# Missoula Fencing Association

1134 Longstaff
Missoula, MT 59801
(406) 926-2175
info@missoulafencing.net

FENCING CLASS REGISTRATION

NAME_____ AGE_____ DOB_____

ADDRESS_____ CITY_____ ZIP_____

GENDER: M F PARENT/GUARDIAN_____

HOME PHONE_____ OTHER PHONE _____

EMAIL:_____

EMERGENCY CONTACT:_____

Waiver:
Although fencing is a very safe sport, and protective equipment is worn, I understand that serious, catastrophic, and perhaps fatal injury may result from participation in any sport or athletic activity. I have enrolled _____in this program. I know, understand and appreciate the nature of this program and its activities, the benefits to expect and the inherent risks involved in participation. I fully know and understand that participation is voluntary and I am free to discontinue participation at any time. I also understand that Missoula Fencing Association, Inc. (MFA), the MFA Board of Directors, any instructors, and the facility owners do not provide insurance coverage for participants. My signature here indicates I have read and understand the above and agree not to hold MFA, the MFA Board of Directors, any instructors, and the facility owners liable for any injury that may result from participation in this class. I also give my permission for photos/video/audio of the enrolled participant to be used as MFA sees fit for promotional purposes.

Signature of Parent/Guardian:_____ Date:_____

Signature of Participant (18 and over): _____ Date: _____

OVER

HEALTH HISTORY/MEDICAL RELEASE

NAME:_____
ADDRESS:_____
_____
AGE:_____ DOB:_____ PHONE:_____
EMERGENCY CONTACT:_____
Insurance Co. and Policy #:_____
_____

PERSONAL MEDICAL HISTORY (current or in past)

| | | | Explain |
|---|---|---|---|
| HEART DISEASE | YES | NO | _____ |
| HEART MURMUR | YES | NO | _____ |
| HEART SURGERY | YES | NO | _____ |
| DIABETES | YES | NO | _____ |
| MUSCLE DISEASE | YES | NO | _____ |
| LUNG DISEASE | YES | NO | _____ |
| EPILEPSY | YES | NO | _____ |
| Chest pains | YES | NO | _____ |
| Dizzy spells | YES | NO | _____ |
| Black outs | YES | NO | _____ |
| Irregular heart beat | YES | NO | _____ |

Have you recently had any broken, sprained, or bruised bones or muscles?
YES NO _____
Current medications and condition(s) you are treating:_____
_____
List any known allergies to medications:_____
List any specific needs or explain any medical problems that may not have been covered
_____
_____

I hereby give my consent for emergency medical care prescribed by a duly licensed medical provider. This care may be given under whatever conditions are necessary to preserve life, limb or well-being.

Signature of Parent/Guardian:_____ Date:_____

Signature of Participant (18 and over): _____ Date: _____

**Please mail registration form to:**

**Missoula Fencing Association**
**1134 Longstaff**
**Missoula, MT 59801**