DISCLAIMER & MEDICAL INFORMATION FORM

This form is a disclaimer. By signing this form you agree to take responsibility for any injuries you may receive or cause whilst attending any of our classes here at Worthing Modern Martial Arts Academy.

You also agree NEVER to use any of your training in a negative way outside or inside of the dojo. Anyone who is found to do so may be asked to leave the club.

Remember, you are an ambassador for WMMAA at all times & you must respect your training & the good reputation of the club.

PLEASE COMPLETE FULLY AND IN BLOCK CAPITALS

SURNAME/FAMILY NAME:……...

FIRST NAME:……

DATE OF BIRTH:……

ADDRESS: ……..……...

POST CODE: ……

TELEPHONE NUMBER: ……..……..

MOBILE NUMBER: ……..……..

E-MAIL ADDRESS: ……..

EMERGENCY CONTACT:……...……...

EMERGENCY CONTACT NUMBER: ……...

I understand that by signing this form that I take responsibility for any injuries I may receive and do not hold WMMAA responsible for any personal loss or injury incurred.

SIGNED: …….. PRINT: ……

DATE: …… WMMAA**:** ……..

WMMAA CONFIDENTIAL MEDICAL QUESTIONNAIRE

PLEASE ANSWER ALL QUESTIONS NO / YES (If yes, please give details)

DO YOU SUFFER, OR HAVE SUFFERED FROM ANY OF THE FOLLOWING?

- ❏ Heart Disease
- ❏ Family History of Heart disease/Strokes
- ❏ Chest Complaints e.g. Asthma/Bronchitis
- ❏ High Blood Pressure
- ❏ Fainting or Dizziness
- ❏ Circulatory/Blood problems
- ❏ Epilepsy/Seizures/Fits
- ❏ Major Surgery
- ❏ Do you regularly take prescribed drugs
- ❏ Bone/joint conditions
- ❏ Do you drink Alcohol
- ❏ Bone or Joint injury
- ❏ Lower Back Pain or injury
- ❏ Do you take regular exercise
- ❏ Do you smoke
- ❏ Has your doctor ever advised you against exercise due to injury/illness
- ❏ Are there any other Medical Conditions you feel we should know about

Details……

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DECLARATION

I understand that whilst every care will be taken to give safe instruction, I accept full responsibility and consider myself fit to exercise. I have answered all questions correctly and all medical and health considerations are noted above.

PLEASE NOTE IT IS YOUR RESPONSIBILITY TO INFORM YOUR INDIVIDUAL INSTRUCTOR OF ANY MEDICAL CONDITION THAT MAY AFFECT YOUR HEALTH WHILST UNDER THEIR INSTRUCTION.

SIGNED: ……..……. PRINT: ……..…….

DATE: …….
(If under 18 a parent or guardian must sign. All given information is confidential)