Honshin Kan Student Information
51 Middle Rincon Rd., Santa Rosa, CA 95409

Student Name:_____ Date of Birth:_____ Age:_____

Address:_____ Zip:_____

Primary Phone:_____ [Cell_ /Text_/LL_] Work Phone:_____

School (if any):_____ Email Address:_____

Medical Insurance:_____ Policy Number:_____

Emergency Contact Name #1_____ Relationship:_____

Primary Phone:_____ [Cell_ /Text_/LL_] Work Phone:_____

Emergency Contact Name #2:_____ Relationship:_____

Primary Phone:_____ [Cell_ /Text_/LL_] Work Phone:_____

Any special physical condition, medications or needs (specify):_____

_____

RELEASE
[Signatures required]

In consideration of the participation of _____ ("the student") in martial arts classes and activities, I, for myself (or the student) and my successors and assignees, hereby waive and release any and all claims, demands and causes of action of whatsoever nature which I (or the student) may now have or ever have against the instructors, the A.J.J.F., Honshin Kan Martial Arts and all of their partners, officers, employees, agents and servants. I understand that the arts and techniques I (or the student) will be learning and practicing are very dangerous. It is possible that by practicing Jujitsu, I (or the student) could be seriously injured, paralyzed, or even killed. I am also aware of the extreme physical demands in learning and practicing the martial arts or related activities. I further understand that I (or the student) should have a thorough physical examination by a licensed medical doctor, who should certify my (or the student's) fitness for participation in the rigorous art of Jujitsu.

I swear that the information I have provided is true and correct. I have read and understand everything in this release and approve of its provisions in their entirety.

Student's Signature:_____ Date:_____

[IF THE PARTICIPANT IS UNDER 18 YEARS OF AGE, THE PARENT OR GUARDIAN MUST SIGN THIS RELEASE FORM.]

Parent/Guardian Signature:_____ Date:_____

Primary Phone:_____ [Cell_ /Text_/LL_] Work Phone:_____

Parent/Guardian email address:_____

Instructor's Signature:_____ Date:_____

CONSENT FOR MEDICAL TREATMENT
[Signature required]

As the above named student or as the parent or legal guardian of the above-named student, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of myself or my dependent.

[IF THE PARTICIPANT IS UNDER 18 YEARS OF AGE, THE PARENT OR GUARDIAN MUST SIGN THIS CONSENT FORM.]

Signature of Student, Parent or Guardian Over 18 Years of Age: _____