

# MARTIAL ARTS REGISTRATION

## YOUTH HAPKIDO & COMBAT HAPKIDO

**FEES: \$35.00 Registration \$20.00 GI (uniform) if needed \$10.00 Belt/Certificate**  
**\$15 National Membership Fee Junior - (age 7-12)**  
**\$30 National Membership Fee Adult – (age 13 and over)**

\_\_\_ YOUTH HAPKIDO – ages 7-12 (5:30-6:25PM) \_\_\_ COMBAT HAPKIDO – ages 13-18. (6:30-7:25PM)

Curriculum would include instruction in foundation skills such as flexibility, stances/posture, coordination, tumbling/break falls, strikes/kicks, blocks/deflections, protocol and safety as well as self defense techniques such as breakaways, basic joint locks, defense against strikes and grabs, basic ground survival skills, and principles of Hapkido. This program is for Middlesex Borough residents only. The session consists of (8) weeks. Children must be registered through the recreation department before the start of the session. **Children not registered for a new session will not be able to participate and will be sent home. ALL registrations received after 4:30PM on the day a new session is due to start, will be considered late and will not be accepted without a late fee of \$10.00.** No exceptions will be made. Class size is limited with registrations being accepted on a first come, first served basis.

Child's Name \_\_\_\_\_ Boy / Girl DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Grade (Sept. 07) \_\_\_\_\_

### EMERGENCY TREATMENT RELEASE

Dates during which release is granted - **FROM: November 1, 2007 TO: December 31, 2008**

#### TO WHOM IT MAY CONCERN:

As a parent and/or guardian of \_\_\_\_\_, a minor, I herewith authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

#### Parent(s)/Guardian Info:

\_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Mothers Name address (if different than above)

\_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Fathers Name address (if different than above)

Mothers e-mail \_\_\_\_\_ Fathers e-mail \_\_\_\_\_

**Other** contact in case of emergency (DO NOT USE YOURSELF): Name \_\_\_\_\_

Phone \_\_\_\_\_ H / W / C Relation to child \_\_\_\_\_ Hospital Preference \_\_\_\_\_

Specific medical allergies, chronic illness or other medical conditions the staff should be aware of: \_\_\_\_\_

\_\_\_\_\_  
This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence. I confirm that my child is up to date on all immunizations as required by the NJ Dept. of Health and Senior Services Annual Immunizations Report. I also agree that all the information provided is correct and factual. If information is found to be false, I understand that my child will be expelled from program without reimbursement of fees paid.

Parent Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**DO NOT WRITE IN BOX! For Office Use ONLY**

\$35 Reg Fee Pd \_\_\_\_\_ \$20 GI Fee Pd \_\_\_\_\_ \$10 Late Fee Pd \_\_\_\_\_

Receipt #(s) \_\_\_\_\_

Date Rcv'd \_\_\_\_\_

For Session (\_\_\_\_/\_\_\_\_/\_\_\_\_) Tested on \_\_\_\_/\_\_\_\_/\_\_\_\_

\$5 Belt Fee Pd \_\_\_\_\_ Receipt # \_\_\_\_\_ Color/Size \_\_\_\_\_

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