

**THE BIGGEST LOSER  
UNCONDITIONAL RELEASE OF LIABILITY**

The undersigned does hereby give permission for myself, \_\_\_\_\_, to attend and participate in The Biggest Loser Contest sponsored by St. Timothy's Episcopal Church, including but not limited to, group exercises, diet plans, work out regimens, and weekly weigh ins. I am familiar with the hazards of vigorous activity and further understand the potential hazards of diet plans and injuries resulting in exercise routines. I, also, recognize the medical complications resulting from possible workout schedules in which I may engage.

I hereby unconditionally release and absolve St. Timothy's Episcopal Church and all clergy, staff, and volunteer leaders involved in these activities from liability for any accident.

In case of emergency, I understand that every effort will be made to secure proper treatment. I hereby give permission for such treatment and consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician, dentist or licensed hospital whether such diagnosis or treatment is rendered at the office of said physician/dentist or at said hospital. My personal health and accident insurance covers any accident or illness that may be incurred during this experience. I will personally guarantee any cost of other liability incurred during evacuation or treatment.

I consent to the use of any visual or audio reproduction that may be taken of the above named participant during TBL sponsored activities to be used, distributed, or shown as St. Timothy's Episcopal Church sees fit, including being posted on St. Timothy's Website (for advertising parish life activities).

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**In case of any illness or injury, contact:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

**(PLEASE SIGN REVERSE SIDE)****HEALTH INVENTORY, September 2009– Aug. 2010**

Name \_\_\_\_\_ Male \_\_\_ Female\_\_\_ Birth date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

## Emergency Contact Information:

1. Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Contact Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Policy Number \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Date of last tetanus booster \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Hospital Preference: Baptist \_\_\_\_\_ Forsyth \_\_\_\_\_ Other \_\_\_\_\_

**DO YOU HAVE:**

Allergies? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Asthma? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Bee Sting Allergy? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Diabetes? \_\_\_\_\_NO \_\_\_YES Takes Insulin \_\_\_no \_\_\_yes

Ear Infections? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Epilepsy/Seizures? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Heart Conditions? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Orthopedic Problems? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Other Problems? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

**HAVE YOU HAD:**

Serious Illness? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Serious Injury? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Surgery? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Childhood Diseases? \_\_\_\_\_NO \_\_\_YES Specify \_\_\_\_\_

**DO YOU:**

Take daily medication? \_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Take emergency medication? \_\_\_NO \_\_\_YES Specify \_\_\_\_\_

Have permission to take, if needed: Tylenol/Ibuprofen \_\_\_NO \_\_\_YES

Pepto-Bismol \_\_\_NO \_\_\_YES

Do you have any special dietary concerns or needs? \_\_\_\_\_

**(PLEASE SIGN REVERSE SIDE)**