, Cardiovascular Technologists, Exercise Physiologists and physicians will be on site to help with each training session. All are CPR/AED certified.

Training will take place at the following locations:

Cincinnati Children's Hospital Medical Center
3333 Burnet Avenue
Cincinnati, OH 45229

Montgomery Inn-Boathouse Parking Lot
925 Riverside Drive
Cincinnati, OH 45202

Terms of Participation

*I understand that my participation in programs offered by Cincinnati Children's Hospital Medical Center (CCHMC) is based on a "Challenge by Choice" philosophy. I recognize that the program is designed to use hands on instruction, engaging, teaching techniques, but that my participation is purely voluntary, and I elect to participate in spite of the risks.

*I am aware that exercising can pose many health risks, abnormal blood pressure; fainting; heart attack, stroke, other injury, etc. This includes all training provided by CCHMC during the progressive marathon training, in for which I and/or my child have enrolled. I understand that staff will make every effort to ensure safety.

*I am aware that I will be conducting training at facilities open to the public and the CCHMC HI will not be responsible for any person or things that may be lost or stolen.

*I am aware that I can only participate once I have obtained medical clearance from a physician.

*Therefore, for myself/my child, I expressly, knowingly and voluntarily assume all risks involved in my participation, and do hereby release CCHMC and its members, trustees, officers, employees, and independent contractors and agents from any and all liability, damages, costs, and expenses arising out of or relating to bodily injury, loss of life or personal property that may occur as a result of participating in this program.

*I have read and understand and accept the terms and conditions stated herein and acknowledge that this agreement shall be effective and binding on the parties during the entire period of participation in the said program.

*Authorization for emergency treatment- I hereby give permission to the licensed medical personnel selected by the CCHMC to arrange necessary emergency related transportation by EMS personnel for this participant and assist with the administration of prescription and over-the-counter medication for the individual participant if needed. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by CCHMC to secure and administer treatment, including hospitalization, for the person named above.

*I understand that the participants will be made up of patients and families from The Heart Center. CCHMC assumes no responsibility or liability for any injury suffered as a result of the behavior of other participants.

Signature of participant:_____

Signature of parent/legal guardian for Participant under age 18

:_____

Date: _____

Emergency Contact Name and Phone Number: _____

Cincinnati Children's

Authorization for Use and/or Disclosure of Limited Protected Health Information

MEDICAL RECORD #: _____ *(completed by CCHMC if applicable)*

****DO NOT USE THIS FORM FOR RESEARCH PURPOSES OR TO RELEASE COPIES OF THE MEDICAL RECORD****

This form gives permission for Cincinnati Children's Hospital Medical Center (CCHMC) to use and/or disclose (release) the health information of the individual below as follows:

Name: _____ Date of Birth: _____
Last First Middle

Address: _____
Address City State/Zip

Primary contact e-mail: _____ Phone: ( ) _____

Information To Use/Disclose

CCHMC may use/disclose the following health information about the individual: *(Select all that apply)*

- ☐ Photographs
- ☐ Video recordings
- ☐ Audio recordings
- ☐ Name and age
- ☐ Parent/guardian names
- ☐ City of residence
- ☐ Admission, discharge, or treated/released status
- ☐ Diagnosis, treatment, prognosis
- ☒ All of the above
- ☐ Other: _____

Purpose of Use/Disclosure

CCHMC may use/disclose this health information for the purposes described below: *(Select all that apply)*

- ☐ CCHMC communications, such as for marketing, advertising, public relations, fundraising, or other related purposes. This may include publications (print or electronic), presentations (at public or private events, on television), or internet sites (e.g., CCHMC websites, partner websites, or social media sites).
- ☐ The media, including print or television journalists.
- ☐ Professional audiences, such as publications (print or electronic), presentations or related internet sites.
- ☒ All of the above
- ☐ Other: _____

By signing below, I authorize CCHMC to use and/or disclose the health information specified in this authorization and confirm to the best of my knowledge that I am legally authorized to represent the interests of this individual.

- CCHMC will not condition treatment, payment, enrollment, or eligibility for benefits on this signed authorization.
- The health information used and/or disclosed as a result of this authorization may be subject to redisclosure by the person or entity receiving such information. At that point, it is no longer protected by the federal privacy regulations. CCHMC is not responsible for the use of information, in whole or in part, by third parties.
- Any photos, images, or other representations specified above become the property of CCHMC or its representatives.
- This authorization is given without promise of compensation. The parent/legal guardian and the individual release to CCHMC any right, title and/or interest of any kind they may have in the information or images produced.

As stated in the Notice of Privacy Practices, I understand that I may withdraw this authorization at any time. Notification of withdrawal must be done in writing and sent to the CCHMC Health Information Management (HIM) Department, 3333 Burnet Avenue, ML 5015, Cincinnati, OH 45229. This authorization will not be withdrawn or expire for situations where CCHMC has already taken action as described in this authorization. This authorization will only expire if revoked by me in writing as stated above.

Signature: _____ Date: _____

Printed name: _____

This form must be signed and dated to be valid. If the individual is an emancipated minor or 18 years of age or older, s/he is required to sign the authorization.

A copy of this authorization must be provided to the individual completing this form.

CCHMC USE ONLY

Department requesting authorization: _____

*Note: The original, signed authorization must be sent to the HIM Department Attn: ECRM (MLC 5015) within 2 weeks of obtaining signature. The department obtaining this authorization must also retain a copy, either on paper or electronically, for internal tracking purposes.