

# Center For Martial Arts & Fitness

PE Bowe School - 115 Hampden St., Chicopee

## Summer Program Registration Form

- Year Round Program     6/26-7/2     8/3-8/7
- NEFC Voucher             7/6-7/10     8/10-8/14
- Summer Camp             7/13-7/17     8/17-8/21
- Deposit: \_\_\_\_\_     7/20-7/24     8/24-8/28
- 7/27-7/31     \_\_\_\_\_

### General Information

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: (        ) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

T-Shirt Size: 6-8    10-12    14-16    Adult:    S    M    L    XL

School: \_\_\_\_\_

Grade: \_\_\_\_\_    Gender (check):     M     F

### TRANSPORTATION PLAN

My child will arrive/dismiss from the program by:

**AM**     Drop Off     Prog Van     Walk

**PM**     Drop Off     Prog Van     Walk

Drop Off Contact(s) \_\_\_\_\_  
\_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

**Mailing Address: 82 Main St., Chicopee**

**Phone: (413) 594-9200 Fax: (413) 594-9300**

**Web Address: CFMAF.net**

### Family Information

Parent/Guardian Name: \_\_\_\_\_

Phone Number: (        ) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (        ) \_\_\_\_\_ - \_\_\_\_\_

Cell Number: (        ) \_\_\_\_\_ - \_\_\_\_\_

### Medical Information

Physician: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Medical Concerns/Allergies or other important info:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Emergency Information (Other than Parents)

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone Number: (        ) \_\_\_\_\_ - \_\_\_\_\_

Comments (allergies, etc) \_\_\_\_\_  
\_\_\_\_\_

My child can walk home:            Yes    No

OR

The following people can pick my child up...  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Liability Waiver

### Parent/Guardian Permission:

My child has permission to participate in activities provided by the Center For Martial Arts & Fitness, Inc. I acknowledge that my child must follow all of the rules in order to participate. In the event that I cannot be reached in an emergency, I hereby authorize that medical/surgical treatment be administered to my child at my expense. I recognize and acknowledge there is a known risk of injury in the participation of Tae kwon do. I assume all risks and hazards incidental to and inherent in participation in this program, except where an agency acted in reckless or gross negligence. I agree that Center For Martial Arts & Fitness, Kenneth R. Goodrich and all persons participating in the instruction of Taekwondo will not be held responsible for any damages or injuries caused by the use of or practice of any techniques presented in the classes. I hereby waive and release any claims that arise out of any decision to authorize medical/surgical treatment, and indemnify and hold harmless the City Of Chicopee, MA, and the Center For Martial Arts & Fitness from claims of third parties arising out of the decision to authorize medical/surgical treatment. My signature certifies that I have read and understood this disclaimer, and all the program rules and regulations.

### Summer Program Transportation Authorization

I give permission to the Center For Martial Arts & Fitness and its employees to transport my child to and from the Center For Martial Arts & Fitness Summer Program. I am aware that they may be transported home to and from special events and field trips during the summer program.

Please circle:    Yes    No    I agree to this in its entirety.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I am aware that pictures of my child may be used for publicity purposes by one or more of the agencies and I consent to the use of such pictures.

Please circle:    Yes            No

