

# Kickboxing Organization of South Africa



## TOURNAMENT/EVENT ENTRY & INDEMNITY FORM

Tournament/Event name: \_\_\_\_\_ Date: \_\_\_\_\_

Athlete Name & Surname: \_\_\_\_\_

Athlete current age: \_\_\_\_\_ Contact number : \_\_\_\_\_

Athlete home address : \_\_\_\_\_

### ATHLETE/PARENTAL DECLARATION

I, \_\_\_\_\_ hereby declare that I am/my child is fit and in good health and can participate in this kickboxing event. Currently I am not/my child is not on any medication or any form of drugs or medication. If the competing athlete is a minor (any person under the age of 19 years of age), the parent parent(s) and/or legal guardian has been notified either personally, telephonically, or electronically of the minor athlete's intention to compete in the Kickboxing event electronically and has given his/her/their permission to do so.

Athletes/Parents/Guardians accept that they will compete at their own risk and carry the inherent risk of injury that may be light and also serious. This risk will be carried solely by the student and/or their parent/ guardian, and no trainers and/or instructors, event organizers, helpers, and officials will be held liable for any claim resulting from delict and/or injury while competing within the event facility. I also exempt the event organizers, trainers, helpers, and officials of all cases of personal injury that may occur at the event and that the First Aid/Medical response officials may attend to me/my child when injured. Should I/my child have to receive any treatment at a hospital or any medical institution due to any injury, I will be responsible to pay my own expenses.

### FEMALE PREGNANCY DECLARATION

As an athlete/child over the age of 14 years old, I declare that I/my child is NOT pregnant.

Sign: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

### DENTAL BRACE DECLARATION

I confirm that I/my child has been fitted with a dental brace. I/my child has been provided with with normal protection to the mouth, gums and teeth and the dental brace itself. I acknowledge that I/my child will at more risk for a mouth injury and/or damage to the braces than any other person taking part in this Kickboxing competition.

Sign: \_\_\_\_\_ Name: \_\_\_\_\_ Date: \_\_\_\_\_

### EMERGENCY CONTACT DETAILS

Contact person : \_\_\_\_\_ Relationship \_\_\_\_\_ Cell : \_\_\_\_\_

# Kickboxing Organization of South Africa



I understand this indemnity form clearly and was not unduly influenced to sign it. I sign this form freely and voluntarily and understand that should I/my child get any form of injury that it will not be due to the negligence of the event organizers, trainers and/or instructors, helpers, officials or any other person involved.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Parent's Signature (if U19 years)

\_\_\_\_\_  
Instructor Signature

Cell : \_\_\_\_\_

Cell : \_\_\_\_\_

Cell : \_\_\_\_\_

## MEDICAL QUESTIONNAIRE

PLEASE INDICATE YES OR NO TO THE FOLLOWING QUESTIONS	YES	NO
Were you ill within the last 14 days?		
Do you use any medicine on a regular basis or within the last 14 days?		
Do you suffer from regular headaches?		
Have you been concussed in the last 6 weeks?		
Have you ever been hospitalised?		
Were you born with any deformities or missing body parts?		
Do you have Hypertension (high blood pressure)?		
Do you suffer from asthma?		
Have you ever fainted during or after a training session?		
Have you ever had any chest pain during or after a training session?		
Have you ever been diagnosed with any skin diseases?		
Do you have any dermatological (skin) conditions at the moment?		
You ever had any issues related to your bones, joints, tendons, or muscles?		
Do you use any supplementation for training or meal replacements at the moment?		
Are you currently on a meal restrictive diet?		

If yes to any question, please provide further details: :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## RINGSPORT ATHLETE MEDIAL (TO BE DONE AT THE WEIGH-IN)

Weight \_\_\_\_\_ Pulse : \_\_\_\_\_ BP: \_\_\_\_\_ Lungs clear : \_\_\_\_\_

Remarks : \_\_\_\_\_

## THE ATHLETE MAY / MAY NOT PARTICIPATE IN EVENT

\_\_\_\_\_  
Physician/Paramedic/Doctor Signature

\_\_\_\_\_  
HCPSA Number

\_\_\_\_\_  
Physician/Paramedic/Doctor Name & Surname

\_\_\_\_\_  
KOSA Ringsport Official Signature

\_\_\_\_\_  
Date of examination

\_\_\_\_\_  
KOSA Ringsport Official Name & Surname