

# REGISTER

Registration fee is \$20.00 nonrefundable and Not tax deductible.

Tax deductible donations are accepted on DONATE tab.

You can win a bracelet by becoming a fundraiser.

Legal Name \_\_\_\_\_

Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Gender \_\_\_\_\_

Age \_\_\_\_\_

Phone Number (Required for Wassap communication) \_\_\_\_\_

## Must Sign Waiver

In consideration of you accepting this entry, I, the participant, intending to be legally bound do hereby waive and forever release any and all right and claims for damages or injuries that I may have against the Event Director, Divine Mercy Family Foundation, and all of their agents assisting with the event, sponsors and their representatives, volunteers and employees for any and all injuries to me or my personal property. This release includes all injuries and/or damages suffered by me before, during or after the event. I recognize, intend and understand that this release is binding on my heirs, executors, administrators, or assignees.

I know that dancing, though fun is a potentially hazardous activity. I should not enter and dance unless I am medically able to do so and properly trained. I assume all risks associated with dancing activity in this event including, adverse conditions, and waive any and all claims which I might have based on any of those and other risks typically found in physical activity. I acknowledge all such risks are known and understood by me. I agree to abide by all decisions of any official relative to my ability to safely complete the dance moves. I certify as a material condition to my being permitted to enter this Zumba dance that I am physically fit and sufficiently trained for the completion of this event and that a licensed Medical Doctor has verified my physical condition.

In the event of an illness, injury or medical emergency arising during the event I hereby authorize and give my consent to my primary Doctor, to any accredited hospital, clinic and/ or physician any treatment deemed necessary for my immediate care. I agree that I will be fully responsible for payment of any and all medical services and treatment rendered to me including but not limited to medical transport, medications, treatment and hospitalization.

To defeat Covid-19 I must maintain social distancing and not participate if I am sick.

By submitting this entry, I acknowledge (or a parent or adult guardian for all children under 18 years) having read and agreed to the above release and waiver.