

PLEASE RETURN THIS FORM, WITH PAYMENT CASH OR CHQ TO KYLIE REYNOLDS OR JILL MARTIN

Please make chq's payable to:

TRADITIONAL SHOTOKAN KARATE-DO FEDERATION OF GAWLER INC.

ACN: 137 175 350

Cost: \$85 per member (new memberships under 12 years old \$45)



MEMBER INFORMATION				
Member First Name:	Surname:	Mr. Mrs.	Miss Ms.	Preferred Name:
Previous JKAA Regn Number:	Postal Address:			
City:	State:	Postcode:	Home phone no.: ( )	
Mobile:	Email:	Date of Joining JKAA/TSKF:		
Affiliated State:	Membership Type: Senior Junior Life	Current Rank:	Club/Dojo: TSKF	
Country of Citizenship:	Birth Date:	Sex: Male Female	Dojo Head: Tick if applicable	
BLACK BELT REGISTER				
<i>(If this information has already been supplied please disregard)</i>				
1st Dan Grading	Date:	Certificate No:		
2nd Dan Grading	Date:	Certificate No:		
3rd Dan Grading	Date:	Certificate No:		
4th Dan Grading	Date:	Certificate No:		
5th Dan Grading	Date:	Certificate No:		
6th Dan Grading	Date:	Certificate No:		
<u>Privacy Statement</u>				
<p><i>The above information is true to the best of my knowledge. I acknowledge that all information recorded on this form is primarily for the use of the Traditional Shotokan Karate-do Federation of Australia Pty. Ltd. and our Insurance Company. The information will be used for administration and insurance purposes only for the business of TSKFA and will remain private and confidential.</i></p>				
Applicant or if under 18 years Parent or Legal Guardian Signature				Date

PLEASE FILL OUT BOTH SIDES OF THIS FORM



## MEDICAL CLEARANCE FORM

Participants Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Dojo: \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING DECLARATION. YOUR DOCTOR OR SPECIALIST CAN USE THIS FORM TO GIVE YOU CLEARANCE (IF REQUIRED) BY COMPLETING THE MEDICAL CLEARANCE SECTION BENEATH:**

Do you have any of the following conditions (please circle as appropriate):

- |   |  |
|---|--|
| <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Chronic chest condition |
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Are you pregnant        |
| <input type="checkbox"/> Any other medical conditions, including injuries or psychological issues that may prevent you from participating |  |
| <input type="checkbox"/> <b>NONE OF THE ABOVE</b>   |  |

Signed: \_\_\_\_\_ Guardian Signed: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**IF YOU ANSWERED YES TO ANY OF THE MEDICAL QUESTIONS, THEN THE FOLLOWING MEDICAL CLEARANCE MUST BE PROVIDED BY YOUR DOCTOR OR SPECIALIST:**

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This medical Clearance form is to be filled out, **signed-off and stamped** by your doctor or specialist.

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Medical Condition requiring clearance: \_\_\_\_\_

Doctors Name: \_\_\_\_\_ Doctor's phone: \_\_\_\_\_

I, Dr \_\_\_\_\_

Say the participant named above suffers from the stated condition and I give medical clearance for this individual to participate in the karate activities of TSKF Gawler Inc.

Notes: \_\_\_\_\_

Doctor's Signature & stamp: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_