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 ☐ YES ☐ NO	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	