

CHARLOTTE MARTIAL ARTS ACADEMY

Information Form

Student Name: _____
Parent's Name _____
Age _____ Date of Birth: _____
Address _____
City _____ State _____ Zip _____
Home # _____ Work # _____
E-Mail Address _____
Previous Experience in Martial Arts? Yes No
Learning Objectives: _____
How did you hear about us? (Circle one)
Phone Book Charlotte Observer Creative Loafing
Rhino Times Charlotte Parent Mag Radio
Birthday Party Other (please specify) _____
Referral _____

Waiver

I fully understand that the instruction, classes and use of any facility are physical in nature and as such there is a very real risk of injury. I accept all such risk for any injury including but not limited to the following: paralysis, head trauma, neck trauma, back trauma, injury to the arm, legs, feet, hands, impaired mental functions, loss or impairment of sight, loss or impairment of hearing, broken bones, internal injuries, genital injuries, dental injuries, lacerations, sprains, disfigurement, infectious diseases such as AIDS, HIV, herpes, hepatitis and others, and other injury that I may incur through my participation in classes, instruction and use of facilities. I further accept all risk of injury that may impair or eliminate my ability to perform gainful employment. I understand that there is physical contact between myself, the other students and the instructors and this contact is an unavoidable part of training that exposes me to injury. I also understand that proper instruction can not and will not eliminate the risk of injury.

Charlotte Martial Arts Academy recommends that you undergo a physical examination before undertaking this activity. I understand that my failure to have a physical exam performed may result in a condition causing serious injury or death. I hereby further represent that I have no medical or other condition that would expose me to any type of unusual risk while participating in classes, instruction and use of facilities

If I am signing this waiver for a minor child I agree that all the terms and conditions contained in the waiver shall apply to the child or children enrolled. I understand that Charlotte Martial Arts Academy is at no time responsible for the supervision of children other than in class and even then only to the limits of verbal correction. I agree to be responsible for and supervise my children and my guests brought into the facility.

By signing below I hereby release and hold harmless Charlotte Martial Arts Academy, Inc, it's instructors, employees, sub-contractors, agents and assignees harmless from any claim or cause of action resulting from any matter relating to the above points as well as any other injury I may receive through my classes, instruction and use of the facilities.

Student _____

Parent (if under 18) _____

Charlotte Martial Arts Academy
Health History

Name: _____

Date: _____

Age: _____

Past and Present Personal Health History (Check if Applicable)

- _____ Diseases of the Heart and arteries
- _____ Abnormal electrocardiogram (ECG)
- _____ High Blood Pressure
- _____ Angina pectoris (chest pain)
- _____ Epilepsy
- _____ Stroke
- _____ Anemia
- _____ Abnormal chest X-ray
- _____ Cancer
- _____ Asthma
- _____ Other lung diseases
- _____ Orthopedic or muscular problems
- _____ Diabetes

If any of the above are checked, please explain further and indicate any recommendations your doctor has made regarding exercise:

Level of Physical Activity

Yes _____ No _____

Is participant currently involved in a regular aerobic exercise program such as walking, jogging, cycling, swimming, step aerobics, etc.?

Yes _____ No _____

Is participant currently participating in weight training?

Yes _____ No _____

Does participant perform stretching exercises on a regular basis?

What best describes participant's level of physical activity during the past 4-6 weeks?

_____ Very Active
_____ Moderately Active

_____ Occasionally Active
_____ Inactive

Charlotte Martial Arts Academy
Health History

Is there a family history of heart disease, hypertension, stroke, diabetes, heart failure, lung disease, or epilepsy? _____ Yes _____ No

If **YES**, please provide information regarding who the relative is, the medical problem, and the age of onset or death:

_____ Yes _____ No Do you currently smoke cigarettes?
If **YES**, how many cigarettes per day? _____
If you smoked in the past, when did you quit? _____

_____ Yes _____ No Are you currently taking medication prescribed by a physician?
If **YES**, indicate name of medication, dosage, and reason why you are taking it:

Please list below any additional exercise information which you think is important for us to know
