



**The Vascular Birthmarks Foundation  
Annual Challenge  
2009  
Walk/Run for Birthmarks  
1 Mile Walk—5K Race  
Friday, May 15, 2009**

**Event Sponsored by The Center for Facial Plastic Surgery and Laser Skin Care & University Ear, Nose & Throat of Northeastern New York**

**QUESTIONS?**

BARB ROTHaupt (518)598-8106 OR BROTHaupt@NYCAP.RR.COM  
BASIA JOYCE @ (518) 495-3938 OR BASIAJIM99@NYCAP.RR.COM

**The Crossings at Colonie  
580 Albany Shaker Road  
Loudonville, New York 12211**

- ◆ Fun & Festivities start @ 5 pm
- ◆ 1 Mile Walk Starts @ 6 pm
- ◆ USATF Certified 5K Course
- ◆ 5K Run Starts @ 7 pm
- ◆ Free T-Shirt for the 1<sup>st</sup> 300 Registered Runners/Walkers
- ◆ Celebrity MC Joe Condon
- ◆ 50/50 Raffle, Activities by Tumbling Tykes
- ◆ Food & Merchandise Vendors
- ◆ Ask the Expert Table
- ◆ Awards presented for the following categories:

- 5K Top M/F Overall
- 5K Top M/F Age Category
  - 19/UNDER
  - 20-29
  - 30-39
  - 40-49
  - 50-59
  - 60/OVER
- 5K Top Team Overall
- 5K Top HS & College Team
- Largest Walking Team

**I AM REGISTERING FOR THE:**  1 Mile Walk  5K Run  Sponsor a Child

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Team Name:** \_\_\_\_\_ **Team Captain:** \_\_\_\_\_

**Note: Each Team Runner must complete a separate form and sign waiver below**

**Age (as of 5/1/2009):** \_\_\_\_\_ **DOB:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

**Shirt Size:** *(Requested size contingent upon availability)*

**Youth:**  SM (6-8)  MD (10-12)  LG (14-16) **Adult:**  SM  MD  LG  XL

**Note: Race packet pickup and Day of Event Registration begins at 3:00 p.m.**

- FEES:**
- Individual Run/Walk:** \$15.00 per entrant if Registered by May 1, 2009 — \$20.00 after May 1<sup>st</sup> and on Day of Event
  - Special Team and/or Student Rate Run/Walk:** \$10.00 per entrant for Students or Teams of 5 or More if Registered by May 1<sup>st</sup> — \$15.00 per entrant after May 1<sup>st</sup> and on Day of Event.
  - Special Family Rate for the 1 Mile Walk ONLY:** \$30 per family. Please list names of family members (Up to 5) \$40 per family after May 1<sup>st</sup> and on Day of Event
    - 1. \_\_\_\_\_ 4. \_\_\_\_\_
    - 2. \_\_\_\_\_ 5. \_\_\_\_\_
    - 3. \_\_\_\_\_
  - I/We Cannot Participate in the Walk/Run But Would Like to Sponsor a Child with Birthmarks to Participate in the One Mile Walk:**
    - \$20.00 Minimum Donation  Other Amount *Note: student rate applies to ages 18 and under*

**Athlete/Participant Release: Please Sign and Date:**

WAIVER OF LIABILITY: I understand that walking and running in races are potentially hazardous activities. I should not enter and run or walk in the Vascular Birthmarks Foundation Annual Challenge 2009 unless I am medically able and properly trained. I agree to abide by any decision of an official relative to my ability to safely complete the run/walk. I assume all risks associated with participating in this event including, but not limited to falls, contact with other participants or volunteers, the effects of the weather, and course conditions, all such risks being known and appreciated by me. Having read this waiver and knowing these facts, and in consideration of your acceptance of my application, I, for myself and anyone entitled to act on my behalf, do waive and release the Vascular Birthmarks Foundation, The Crossings of Colonie, the Town of Colonie, the run timers, and all other sponsors, their representatives and successors from all claims and/or liabilities of any kind arising out of my participation in this event even though that liability may arise out of negligence or carelessness on the part of the persons named in this waiver. I also grant permission to all the foregoing to use any photograph, motion picture, recordings, or any other record of this even for any legitimate purpose.

\_\_\_\_\_  
Signature (Under 18—Legal Guardian's Signature) \_\_\_\_\_ Date \_\_\_\_\_

**SEND COMPLETED FORM AND PAYMENT TO: VBF, PO Box 106, Latham, NY 12110**

**Please Check Method of Payment:**  Check (Enclosed)  MasterCard  Visa  Discover

**Credit Card No.** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_ **3-digit Verification Code:** \_\_\_\_\_

[Please Make Checks Payable to The Vascular Birthmarks Foundation, Submit with this Application and mail to address above\* ]

**Total Amount Enclosed or to be Charged: \$** \_\_\_\_\_

Visit Us at [Birthmark.org](http://Birthmark.org)

VBF is a fully approved Not-For-Profit • Federal Tax ID#16-1515227