

Beikoku Shido-kan Association

NATIONAL SEMINAR WAIVER FORM

All seminar participants must complete this first section.

WAIVER: In consideration of the acceptance of this application, I do hereby for myself, my family, my heirs, executors and administrators, waive and release any and all rights and claims for damages I or the minor for whom I am parent/guardian may have against the Beikoku Shido-kan Association, and or Original Okinawa Karate, and or Sheraton Lansing Hotel (Lexington Collection) and their officials, employees or volunteers for any and all injuries or damages which may be suffered as a result of practicing for, traveling from, or participating in the "National Training Seminar". Finally, I agree to allow, without compensation, the unrestricted use of any photographs, films or video tapes of myself by approved conference photographers. I understand that personal photography, videotaping or digital recording during formal seminars is not permitted.

Name _____

Participant Signature **X** _____

X _____

Parent/Guardian Signature (If under 18)

Date _____

MEDICAL TREATMENT AUTHORIZATION FORM

The following form must be completed and signed by a parent or guardian for all youth participants under 18 years old before they can participate in the National Training Seminar activities.

This form is intended to be used to give a medical facility permission to treat the participant for minor injuries or medical problems. In the event of serious injury or illness, the parent or person designated will be contacted. Treatment will proceed before contacting the parent or person designated **only if the situation is urgent and does not permit delay.**

Participant's name _____

Birthdate _____ Phone (_____) _____

Address _____

City _____ State _____ Zip _____

PHYSICIAN INFORMATION:

Primary care physician's name: _____

Physician's address: _____

Physician's phone: (_____) _____

HEALTH INSURANCE INFORMATION:

Policy holder's name and relationship to participant _____

Policy holder's address _____

Please attach a photocopy of both sides of your insurance card or complete the following information:

Insurance company's name and address _____

If you have HMO insurance, please list the emergency treatment authorization phone number:

Phone (_____) _____

Employer's name and address _____

Business phone (_____) _____

All policy numbers (please identify) _____

INFORMATION NEEDED ABOUT PARTICIPANT:

Please check yes or no. If yes, explain below or on another sheet if you need more room.

YES NO

Does the participant have a chronic health problem or illness? _____

Does he or she have any acute illness now? _____

Has the person been treated recently for some medical problem? _____

YES NO

List any medications he or she is now taking for treatment of any medical problem. _____

Does the participant have any allergies to medication or local anesthetics? _____

Does he or she have any allergies? _____

Date of his or her last tetanus shot _____

OFFICIAL AUTHORIZATION FOLLOWS:

I (parent or legal guardian), _____, recognize that while attending this program, medical treatment on an emergency basis may be necessary for my child, and I further recognize that NTS staff may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the circumstances and to assume the expenses of such care. I also authorize the medical facility to release any and all information required to complete insurance claims and also authorize insurance payment directly to the medical facility.

Signature of Parent/Guardian of minor participant or of participant aged 18 and up:

X _____

Date _____ Address _____

Phone: Day (_____) _____
Evening (_____) _____



**Sponsored by the
Beikoku Shido-kan
Karate-do Association**

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