ANIKA TAE KWON DO (ATKD)

STUDENT REGISTRATION & EMERGENCY INFORMATION FORM

CONFIDENTIAL – FOR MEDICAL PERSONNEL IF REQUIRED

STUDENT INFORMATION

Full Legal Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Medicare / Health Card Number: _____

PARENT / GUARDIAN (if minor)

Name: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

EMERGENCY CONTACT (if different)

Name: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

MEDICAL INFORMATION

Family Doctor (if applicable): _____

Doctor Phone: _____

Known Medical Conditions: _____

Allergies: _____

Current Medications: _____

Previous Surgeries / Injuries: _____

CONSENT

I confirm that the above information is accurate and up to date.

Signature (Parent/Guardian if minor): _____

Printed Name: _____ Date: _____

에이티케이
ANIKA
TAEKWONDO