



PCB Parks & Recreation

Yoshukai Karate

Instructor: Rolan Peak



Participant Name: _____ Ph.# _____

Address _____

City _____ State _____ Zip _____

Parent/Guardian _____ Ph.# _____

Emergency Contact _____ Ph.# _____

Date of Birth ____/____/____ Male _____ Female _____

All Participants will be on a 3month testing cycle and will be responsible for payment at the beginning of each testing cycle. If payment is not made by the 10th of each month the participant will be subject to a \$10.00 late fee. Payment is required for class participation. There will be a \$10.00 discount for each additional family member. There is a mandatory association fee due at registration for basic and advanced participants. ***All association fees are paid to the instructor.***

Initial

\$120.00 Per Testing Cycle

Basic & Advanced Classes 8yrs & Up

Basic Skills: 6:30pm-7:30pm _____

Advanced Classes: 7:30pm-8:30pm _____



Lil' Dragons 5yrs -7yrs

Lil' Dragons: 6pm-6:30pm _____

Monday & Wednesday Night Classes

PARTICIPATION PERMISSION: I as an adult 18 and older, or the parent or legal guardian of the above named participant, hereby give my approval to participate in the activity described above. I assume all risks and hazards incidental to the conduct of the activities and transportation to and from the activities. I understand that supervision is only during the hours of scheduled practice and games. I also give the City of Panama City Beach permission to take pictures during activities, practices and games for publicity purposes. I hereby release, absolve, indemnify, and hold harmless the City of Panama City Beach, Bay County School District, the organizers, sponsors, supervisors, representatives, employees, volunteers and any or all of them from any injuries I may or my child may sustain as a participant in these activities. Participants are involved at their own risk. Registration fees do not provide for insurance.

Further, I hereby grant the City of Panama City Beach Parks & Recreation Department staff as agent(s), for the undersigned to consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act, whether such diagnosis, or treatment is rendered in physician's office or hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis treatment or hospital care which the physician, in the exercises of his best judgment, may deem advisable.

Signature of Parent/Legal Guardian or Adult 18& Older

Date

Email _____

