Capoeira MarAzul

Registration Form & Initial Health Screening

Name: _____

Address: _____

Email: _____

Family doctor: _____

Date of Birth: _____ Telephone: _____

Do you suffer from (Please give details if YES):

Asthma/ Respiratory condition	Yes/No	
Diabetes	Yes/No	
Epilepsy	Yes/No	
Heart condition	Yes/No	
Haemophillia / Blood condition	Yes/No	
Back / Joint condition	Yes/No	
Dyslexia	Yes/No	
Dyspraxia / Coordination differences	Yes/No	
Attention deficit hyperactivity disorder	Yes/No	
Condition related to nervous system	Yes/No	
Autism/ Asperger's syndrome	Yes/No	
Sight/ hearing differences	Yes/No	
Other (please give full details)		

Personal details:
We hold details of your name, date of birth, contact details, doctor, relevant health conditions and criminal record (as declared on the insurance form), for the purposes of administering your membership. The information on the insurance form we pass on to our insurance provider (currently the National Association of Karate and Martial Arts Schools, NAKMAS) for the purpose of providing you with insurance. We may use your contact details to send you relevant information about classes and your membership. We will not sell or pass on your details to any other third parties (except as required for the purposes of providing you with insurance, or if required by law).

NOTICE
I hereby agree to voluntarily participate in the capoeira programmes offered by Capoeira MarAzul. I will inform the instructor of any medical condition that may affect my participation. I recognise that injuries can potentially occur in any martial art or physical activity, including capoeira. I understand and accept that risk. Capoeira MarAzul will exercise all reasonable care in the supervision of activities and guidance of students. For online classes I confirm I have a suitable and sufficient space to train and take responsibility for my own wellbeing in the classes. I confirm that the personal details on the form are correct, I have completed the health information to the best of my knowledge and will inform you should my health alter at any time.

Signature: _____ Date: _____