

REFLEX MARTIAL ARTS CENTRE

APPLICATION FORM

NAME: _____

SEX: M/F _____

MEMBER NO: _____

AGE: _____

DATE OF BIRTH: _____

E MAIL: _____

ADDRESS: _____

SUBURB: _____

POSTCODE: _____

PHONE :(HOME) _____

(MOBILE) _____

EMERGENCY CONTACT:

NAME: _____

PHONE: _____

RELATIONSHIP: _____

Please answer the following questions:

1. Has he/she ever had any injury, illness, back or joint condition that may be aggravated by vigorous exercise? _____

2. Has he/she ever had Arthritis, Asthma, Diabetes, Epilepsy, Hernia, Dizziness, Gout, Circulation problems or an Ulcer or other?

3. Does he/she suffer from any allergies? YES / NO If yes please list:

4. Is he/she on any medication that may affect their training? _____

I _____ wish to enrol myself/son/daughter
with the Reflex Martial Arts Centre.

I hereby agree to do as follows:

1. To guarantee myself/son/daughter:
 - A) To abide with the condition of training set down by the Reflex Martial Arts Centre.
 - B) To maintain good manners and show respect for their instructors and fellow students
 - C) To endeavour constantly to improve myself both mentally and physically through my study of Martial Arts, Kickboxing and fitness
 - D) To put the art into use for self defence only. (Persons who use the Art to bully or in brawls or do not conduct themselves properly in public will be expelled without prior notice from the Reflex Martial Arts Centre.)
2. That I enrol myself/son/daughter to join and train with the Reflex Martial Arts Centre at my own risk and that it's instructors, servants and any other trainees will not accept any responsibility whatsoever for accidental death, personal injury or damage to property which may arise directly or indirectly from martial arts before, during or after training. I hereby indemnify the Reflex Martial Arts Centre, its instructors, its servants and other trainees from any actions/suits, claims and demand whatsoever. I warrant to the Reflex Martial Arts Centre that t have furnished details of any medical condition I have and of all recent medical treatment received by me.

Signature: _____ **Date:** _____

Full Name: _____

Method: Mthly/12V/4Mths/Term/Cas/EzyPay/PayPal