AIEK KARATE

David Bishop Traditional School of Wado-Ryu Karate

REGISTRATION FORM / MEDICAL FORM

Pupils Name: _____

Parents Name and Initials: _____

Home Address: _____

_____

_____

Contact Telephone Number: Home: _____

Work: _____

Mobile: _____

Name and Address of Family Doctor: _____

_____

_____

Telephone Number: _____

Pupils NHS Number: _____

Club Attended: _____

Has your child had any of the following?

Asthma or Bronchitis	Yes [ ]	No [ ]
Heart Condition	Yes [ ]	No [ ]
Fits, Fainting or Blackouts	Yes [ ]	No [ ]
Severe Headaches	Yes [ ]	No [ ]
Diabetes	Yes [ ]	No [ ]
Allergies to any known drugs	Yes [ ]	No [ ]
Any other Allergies e.g. Food	Yes [ ]	No [ ]
Any other illness or disability	Yes [ ]	No [ ]
Travel sickness	Yes [ ]	No [ ]

If the answer to any of the above question is YES then please give details on the next page:

IMMUNISATION

Has your child received a vaccination against Tetanus in the last FIVE years?

Yes [ ] No [ ]

Is your child receiving medical or surgical treatment of any kind?
From either you're Family Doctor or Hospital?

Yes [ ] No [ ]

Has your child been given specific medical advice following in an emergency?

Yes [ ] No [ ]

If the answer to either of these questions is YES then please give details below
(Including dosage or any medication/tablets)

Signed:_____

Date:_____

Father/Mother/Legal Guardian