

CHILD'S RELEASE RECORD

The child will be released only to the person(s) authorized, or in the manner authorized, in writing, by the custodial parent(s) or legal guardian(s).

The following people are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parent(s) or legal guardian(s) cannot be reached:

CHILD'S NAME: _____

Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

CHILD HEALTH AND DEVELOPMENT QUESTIONNAIRE

CHILD'S NAME: _____

Child's Physician: _____ Telephone Number: _____

Child's Dentist: _____ Telephone Number: _____

Please answer the questions on this form. We feel this information will help us to be more effective in working with your child.

Childhood Diseases child has had:	Date
_____ Chicken Pox	_____
_____ Measles	_____
_____ 3 day (Rubella)	_____
_____ 10 day (Rubella)	_____
_____ Scarlet Fever	_____
_____ Mumps	_____
_____ Strep Throat	_____
_____ Hepatitis	_____

Surgery _____ Date: _____

Has child had: Allergies _____ Serious illness/accident _____ Burns _____
Convulsions _____ Other _____

List any identifying scars, birthmarks, skin discolorations: _____

Special need of child: _____

Is your child taking over the counter or prescribed medication regularly at home?
If yes, what? _____

List any known allergies to food or the environment.

What is the allergic reaction? _____

Have you ever suspected or has your child ever had seizures? _____

What is your child's favorite activity at home? _____

Does your child have temper tantrums? _____ Does your child bite his/her nails? _____

Twist his/her hair? _____ Does your child complain of feeling ill often? _____

Does your child have a regular playmate? _____ Same age? _____ Older _____ Younger _____

Does your child get along well with groups of children or is he/she more of a loner? _____

If you could describe your child in one word, what would it be? _____

Please list your child's strong points, such as happy, curious, loving. _____

Child's habit's, fears, etc. _____

Is there anything else, medical or otherwise that we need to know about your child?

I give permission to consult the child's physician listed above in case of emergency if I/we cannot be reached.

Signature of Parent or Legal Guardian

PERMISSION TO RIDE FORM

I hereby grant permission for _____ to ride on the designated bus
(child's name)

route that includes pick up from _____ School to the Samurais After School
(child's school)

program at National Karate MMA.

I hereby grant permission for _____ to ride to any field trip scheduled
(child's name)

during the school year and during our summer camp.

1. I authorize National Karate MMA representatives to obtain medical treatment for my child in case of serious illness or injury and agree to pay for such treatment.
2. I understand that National Karate MMA employees who usually dispense medications may or may not be present during field trips. Medications will be dispensed by a responsible staff member.
3. I have documented below all precautions and instructions regarding my child's medication. I have noted any special health-related conditions or allergies regarding my child.

(Signature of Parent/Guardian)

RELEASE FOR EMERGENCY CARE

This form must contain only one child's name, be notarized and updated annually.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child _____ in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants it.

Family Physician's Name/Health Care Resource Telephone Number

Allergies: _____

Date of last DPT or Tetanus: _____

Insurance Company covering child: _____

Policy Number: _____ Group Number: _____

Signature of Custodial Parent/Legal Guardian Date: _____

Home Telephone #: _____ Cell #: _____ Work #: _____

Emergency Contact: _____ Telephone #: _____

Address: _____

City: _____ State: _____ Zip: _____

STATE OF _____
COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____
by _____, who is personally known to me or who has produced
_____ as identification.

Signed: _____

Name Printed _____

Title or rank _____

**STUDENT IDENTIFICATION RECORD
AND LIABILITY RELEASE**

Enrolled Date:

Child's full legal name: _____ Child's preferred name: _____

Date of Birth: ____/____/____ Age: _____ Sex: M F

Child's Address: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

E-mail Address: _____ Mobile phone provider: _____

Father's Name: _____ Mother's Name: _____

Father's Workplace: _____ Mother's Workplace: _____

Father's Work #: _____ Mother's Work #: _____

Father Cell #: _____ Mother's Cell #: _____

Emergency Contact: _____ Telephone #: _____

I do _____ do not _____ give consent for my child to be photographed and/or videotaped for social media, internet, and/or print copy advertising and promotions.

How did you hear about us? Circle one: Facebook-Google-Lowcountry Parent-Yellow Pages-Other

Did a current NK MMA student refer you to us? Yes No Name of Student _____

Is there any information about the student that the National Karate MMA staff should be aware of? (ex. Learning disabilities, physical impairments, emotional issues)

RELEASE FORM

I, _____, understand that National Karate MMA., NK MMA LLC, National Karate Institute, Summerville Samurais, Goose Creek Samurais, KHMD, LLC, West Ashley Samurais, NCW Enterprises, LLC, its instructors, owners, partners and staff are not responsible in any way for personal injuries that may occur before, during or after martial arts classes or any activities taking place on the premises owned by the above mentioned.

I understand that National Karate MMA., NK MMA LLC, National Karate Institute, Summerville Samurais, Goose Creek Samurais, KHMD, LLC, West Ashley Samurais, NCW Enterprises, LLC, its instructors, owners, partners and staff, do not carry any medical insurance for students or persons participating in class or doing any activity on the premises.

I understand that I must have my own medical insurance to participate in karate classes or any function that occurs on the premises located at 827 Travelers Blvd. Summerville, SC 29485, 105 St. James Ave. Goose Creek, SC 29445 and 1119 Wappoo Rd. Suite K Charleston, SC 29407. I understand that karate training does involve physical contact in sparring and other training drills, and that participation is at one's own risk. A student may choose not to participate in any class function that requires physical contact (sparring, etc.) with another person. A student's parent may choose this option if the student is under 18 years of age.

I understand that violation of any agreement on this release form can result in immediate dismissal from participation in karate classes or functions held by National Karate MMA.

I have read all of the above and fully agree to and understand my commitments to the conditions stated in this signed document.

Parent's Signature: _____ Date: _____
(if participant is under 18 years of age)