

**Maples Martial Arts
1036 Country Lane
Castroville, TX 78009**

**DROP 'N' SHOP
RELEASE OF LIABILITY & CONSENT FORM**

NAME OF CHILD: _____
ADDITIONAL CHILD: _____
ADDITIONAL CHILD: _____

Parent/Guardian: _____ **Relationship:** _____
Address: _____ **City:** _____ **St:** _____ **Zip:** _____
Home/Cell Phone: _____ **Work Phone/other:** _____

* Listed emergency contacts are in case parents/guardians cannot be reached. I authorize these individuals to pick up my child in the event that I cannot. List individuals in the order you would like them contacted in case of emergency and parent/guardians listed above cannot be reached.

1. Name: _____ **Phone:** _____ **Relationship:** _____
2. Name: _____ **Phone:** _____ **Relationship:** _____
3. Name: _____ **Phone:** _____ **Relationship:** _____

I, THE UNDERSIGNED, DO HEREBY VOLUNTARILY ATTEND MARTIAL ARTS CLASSES UNDER THE WORLD BLACK BELT FEDERATION (WBBF) AT MAPLES MARTIAL ARTS, TAUGHT BY BUCK MAPLES AND/OR ASSISTANTS. I REALIZE THAT IN THE STUDY OF MARTIAL ARTS, THE RISK OF INJURY (ALTHOUGH EVERY PRECAUTION IS TAKEN TO PREVENT ANY) DOES EXIST. IN KNOWING THIS, I HEREBY ASSUME FULL RESPONSIBILITY FOR ANY AND ALL DAMAGES, INJURIES, OR LOSSES THAT I MAY SUSTAIN OR INCUR WHILE ATTENDING CLASS OR PARTICIPATING IN ANY ACTIVITY INVOLVING WHAT I HAVE LEARNED OR AM CURRENTLY LEARNING. I HEREBY WAIVE ALL CLAIM AGAINST THE SCHOOL, INSTRUCTORS, OTHER STUDENTS, AND PROPERTY OWNER WHERE THE TRAINING OR ACTIVITY TAKES PLACE, FOR ANY CLAIM FOR INJURIES OR LOSSES THAT I MIGHT SUSTAIN OR INCUR. I ALSO AGREE TO ABIDE BY ALL RULES AND REGULATIONS ADOPTED, INCLUDING THE TIME AND PLACE SCHEDULED FOR INSTRUCTION.

FURTHER MORE, I GRANT PERMISSION TO MAPLES MARTIAL ARTS AND THE WORLD BLACK BELT FEDERATION (WBBF) AND/OR EMERGENCY PERSONNEL TO PERFORM OR PROVIDE ANY NECESSARY MEDICAL CARE, SHOULD THE NEED ARISE WHILE PARTICIPATING IN MAPLES MARTIAL ARTS ACTIVITIES.

IF APPLICANT IS UNDER 18, APPLICATION MUST BE SIGNED BY A PARENT OR GUARDIAN.

**MAPLES MARTIAL ARTS HIGHLY RECOMMENDS THAT EACH STUDENT HAVE A PHYSICAL PRIOR TO HIS PARTICIPATION IN THE SCHOOLS ACTIVITIES.
PLEASE LIST BELOW ANY PHYSICAL HANDICAPS/ MEDICAL CONDITIONS OR ALLERGIES THAT MAPLES MARTIAL ARTS NEEDS TO BE AWARE OF:**

I UNDERSTAND THAT DURING THE COURSE OF A STUDENTS TRAINING, PICTURES MAY BE TAKEN FOR PUBLICATIONS IN THE NEWSPAPER OR OTHER FORMS OF ADVERTISING. I GIVE PERMISSION TO MAPLES MARTIAL ARTS TO PUBLISH SUCH PICTURES.

I ALSO UNDERSTAND THAT THE MONTHLY TUITION IS DUE ON THE FIRST OF EACH MONTH IN FULL.

I HAVE FILLED IN THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE AND WILL INFORM MAPLES MARTIAL ARTS OF ANY CHANGES IN THE FUTURE.

Signature of Parent/Legal Guardian

Date

Printed Name