HEROES CIRCLE
POWER PEACE PURPOSE
CANADA
PO Box 28036 Oakridge R.O
London, ON N6H5E1
www.kidskickingcancer.ca

Registration Form

Student Information

Student Last Name: _____First Name: _____

Street:_____City:_____ Prov:_____Postal Code:_____

Home Phone:_____Date of Birth: _____/_____/_____

Patient's Physician: _____Phone:_____

Primary Hospital:_____

Primary language spoken in the home:_____

Known allergies or other medical conditions:_____

Parent or Legal Guardian Information

Primary Legal Guardian

Last Name:_____ First Name:_____

Address (*if different from patient*): Street_____ City_____ Prov___ Postal Code_____

Contact Information

Home:_____ Cell:_____

Work:_____ Other:_____

Email:_____

Secondary Guardian

Last Name:_____ First Name:_____

Address (if different from patient): Street_____ City_____ Prov___ Postal Code_____

Contact Information

Home:_____ Cell:_____

Work:_____ Other:_____

Email:_____

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Permission Form

Must be completed for patient and all *participating* siblings.

1. I am the parent/legal guardian of the patient and all participating siblings listed below.
2. I understand that the Heroes Circle martial arts program is a combination of meditation, karate forms, visualizations, and breathing techniques. There is no sparring or board breaking that would pose a unique danger to children. However, in any physical activity there is always the threat of accident or injury. I understand that Kids Kicking Cancer Corp. accepts no responsibility and is not liable for any injury to my child(ren) as a result of their participation in martial arts therapy programs. I accept full responsibility for the safety of my child(ren) while participating in the Heroes Circle programs.
3. I understand that Kids Kicking Cancer Corp. accepts no responsibility for the loss, damage or theft of personal property.
4. I grant full permission for communication and sharing information between the Heroes Circle staff, facilitators and hospital/medical staff as it relates to my child(ren's) care and involvement in the Heroes Circle programs.
5. I grant full permission for my child(ren) to participate in Heroes Circle programs, which may include transportation, class activities, trips, outings and meetings.
6. I grant full permission to Kids Kicking Cancer Corp., their agents, representatives and appointees to photograph and/or videotape my child(ren) and to use, publish and release for publication such photos relating to the Heroes Circle program. The name(s) of my child(ren) may be used in connection with the above-stated photographs with the understanding that there will be no exploitation of my child(ren) and that any photographs and/or videos will conform to good standards of taste.
7. In addition to myself, my child(ren) may be released from The Heroes Circle programs to the following individuals:
   Name_____Relationship to Child(ren) _____ Phone:_____

   Name_____Relationship to Child(ren) _____ Phone:_____
8. Please list below all child(ren) participating in the Heroes Circle programs. Include the patient's name and any siblings *that will be participating*. By listing their names below, you are acknowledging that you have full permission from your children's physician(s) to participate in all Heroes Circle programs and you are accepting responsibility for their participation.

Allergies/Health Concerns

Patient Name:_____Date of Birth: ____/____/_____

Participating Sibling: _____Date of Birth: ____/____/_____ _____

Participating Sibling: _____Date of Birth: ____/____/_____ _____

Participating Sibling: _____Date of Birth: ____/____/_____ _____

Participating Sibling: _____Date of Birth: ____/____/_____ _____

Participating Sibling: _____Date of Birth: ____/____/_____ _____

Participating Sibling: _____Date of Birth: ____/____/_____ _____

Please Sign below to Complete your Enrollment-Thank you!

Parent/Guardian Signature: _____Date____/_____/_____

Print Name:_____

Relationship to Patient:_____ Relationship to other children:_____