

Cutting Edge Martial Arts
2024 PIR/Winter Camp Registration Form

Registration by drop-off of the first camp session. Daily camp schedule and items needed will be emailed out the week before each camp. All camps are held at Cutting Edge Martial Arts, 2430 N7th #2, Bozeman.

Camp sessions: PIR 9/30, 10/17, 10/18, 1/20, 5/23
Winter 12/26-27, 1/2-3

Camp times: 9am-5pm.
Drop off 8:30am

Sessions (Circle): PIR 9/30 10/17 10/18 1/20 5/23 Winter 12/26 12/27 1/2 1/3

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