



Aikido Academy
9 W. Woodward Ave
Los Angeles, CA, 91801

Name _____ Date of Birth _____
mm/dd/yyyy

Parents Name if Minor _____

Address _____ Phone _____
_____ Email _____

Emergency Contact _____
Name Phone

Health Coverage (if none please specify, N/A)
Carrier _____
Number _____

Do you have any medical conditions which can effect your ability to Train Aikido? Yes No

If yes please specify _____

_____ please refer to your doctor if you have any condition that requires prior medical approval

Have you trained in any other martial art? Yes No

If so please specify which, and how many years, if Aikido please specify rank.

By signing below you agree to follow all the rules, regulations and requirements of the dojo and pay all applicable fee's thereof.

_____ signature (parent if minor)

_____ Date
