

MEDICAL QUESTIONNAIRE FORM

This form is mandatory for all competitors

1. Do you have any allergies to any medications? Yes No

If you answered yes, please indicate which medications: _____

2. Do you take any medications regularly? Yes No

If you answered yes, please indicate which medications: _____

3. Do you wear contact lenses? Yes No

4. Do you have a history of any of the following conditions?

Epilepsy (seizures) Yes No

Lung disease Yes No

Heart disease Yes No

Diabetes Yes No

High blood pressure Yes No

If you answered Yes to any part of question four, please complete question five.

5. I hereby state that I am under the care of a physician for the treatment of _____

and that I have been medically cleared by that physician to participate in this tournament.

Please read carefully:

I hereby certify that the above information is true and accurate to the best of my knowledge and hereby agree that I WILL NOT be permitted to participate in this tournament if this MEDICAL QUESTIONNAIRE FORM is not completed and returned prior to the 2015 KUKKIWON INTERANTIONAL CUP & WASHINGTON D.C. TAEKWONDO OPEN.

COMPETITOR'S SIGNATURE: _____ DATE: _____

If competitor is under age 18, this must be signed by parent or legal guardian.

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

CERTIFICATION

Competitor's Name: _____ Age: _____

Parent's Name: _____ Home Phone: _____

Home Address: _____

If you are a minor (under 18 years old) and will be at the tournament without a parent, the statement below must be read and signed by a parent or legal guardian and returned prior to participating in any competition or event. The undersigned competitor (parent or legal guardian of the competing minor) represents that s/he has the authority to consent to the medical care and treatment of such a competitor by the designees of 2015 Kukkiwon International Cup & Washington DC TKD Open.

PARENT / LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

PARENT / LEGAL GUARDIAN SIGNATURE: _____ DATE: _____