



RELIONCE
SELF DEFENSE, INC

Student Enrollment Form

PERSONAL INFORMATION

Name: _____ Sex _____ Member No. _____

Age _____ Date of Birth _____ Year of School _____

E-mail: _____

Home Phone: _____ Mobile Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Previous Martial Arts training: _____ Ranks achieved: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Mailing Address: _____

Street Address: _____

City, State, Country: _____

Home Phone: _____ Mobile Phone: _____

We reserve the right to refuse registration to any individual, for any reason.

PAYMENT METHOD

Cash _____ Check _____ Money Order _____

Signature _____

Total Due _____ Date _____ Check/Money Order # _____

Medical History Evaluation Form

Name _____

This section is to be carefully completed by the student/parent prior to participating in any ReLIONce Self Defense training program in order to help detect and avoid possible risks.

Explain "YES" answers in the space provided below. **Please circle the appropriate answer.**

- Y / N 1. Has a doctor ever denied or restricted your participation in sports for any reason?
- Y / N 2. Do you have an ongoing medical condition (like diabetes or asthma)?
- Y / N 3. Have you ever passed out or nearly passed out during or after exercise?
- Y / N 4. Have you ever had discomfort, pain, or pressure in your chest during exercise?
- Y / N 5. Does your heart race or skip beats during exercise?
- Y / N 6. Do you have high blood pressure?
- Y / N 7. Do you have high cholesterol?
- Y / N 8. Do you have a heart murmur?
- Y / N 9. Have you had a bone or joint injury? If yes, circle below:
Head Neck, Shoulder, Upper Arm, Elbow, Forearm, Hand/Fingers, Chest
Upper back, Lower back, Hip, Thigh, Knee, Calf/shin Ankle Foot / Toes
- Y / N 10. Have you ever had a stress fracture?
- Y / N 11. Do you regularly use a brace or assistive device?
- Y / N 12. Have you ever had a head injury or concussion?
- Y / N 13. Have you ever had a seizure?
- Y / N 14. Do you have headaches with exercise?
- Y / N 15. Have you had any problems with your eyes or vision?
- Y / N 16. Do you wear glasses or contact lenses?
- Y / N 17. Are there any additional medical, mental or physical limitations that may hinder your training?

Explain "Yes" Answers here: (Attach additional sheets as needed)

I hereby state, that I have to the best of my ability, answered the above questions honestly and completely.

Signature: _____ Date: _____

NOTE: ENROLLMENT, HISTORY, POLICY & PROCUDRES AND ALL CONSENT FORMS MUST BE COMPLETED PRIOR TO TRAINING IN ANY RELIONCE SELF DEFENSE PROGRAM.