Elite Freestyle Karate, LLC

**Karate Participation Waiver**

Participant’s Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_E-Mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Additional D.O.B\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have chosen to participate in the Elite Freestyle Karate, LLC program of progressive physical exercise. I hereby waive any claim may have at any time against Elite Freestyle Karate (“EFK”) Regarding any personal injury of damage I may suffer or incur by such participation. I have been advised that participation in EFK’s karate and exercise program may result in: Abnormal blood pressure, fainting, disorders of the heartbeat, rare instances of heart attack, broken bones and tissue and muscle tearing. I hereby accept these risks. To my knowledge, I do not have any limiting physical condition or disability that would preclude my participation in EFK’s Karate & exercise program and further, certify that I have fully and accurately complete read all forms submitted to me by EFK intended to disclose any such limiting physical condition or disability.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

I also understand that a physician’s examination should be obtained by all participants prior to involvement in the exercise program. If participant refuses or fails to obtain a physician’s permission, he/she must sign the following statement: I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have been informed that it is advisable for me to obtain a physician’s approval for participation in a progressive exercise program. I fully understand the strenuous nature of the program. I accept the complete responsibility for my health and wellbeing in the voluntary exercise program. I understand that no responsibility is assumed by EFC or the employees of the exercise program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

 **Health History**

1. History of heart problems? (Y) (N) 7. Lung Problems (asthma)? (Y) (N)
2. High blood pressure? (Y) (N) 8. Diabetes? (Y) (N)
3. Difficulty with exercise? (Y) (N) 9. Do you smoke? (Y) (N)
4. Chronic Illness? (Y) (N) 10. Are you over weight? (Y) (N)
5. Body disorders? (Y) (N) 11. High blood cholesterol? (Y) (N)
6. Muscle, bone or joint disorders? (Y) (N) 12. Problems w/ hands or feet? (Y) (N)

***If you answered “YES” to any of the above questions, a doctor’s note may be required in order for you to participate.***

Any other problems or statements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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