Hawaii Wado Karate Association

Last Name_____First Name_____Birthdate_____Male___Female___

Street_____City_____Zip_____Preferred Phone Contact #_____

Parent or
Guardian Name (if under age 18)_____ Relationship_____Phone_____

Emergency
Contact (if not parent)_____Relationship_____Phone_____

email contact_____Cell Phone text message number_____

The undersigned clearly understands and agrees to the following:

1. That if the applicant is under a physician's care, this dojo will not consider this application without written consent to participate from that physician.
2. This dojo will not be responsible for any injuries incurred during training. The applicant assumes the risk of injuries that may be sustained on the dojo premises.
3. Violations of the dojo rules may result in immediate dismissal.
4. That in the event of voluntary or requested dismissal, the latter the result of violations of the dojo rules, no refunds will be made.
5. That this dojo will not be responsible for loss of personal property left on the premises.

Agreed:_____Date:_____

(must be signed by parent or guardian if applicant below age 18)