MEDICAL CERTIFICATE

NAME_____ **DATE**_____

I certify that the person whose name appears above is, to the best of my knowledge, on the date stated with my signature, free from infectious disease. That he/she has no history of heart or circulatory problems and no respiratory problems.

Therefore _____ ***should have no difficulty with exercising or training in the martial arts.***

I agree to inform Original Taekwon-Do & Fitness Center in the event of any change in the medical or physical condition which could put the above named student at risk if he/she continues to train on a regular basis.

Doctor's comments or recommendation_____

_____

_____

Physician's Signature_____ **Date**_____

I waive my obligation as a member, or parent/legal guardian of a member, to be medically released by a physician prior to participating in a martial arts program. I certify that to the best of my knowledge the above named member is free from infectious disease, has no history of heart or circulatory problems, and there appears to be no reason why a martial arts program should not be undertaken.

Student's Signature [Over 18 yrs.]_____

Parent/Guardian's Signature_____

ORIGINAL
TAEKWON-DO
& FITNESS
CENTER

N.Y.
STATE
HEADQUARTERS
INTERNATIONAL
TAEKWON-DO
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