

GRAPPLING ARTS Association MEMBERSHIP MEDICAL EXTRA



If the student details any 'relevant medical conditions' in the "**GAA MEMBERSHIP and INSURANCE PACKAGE**" form or you have a concern regarding the student, please get them to fill out the following

Name

Medical History

If you suffer from any of the conditions listed below, you should circle the appropriate condition.

Please then take this Form to your Doctor and ask him/her to complete Section 8. This must be done before you train.

As with any other sport or physical activity, it is advisable to consult your Doctor before you begin training.

Migraine	Epilepsy	Respiratory Problems
Diabetes	Hay Fever	Heart Disorders
Nervous Disorders	Haemophilia or other Blood Disorder	Other (please specify below)

Please also list any injuries which may affect your training that you have received to Bones, Joints, Back, Sight etc detailing the date and nature of the injury

Details

GRAPPLING ARTS Association MEMBERSHIP MEDICAL EXTRA



Medical Consent Note (To be completed by your doctor only if you ticked an item above)

I understand that the above named is a patient under your care. He/she wishes to train in the Martial Arts and has identified the medical condition shown overleaf. In the **CLUB NAME**, all instruction is undertaken by skilled and responsible coaches. Most classes are of approximately one hour to one hour and a half duration and consist of a warm up, substantive lesson and cool down. Physical activity can be quite strenuous, but children do not engage in sparring. Partnered, pre-arranged, practice is used but this is always under close supervision. As with any physical activity, there is a slight risk of impact injuries. Junior students of over 11 years work with partners more frequently. They occasionally engage in controlled sparring under close supervision.

Please would you complete the next section of this Form and return it to your patient. Thank you for your co-operation.

MEDICAL CONSENT DECLARATION

NAME OF PATIENT

BRIEF DESCRIPTION OF MEDICAL CONDITION

I have read the description of the Martial Arts training that my patient wishes to undertake.

He / She **IS / IS NOT capable of safely taking part**

Doctor's Name

Professional Address

Signature **Date**

Declaration

I accept that the practice of Martial Arts / Combat Sport involves the risk of serious injury.

The information provided on this addition to the Membership Application Form and the form itself is correct to the best of my knowledge.

Signed: (Parent or Guardian if under 18)

Date: