

# KUPUNA AIKIDO

## APPLICATION FORM

PERSONAL INFORMATION		
NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE:	DAYTIME PHONE:	
CELL PHONE:	EMAIL ADDRESS:	
NAME OF MEDICAL INSURANCE CARRIER:		
DOCTOR'S NAME:	DOCTOR'S PHONE:	
SPECIAL HEALTH, MEDICATIONS, AND MEDICAL CONCERNS  <div style="display: flex; justify-content: space-around; width: 100%;"> <span>YES</span> <span>NO</span> </div>	IF YES, LIST DETAILS (add separate page if required)          DOCTOR'S STATEMENT ATTACHED	
WAIVER OF LIABILITY		
I have read the Kupuna Aikido RELEASE, WAIVER OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT and agree to all its conditions	SIGNATURE	