

2023 YKI Summer Camp Registration Form

Date: July 20th – 22nd, 2023

Place: Thursday Night Training and Testing at TYKI Dojo:
3550 S. Washington Ave, #8627

Friday and Saturday Training at Titusville Civic Center:
4220 S. Hopkins Ave, Titusville, FL (lunch and dinner provided)

Hotel: Fairfield Inn & Suites by Marriott (321-385-1818)
4735 Helen Hauser Blvd., Titusville, FL
\$89.00 per night, plus tax, per room (includes breakfast)
PLEASE contact hotel directly to reserve a room (mention Yoshukai Camp for discounted rate).

Training Fee: Please select from the options below:

\$220 Full Camp (per person)

OR

\$25 Thursday Night Training (per person)
\$110 Day Camp – Friday (per person)
\$110 Day Camp – Saturday (per person)

Registration is required by July 1st, 2023. Unaccompanied minors MUST provide a signed Permission to Treat form (see attached).

Questions: Direct all inquiries to your instructor or Christina McClernan
738 NE 7th Ave.,
Gainesville, Florida 32601
Email: chris.mcclernan@yoshukai.org
Ph: 352-262-8376

Name: _____

Address _____

City/State: _____ Zip: _____

Phone: (____) _____ Email: _____

Instructor: _____ Age: _____ Rank: _____

(1) free t-shirt for each FULL CAMP participant registered by July 1st. Please indicate size desired:

Adult: S M L XL XXL XXXL

Additional T-shirts please include \$20.00 per shirt.

(Please indicate size/quantity and include payment with registration)

Adult: S _____ M _____ L _____ XL _____ XXL _____ XXXL _____

Yoshukai Karate International

Permission to Treat

PERMISSION TO TREAT (REQUIRED FOR ALL PARTICIPANTS UNDER AGE 18)

In presenting my son/daughter for diagnosis and treatment (name) _____
Parent Legal Guardian
for _____ of _____ years of age, hereby voluntarily consent to
Son Daughter
the rendering of such care, including diagnostic procedures, surgical and medical treatment and blood transfusions, by
authorized members of the hospital staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my
child's condition.

I have read this form and certify that I understand its contents.

We/I hereby give our (my) consent to _____
(Name of Person or Agency)

who will be caring for our (my) child _____
(Name of Child)

for the period _____ to _____ to arrange for routine or
emergency medical/dental care and treatment necessary to preserve the health of our (my) child.

We/I acknowledge that we (I am) responsible for all reasonable charges in connection with care and treatment rendered
during this period.

Family Physician: _____ Medications: _____

Pediatrician: _____ Child's Allergies: _____

Telephone: _____ Date of last tetanus booster: _____

In case of emergency, I can be reached at the following telephone number: _____

Alternate Contact/Telephone: _____

Health Insurance: _____

Policy/Group Number: _____ Telephone: _____

SIGNATURE

Signature: _____ Date: _____

Notary Signature: