Reset

Kupuna Aikido

APPLICATION FORM

PERSONAL INFORMATION		
NAME:		
ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE:	DAYTIME PHONE:	
CELL PHONE:	EMAIL ADDRESS:	
NAME OF MEDICAL INSURANCE CARRIER:	Dr's Name: Dr's Phone:	
SPECIAL HEALTH, MEDICATIONS, AND MEDICAL CONCERNS YES ☐ NO ☐	IF YES, LIST DETAILS BELOW (add separate page if required) Doctor's Statement regarding special medical condition is attached	
I HAVE COMPLETED THE FULL SERIES OF COVID VACCINATIONS AND WILL BRING A COPY OF MY VACCINATION CARD TO THE FIRST DAY OF CLASS.		
I have read the Kupuna Aikido RELEASE, WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNIFICATION AGREEMENT and agree to all of its terms and conditions.	SIGNATURE	