

**“Rock & Roll Yosemite”
A Cycling Park Experience**

Thanks for your interest in Rock ‘n Roll Yosemite, May 11-14, 2009. Please read and complete the following forms by the indicated dates. It is anticipated that the event will be filled to capacity, so participants will be accepted on a first come basis.

Forms to be completed and returned:

- Registration Form w/ deposit
- Medical History Form
- Liability and Photo Release

Payment Schedule:

- Deposit: \$100 (due March 1, 2009)
- Final Payment: \$350 (due April 10th)

(Final payment must be received by April 10, or spot will be forfeited to those on waiting list.)

Checks made payable to: “Access Leisure, City of Sacramento”

(Do Not Send Cash)

Refund Request Deadline: April 1, 2009. Refund requests after April 10 to include “Final Payment” only.

NO REFUNDS after April 24, 2009

Mail Requested Material To:

Rock n’ Roll Yosemite

c/o Jenny Yarrow (916) 808-6017

3291 Truxel Rd., # 26

Sacramento, Ca. 95833

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Registration Form

Name: _____ **Sex:** _____
(last) (first) (M) (F)

Address: _____
(street)

(city) (state) (zip)

Phone: (_____) _____ - _____ **Date of Birth:** ____/____/____
(mm/dd/yy)

Cell # (_____) _____ - _____

E-mail: _____ **T-shirt size** _____

Number of Years Handcycling?: _____ **Do you have a bike?:** Yes _____ No _____

Participants Physical Challenge(s): _____

Assistive Devices: Wheelchair ____ Crutches ____ Braces ____ None ____

Participants will be required to perform all activities of daily living. No medical or personal care services will be provided through the Rock ‘n Roll Yosemite program. There are medical services available in the valley through Yosemite National Park.

Housing: (Housing is based on double occupancy for each cabin)
(http://www.yosemitepark.com/Accommodations_HousekeepingCamp_LodgingDetails.aspx)

Preferred Roommate(s): _____

Nutritional Restrictions: _____

Signature: _____

Phone: (_____) _____ - _____

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Health History Form

Name: _____ **Sex:** _____
(last) (first) (M) (F)

Address: _____ / _____ / _____
(street) (city) (zip)

Phone: (____) _____ - _____ **Date of Birth:** ____/____/____
(mm/dd/yy)

Cell # (____) _____ - _____

Emergency Contact: _____ (____) _____ - _____
(name) (phone)

Address: _____ / _____ / _____
(street) (city) (zip)

Relationship: _____

Disability (describe in detail): _____

Recent Health Concerns: Describe any significant illnesses &/or operations in past 2 years.

Describe any specific physical limitations: _____

History of Seizures?: _____
(yes) (no)

Medications (describe current medications w/ dosage & frequency): _____

Allergies & Reactions: _____
