Cutting Edge Martial Arts
2025-26 PIR/Winter Camp Registration Form

Please complete registration by the first camp session attended. Workout clothes/uniforms, snacks, lunch, and water needed for all camps. All camps are held at Cutting Edge Martial Arts, 2430 N7th #2, Bozeman.

Sessions (CIRCLE): 9/29 10/16 10/17 12/22 12/23 12/29 12/30 1/19 5/22
Times: 9am-4pm. Drop off 8:30am

Camper's name: _____ Date: _____
Camper's age at time of camp: _____ Camper's date of birth: _____ Sex: M F
Name of parent or guardian: _____
Address: _____ Primary phone: _____
Email: _____ Secondary phone: _____
School camper attends: _____ Going into which grade? _____
If camper has prior experience in martial arts, what rank? _____
If camper is not a student of our school, how did you hear about it? _____
Is there anything else you would like us to know about your child? _____
_____
Does your child have any of the following allergies?
Hay fever Bee stings Insect bites Penicillin Peanuts Other _____

If the above can't be reached, whom should we contact in case of emergency? _____
Relation of contact to camper: _____ Emergency phone: _____

Has your child had any of the following?
Chicken pox Tuberculosis Epilepsy Hepatitis Mononucleosis
Other(including heart or lung conditions or any other chronic or recurring illness) _____
Does your child have asthma? Y N Does your child wear glasses or contacts? Y N
Is your child taking any medication? Y N If yes, please list medications and reason: _____
_____

I hereby give permission for Cutting Edge Martial Arts to dispense prescribed medications to my child.
Parent or guardian's name: _____ Signature and date: _____

Has your child ever been hospitalized? If so, please indicate when and for what reasons: _____
_____
Local doctor's name: _____ Phone: _____
I hereby swear that all the foregoing information is true and correct to the best of my knowledge.
Parent or guardian's name: _____ Signature and date: _____

In the event that my child needs immediate medical care and neither parent nor the child's local doctor is available, I authorize Cutting Edge Martial Arts to seek emergency treatment at Bozeman Deaconess Hospital and to have a doctor or nurse administer necessary medical treatment and/or to have necessary X-rays taken for emergency care.
Parent or guardian name: _____ Signature and date: _____

Insurance company: _____
Policy number: _____
Insurance Phone: _____ Claimant's name: _____
Claimant's signature and date (for care): _____

Drop off at CEMA, 2430 N7th #2 OR Mail to: Mark Austin, 307 Helen Dr., Belgrade, MT 59714