



In support of York Region District Stroke Centre
Strides for Stroke
 5K Run/Walk



Registration Form

Please complete one form for *each* participant

NAME _____

ADDRESS _____

CITY, PROVINCE, POSTAL CODE _____

TELEPHONE _____

EMAIL ADDRESS _____

Male Female Date of Birth: _____ / _____ / _____
MONTH DAY YEAR

TEAM NAME (IF APPLICABLE) _____

T-shirt Size: S M L XL

T-Shirts and Race Kits guaranteed for the first 500 registered participants

INDIVIDUALS
 \$30 Early \$40

TEAM
 \$100 Early \$125
Teams consist of up to 5 participants

SCHOOL TEAM
 \$60 Early \$80

SCAMPER (Children 12 and under are FREE):
Please fill out the information below for children participating in the SCAMPER race.

NAME _____

ADDRESS _____

Male Female Date of Birth: _____ / _____ / _____
MONTH DAY YEAR

Registration Fees (please check applicable box) Amount Enclosed: \$ _____

VISA M/C Amex Cash Cheque

CARD NUMBER _____ / _____
EXPIRY DATE

SIGNATURE NAME ON CARD _____

Cheques payable to: **YORK CENTRAL HOSPITAL FOUNDATION**
 10 Trench Street, Richmond Hill, Ontario, L4C 4Z3

WAIVER & RELEASE OF LIABILITY:

I hereby give my permission for my photograph to be reproduced in publications related to York Central Hospital. I am participating at my own risk and waive all claims of every nature against the organizers, officials, sponsors, and any other participating agencies in respect to activities. I also fully understand the rigors of such a competition and I have prepared myself physically for the race/walk. At the time of registration, I will inform the race organizers regarding any relevant medical condition. I, the undersigned, have read the above waiver and release, and understand that I have given up substantial rights by signing it, and sign it voluntarily.

Signature: _____

Guardian (if under 18 yrs) _____



In support of York Region District Stroke Centre

Strides for Stroke

5K Run/Walk

Pledge Form



RUNNER/WALKER INFORMATION:

PARTICIPANT'S NAME: _____ TELEPHONE: _____

ADDRESS: _____

NAME: _____ TELEPHONE: _____

ADDRESS: _____

POSTAL CODE: _____

AMOUNT:
 CASH CHEQUE RECEIPT REQ'D

NAME: _____ TELEPHONE: _____

ADDRESS: _____

POSTAL CODE: _____

AMOUNT:
 CASH CHEQUE RECEIPT REQ'D

NAME: _____ TELEPHONE: _____

ADDRESS: _____

POSTAL CODE: _____

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POSTAL CODE: _____

AMOUNT:
 CASH CHEQUE RECEIPT REQ'D

In support of York Central Hospital's **YORK REGION DISTRICT STROKE CENTRE**

- ✓ Photocopy as required for additional sponsors
- ✓ Tax receipts will be issued for donations of \$20 or more, if requested
- ✓ Please make cheques payable to

YORK CENTRAL HOSPITAL FOUNDATION
10 Trench Street, Richmond Hill, Ontario, L4C 4Z3

Charitable/Business Number: 11930 6215 RR0001

At York Central Hospital Foundation, we appreciate your support and we treat your personal information with respect. We do not rent, sell or trade any personal information.