



**STUDENT REGISTRATION 2020**

**STUDENT INFORMATION**

Student First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Primary Language Spoken in Home: \_\_\_\_\_

**STUDENT MEDICAL INFORMATION**

Primary Hospital: \_\_\_\_\_  
 Primary Diagnosis: \_\_\_\_\_  
 Primary Physician: \_\_\_\_\_ Physician Phone Number: \_\_\_\_\_  
 Any known allergies or other medical conditions: \_\_\_\_\_

**PARENT OR LEGAL GUARDIAN INFORMATION**

Guardian First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Relationship to Student: MOTHER  FATHER  OTHER LEGAL GUARDIAN   
 Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_

Additional Guardian First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Relationship to Student: MOTHER  FATHER  OTHER LEGAL GUARDIAN   
 Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone (if different): \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_



## STUDENT REGISTRATION 2020

### CONSENT AND PERMISSION

1. I am the parent/legal guardian of the patient and all participating siblings listed below.
2. I understand that the Kids Kicking Cancer martial arts program is a combination of meditation, karate forms, visualizations, and breathing techniques. There is no sparring or board breaking that would pose a unique danger to children. However, in any physical activity there is always the threat of accident or injury. I understand that Kids Kicking Cancer, Inc. accepts no responsibility and is not liable for any injury to my child(ren) as a result of their participation in martial arts therapy programs. I accept full responsibility for the safety of my child(ren) while participating in Kids Kicking Cancer programs.
3. I understand that Kids Kicking Cancer accepts no responsibility for the loss, damage or theft of personal property.
4. I grant full permission for communication and sharing information between Kids Kicking Cancer staff and hospital/medical staff as it relates to my child(ren's) care and involvement in Kids Kicking Cancer programs.
5. I grant full permission for my child(ren) to participate in Kids Kicking Cancer programs, which may include transportation, class activities, trips, outings and meetings.
6. I grant full permission to Kids Kicking Cancer, their agents, representatives and appointees to photograph and/or videotape my child(ren) and to use, publish and release for publication such photos relating to the Kids Kicking Cancer program. May include Kids Kicking Cancer website and social media. The name(s) of my child(ren) may be used in connection with the above-stated photographs with the understanding that there will be no exploitation of my child(ren) and that any photographs and/or videos will conform to good standards of taste.

### PARTICIPATING SIBLINGS

Please list all child(ren) participating in the Kids Kicking Cancer program:

Primary Student Name: \_\_\_\_\_

List Participating Siblings Below:	Date of Birth:	Any Allergies / Health Concerns?
Name: _____	_____	_____
Name: _____	_____	_____
Name: _____	_____	_____
Name: _____	_____	_____

### EMERGENCY CONTACT INFORMATION

Please provide the individuals that your child(ren) may be released to and/or serve as emergency contact:

List Emergency Contacts Below:	Relationship to child(ren):	Phone Number:
Name: _____	_____	_____
Name: _____	_____	_____

*Please Sign:*

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_



**TRANSPORTATION REGISTRATION 2020**

**TRANSPORTATION**

*(Transportation is optional – please only complete this page if your children will be using our transportation services.)*

**Transportation phone number: (248) 667-6903**

If you are unable to provide transportation for your child(ren), Kids Kicking Cancer will provide transportation from home or school to class within a limited radius of class location. The following rules apply:

1. Pick-up time varies from week to week. However, children must be ready for pick-up 1 ½ hours prior to class.
2. We need to hear from you each week. A Kids Kicking Cancer staff member will call you the day before class, and either speak with your or leave a message. Please call back by 9:00 am the day of class to let us know if your child needs a ride.
3. If, in an emergency you must cancel the day of class, please call as early in the day as possible (248) 667-6903.
4. Children using the Kids Kicking Cancer van services are expected to behave in a safe and courteous manner with all KKC staff and other students.
5. Children must wear seatbelts at all times.
6. Please give your child a snack and drink before getting on the van. Additional snacks / drinks are provided during class.
7. Changes in transportation locations (pick-up or drop-off) require written permission of the parent or legal guardian.

**PICK-UP LOCATION**

HOME

SCHOOL Name of School: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

OTHER Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number of Pick-Up Location: \_\_\_\_\_

**DROP-OFF LOCATION**

HOME

OTHER Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number of Drop-Off Location: \_\_\_\_\_

Number of children requiring transportation: \_\_\_\_\_

*Please Sign:*

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_