KICKS BACK

ROCK CF

Your Specs

Patient Name _____ **DOB** _____

Address _____

City _____ **State** _____ **ZIP** _____

Phone _____ **Email** _____

CF Care Center _____

CF Physician _____

What are your current exercise habits?

Do you have any exercise goals?

How would you like to improve or maintain your health and lung function?

Would you be interested in providing a picture of you (or CF patient) and your new kicks for the Rock CF Foundation's website and social media outlets? *(Patient's last name will not be used)*

Please Circle

Foot Specs

Mens/Ladies/Youth/Kids Shoe Size _____ Stability/Neutral/Not Sure

Shirt Size

Mens/Ladies/Youth S/M/L/XL

As part of the Kicks Back program, Rock CF would also like to register shoe recipients for a race of their choice. If you would like to run/walk a 5K, 10K, Half Marathon, or any other distance please email emily@letsrockcf.org!

I hereby release and hold harmless of myself, my child, and/or representatives of the Rock CF Foundation, RunDetroit, and any sponsors. By signing this I agree that I am running/walking under my own will and under the guidance of my physician. I understand that I am responsible for medical coverage for me and/or my child.

_____ _____

Patient/Guardian Signature CF Physician Signature