OFFICE USE ONLY

Bib#: ______________________________

Wave Time: ______________________________

Paid: ______________________________

PARTICIPANT TRANSFER FORM

PLEASE PRINT CLEARLY

Replacing (Full Name): ______________________________

First name: ______________________________

Last name: ______________________________

Email: ______________________________

PERSONAL DETAILS

Date of Birth: ______/_____/______

Gender: ☐ Male ☐ Female

Preferred contact number :(_____) ___________

Postcode (for reporting purposes):___________

Do you have any existing medical conditions which may impact your ability whilst participating in Stadium Stomp? If yes, please detail:

____

____

Emergency contact name: ______________________________

Phone number: (______) ______________

☐ **I have read and agree with all of the Terms and Conditions**

Signature: ______________________________

Print name: ______________________________

Date: ______/_____/______