

This is an important legal document. Read it carefully before signing below.
Release and Waiver of Liability and Indemnification, Acknowledgement and Assumption of Risk, and Willful Participation Agreement

IN CONSIDERATION of being permitted to participate in any way in RideMN1 Inc. sponsored Activities I, for myself, my personal representatives, assigns, heirs, and next of kin:

-ACKNOWLEDGE, agree and represent that I understand the nature of the Activities and that I am qualified, in good health, and in proper physical condition to participate in such Activities. I further acknowledge that the Activity will be conducted over public Roads and facilities open to the public during the Activities and upon which the hazards of traveling are to be expected. I further agree and warrant that if, at any time, I believe conditions to be unsafe, I will immediately discontinue further participation in the Activity.

-FULLY UNDERSTAND that (a) BICYCLING ACTIVITIES INVOLVE RISKS AND DANGERS OF BODILY INJURY, INCLUDING PERMANENT DISABILITY, PARALYSIS AND DEATH (“RISKS”); (b) these Risks and dangers may be caused by my own actions or inactions, the actions or inactions of others participating in the Activity, the conditions in which the Activity takes place, or THE NEGLIGENCE OF THE “RELEASEES” NAMED BELOW; (c) there may be OTHER RISKS AND SOCIAL AND ECONOMIC LOSSES either not known by me or not readily foreseeable at this time; and I FULLY ACCEPT AND ASSUME ALL SUCH RISKS AND RESPONSIBILITY FOR LOSSES, COST, AND DAMAGES I may incur as a result of my participation in the Activities.

-HEREBY RELEASE, DISCHARGE, AND COVENANT NOT TO SUE RideMN1 Inc., its’ respective administrators, directors, agents, officers, members, volunteers, and employees, other participants, any sponsors, advertisers, and if applicable owners and lessors of premises on which the Activities take place, (each considered one of the “RELEASEES” herein) FROM ALL LIABILITY, CLAIMS, DEMANDS, LOSSES, OR DAMAGES ON MY ACCOUNT CAUSED OR ALLEGED TO BE CAUSED IN WHOLE OR IN PART BY THE NEGLIGENCE OF THE “RELEASEES” OR OTHERWISE, INCLUDING NEGLIGENT RESCUE OPERATIONS. And, I FURTHER AGREE that if, despite this Release and Waiver of Liability and Indemnification, Acknowledgement and Assumption of Risk, and Willful Participation Agreement I, or anyone on my behalf, makes a claim against any of the Releasees, I WILL INDEMNIFY, SAVE, AND HOLD HARMLESS EACH OF THE RELEASEES from any litigation expenses, attorney fees, loss, liability, damage, or cost which any incur as a result of such claim.

I AM 18 YEARS OF AGE OR OLDER, HAVE READ AND UNDERSTAND THE TERMS OF THIS AGREEMENT, UNDERSTAND THAT I AM GIVING UP SUBSTANTIAL RIGHTS BY SIGNING THIS AGREEMENT, HAVE SIGNED IT VOLUNTARILY AND WITHOUT ANY INDUCEMENT OR ASSURANCE OF ANY NATURE AND INTEND IT OT BE A COMPLETE AND UNCONDITIONAL RELEASE OF ALL LIABILITY TO THE GREATEST EXTENT ALLOWED BY LAW. I AGREE THAT IF ANY PORTION OF THIS AGREEMENT IS HELD TO BE INVALID, THE BALANCE, NOTWITHSTANDING, SHALL CONTINUE IN FULL FORCE AND EFFECT.

PARTICIPANT NAME (PRINTED): _____

PARTICIPANT SIGNATURE: _____

ADDRESS: _____
 (Street) (City) (State) (Zip)

PHONE: (_____) _____ DATE: _____

RIDEMN1 BIKE RIDE

EMERGENCY CONTACT - MEDICAL INFORMATION
INFORMATION RELEASE AND TREATMENT AUTHORIZATION

Cyclist's Name _____

Emergency Contacts:

#1 Name _____ Relationship _____

Daytime Phone _____ Evening Phone _____

#2 Name _____ Relationship _____

Daytime Phone _____ Evening Phone _____

NOTE: If you are wearing a Medical Bracelet, please check here and provide the medical contact telephone number and your Identification Number - ___ I am wearing a Medical Bracelet

My ID Number is: _____ In case of medical emergency call: _____

Please provide medical information that may assist you in an emergency. In addition to the items listed, provide further information here: _____

- | | | | |
|----------------------------|--------------------|--------------------------|--------------------|
| Allergies | Y__ N__ Date _____ | High/Low Blood Pressure | Y__ N__ Date _____ |
| Asthma | Y__ N__ Date _____ | Hypoglycemia | Y__ N__ Date _____ |
| Back Pain | Y__ N__ Date _____ | Hypothermia/Frostbite | Y__ N__ Date _____ |
| Blurred/Double Vision | Y__ N__ Date _____ | Memory Loss | Y__ N__ Date _____ |
| Broken Bones | Y__ N__ Date _____ | Menstrual Problems | Y__ N__ Date _____ |
| Chemical Use/Abuse | Y__ N__ Date _____ | Neck Pain | Y__ N__ Date _____ |
| Concussions | Y__ N__ Date _____ | Numbness in Hands/Feet | Y__ N__ Date _____ |
| Diabetes | Y__ N__ Date _____ | Pulmonary/Cerebral Edema | Y__ N__ Date _____ |
| Digestive Problems | Y__ N__ Date _____ | Ringling in Ears | Y__ N__ Date _____ |
| Dizziness | Y__ N__ Date _____ | Seizures/Convulsions | Y__ N__ Date _____ |
| Epilepsy | Y__ N__ Date _____ | Sprains | Y__ N__ Date _____ |
| Fears (height, dark, etc.) | Y__ N__ Date _____ | Ulcers | Y__ N__ Date _____ |
| Hallucinations | Y__ N__ Date _____ | Unconsciousness | Y__ N__ Date _____ |
| Heart Problems | Y__ N__ Date _____ | Weakness of Limbs | Y__ N__ Date _____ |

List medications here: _____

Waiver: I hereby authorize the release of the medical information above to medical personnel if deemed necessary. I also authorize all medical, diagnostic, surgical, and hospital procedures as may need to be performed by a treating physician. This authorization is given in advance of any specific diagnosis, treatment, or hospital care being required and is in effect for the duration of the event. I have read the information on this form and certify that the information I have provided is accurate and correct.

Participant's Signature: _____ Date: _____