

**Martial Arts Carolina**  
**3555 - 2 Matthews Mint Hill Road**  
**Matthews, NC 28105**  
**(704) 847-2222**

**Child Information**

Full Name \_\_\_\_\_  
Nick Name \_\_\_\_\_  
Birth Date(mo/day/Year) \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
School \_\_\_\_\_  
Current Grade Level \_\_\_\_\_  
Doctors Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

**Family Information**

Mother's Full Name \_\_\_\_\_  
Address \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening \_\_\_\_\_ Cell \_\_\_\_\_  
E-Mail Address \_\_\_\_\_

Father's Full Name \_\_\_\_\_  
Address \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening \_\_\_\_\_ Cell \_\_\_\_\_  
E-Mail Address \_\_\_\_\_

**Guardian Information**

Full Name \_\_\_\_\_  
Address \_\_\_\_\_  
Day Phone \_\_\_\_\_ Evening \_\_\_\_\_ Cell \_\_\_\_\_  
E-Mail Address \_\_\_\_\_

PERMISSION TO OBTAIN MEDICAL CARE

I the undersigned, give permission to Martial Arts Carolina to act in my behalf in emergency situations to obtain medical treatment for my child. I agree to accept full responsibility for the payment of all ambulance, hospital, and physician's bills or charges for any service.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

<b>Emergency Contact Information:</b>
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Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ 2nd # \_\_\_\_\_

