Galway City School of Judo

Membership Form

Name : ________________________________

Address : ________________________________

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Date of Birth : __/__/____

Judo Licence No. : ____________

Age : _____

Male [ ] Female [ ] Tick

Email : [ ]

Parents/Guardian : ____

Phone Numbers : ______________________ & ______________________

In the event of illness, having parental responsibility, I give permission for medical treatment to be administered where necessary by a nominated first aider suitably qualified medical practitioners. If I cannot and my child needs emergency hospital treatment, I authorize a qualified medical practitioner to provide emergency treatment or medication

I understand that photographs may be taken during or at sport related events and may be used in the promotion of sports

Medical Information

	Yes	No
Has your doctor ever said your child has a heart problem ?		
Does your child suffer from Diabetes ?		
Does your child suffer from Epilepsy ?		
Does your child suffer from Asthma ?		
Does your child suffer from any other respiratory problems ?		
Does your child ever feel faint or have spells of severe dizziness ?		
Does your child have any bone or joint problems such as arthritis ?		
Does your child suffer from allergies, which may interfere with participation in exercise ?		
Has your child had recent surgery ?		
Others - Please state ?		

If you answered yes to any of the above please give details

[ ]

I certify that, to the best of my knowledge and belief, the foregoing details are corect in the event of being accepted, I undertake to abide by the Constitutiuon and Bylaws of Gcsj, together with any amendments that may be made during my period of memeber ship

Signed ______________________________ Date _____________________

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