



Registration Form

Club Name	
Representative	

	Name	Rank	Shinpan	Lunch	Category	Fee
1	<i>Example John Doe</i>	<i>Ikyu</i>	<i>No</i>	<i>L</i>	<i>A</i>	<i>\$30</i>
2	<i>Example Tim Smith</i>	<i>4th Dan</i>	<i>Yes</i>	<i>L</i>	<i>C</i>	<i>\$20</i>
3						
4						
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8						
9						
10						
11						
12						
13						
14						
15						
16						
					Total	

Category	Level		
A	Mudansha		
W	Women	Lunch	L
B	Shodan&Nidan	Veg lunch	VL
C	Sandan and above		

Team Registration

1	
2	
3	
4	
5	

Waiver of Liability for Special Martial Arts Events

Event: Stratford Kendo Club Invitational

Date: May 9, 2020

Location: St. Michael's Catholic Secondary School
240 Oakdale Ave.
Stratford, Ontario, N5A 7W2

Name:

Home Club:

Address:

Dan/Kyu:

Release of Liability

I hereby submit my application to participate in the Martial Arts Event ("Event") described above, and I agree to abide by the rules and regulations set by St. Michael's Catholic Secondary School & Stratford Kendo Club in connection with the Event. I hereby release and indemnify St. Michael's Catholic Secondary School, Stratford Kendo Club, their directors, officers, employees, instructors, members, volunteers and invitees and licensees from any and all claims, demands, actions, causes of action, loss, damage, costs or any other liability or obligation whatsoever arising out of or in connection with my participation in the Event of the Stratford Kendo Club, whether relating to personal injury or damage to or loss of property or otherwise, whether going to or away from or at or in the premises of St. Michael's Catholic Secondary School or elsewhere, and whether in contract or in tort.

I certify that I am in excellent physical health, and can participate in strenuous and hazardous activities. I further certify that there are no physical limits to my participation in the Event. In the event of an emergency I authorize Stratford Kendo Club and Tournament organizers to secure from any hospital, physician, and/or medical personnel any treatment deemed necessary for my immediate care and I agree that I will be responsible for payment of any and all medical services required.

Signature of Participant:

Date:

Signature of Parent or Guardian:
(If participant is less than 18 years of age)

Date: