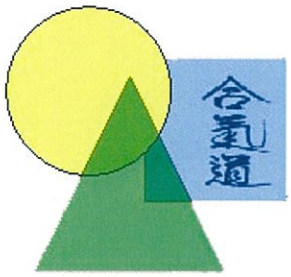

Aikido Academy
9 W. Woodward Ave
Los Angeles, CA, 91801

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