PWA'S FRIENDS FOR LIFE BIKE RALLY MEDICAL FORM

If you have already registered, please update this information on your personal fundraising page.

Please complete this form and return to PWA along with a copy (front and back) of your Provincial Health Card. This information will remain completely confidential and will be securely destroyed after the Bike Rally.

Fax: 417-506-1404 **Email: bikerally@pwatoronto.org**

OHIP#: ______________________ Date of Birth: ______________________

Name: ____

Address: ____

Home Phone: ______________________ Cell Phone: ______________________

Emergency Contact (Name and Relationship): ______________________

Emergency Contact Phone Number: ______________________

Can we release medical information to this person? Yes ________ No ________

Can this person make medical decisions for you? Yes________ No ________

Family Doctor: ______________________ Phone: ______________________

Medical Conditions: ____

Medications: ____

Do any of your medications require refrigeration? Yes________ No ________
(If yes, please email wellness@bikerally.org with a complete list of medications)

Do you have any known Allergies? Yes ________ No ________

If yes, please list: ____

Do you carry an Epi-pen? Yes________ No ________

Have you ever been hospitalized due to an allergic reaction? Yes ________ No ________

Date of Last Tetanus shot: ____

(Back of Page)

Name: ____

I acknowledge and agree that the Toronto People With AIDS Foundation (PWA) and the Friends For Life Bike Rally (FFLBR) may collect and retain information about me, such as my name, age, gender, and email address ("**Personal Information**"). Collection of this Personal Information and use of Personal Information is for the administration of the Software only. PWA and FFLBR will not sell, share, or transfer this data to third parties unless we indicate this to you. I understand that PWA and FFLBR may employ other companies to perform functions on our behalf, such as sending emails, or providing marketing assistance. These companies may have access to Personal Information needed to perform their functions, and may not use such information for other purposes. In the event PWA and FFLBR employ third parties, we will advise you of the name of those third parties. By assenting to this agreement, you agree that you understand and accept our data collection and privacy policy.

To view PWA's Disclaimer and Confidentiality Policy, please visit:
http://www.pwatoronto.org/english/confidentiality.php

I certify that the information provided on this form is accurate and complete to the best of my knowledge and contains no misrepresentations or material omissions. I will inform the Toronto People With AIDS Foundation's Special Events Coordinator and Wellness Co-Leads of any relevant changes in my state of health subsequent to my application and prior to the Friends For Life Bike Rally. By signing this form, I grant permission for this information to be provided to those with a legitimate need to know.

Signature: ____________________________________ **Date: ________________________**

PWA'S FRIENDS FOR LIFE BIKE RALLY CONSENT TO MASSAGE/CHIROPRACTIC AND COMPLEMENTARY THERAPIES SERVICES AND WAIVER OF LIABILITY

I am a participant in PWA's Friends For Life Bike Rally (the "event"). During the event I have requested massage and/or chiropractic services and/or complementary therapies from volunteers associated with the event providing such services, and I hereby consent to the services I have requested, pursuant to the *Health Care Consent Act*, 1996.

In consideration of receiving the requested services, I acknowledge and agree to the following:

1. I will provide accurate and complete information about my health to the volunteer from whom I seek services.

2. I acknowledge and agree that any services provided will be based upon the personal health information provided by me.

3. I understand that I may withdraw my consent to services in writing at any time.

4. I understand that the volunteer may, in his or her discretion refuse me services.

5. I hereby, on my own behalf and on behalf of my heirs, estate, successors and assigns, release, waive and forever discharge the volunteer and the sponsor of the event, Toronto People With AIDS Foundation, its directors, officers, employees, agents and volunteers from whom I have sought services of and from all claims, demands, damages, costs, expenses, actions in law and in equity arising in any manner from the massage or chiropractic services provided to me, regardless of whether such loss or damage was caused or contributed to by negligence on the part of the volunteer.

6. I understand that there are inherent risks involved in receiving chiropractic services, massage services or complementary therapies including the possibility of bodily injury or death, and I voluntarily take such risks upon myself.

7. I confirm that I have read this consent and waiver. I understand its terms and effect, and I have agreed to it freely and voluntarily, without any inducement or coercion.

________________________________	________________________________
Date	Print Name
________________________________	________________________________
Date of Birth MM/DD/YY (Participant must be over 18)	Signature