



# Unifield ITF Legacy Weekend

April 7-9th, 2017

Marriott Hotel Farmington

Unified International Taekwon-Do Federation, LLC

50 Bulkeley Hill Rd

Colchester, CT 06415

Contact: [sec.general@unifield-itf.com](mailto:sec.general@unifield-itf.com)

Paypal Account: [admin@unifield-itf.com](mailto:admin@unifield-itf.com)

Name

Address

City  State  Zip Code

Country

Date of Birth   Male  Female TKD Rank

Email  Phone Number

Tkd School & Instructor:

Event	Early Registration March 17th	By April 3rd	After April 3rd
Seminar & Banquet	<input type="checkbox"/> \$125	<input type="checkbox"/> \$150	Not Available
Seminar Only	<input type="checkbox"/> \$75	<input type="checkbox"/> \$85	<input type="checkbox"/> \$100
Banquet Only	<input type="checkbox"/> \$60	<input type="checkbox"/> \$65	Not Available
Additional Attendees	# of People <input type="text"/>	# of People <input type="text"/>	

Payment Total \$

Forms of payment; Paypal, Check or Money order

Paypay- [www.Paypal.com](http://www.Paypal.com) Send money to: [admin@unifield-itf.com](mailto:admin@unifield-itf.com)

Check or Money order mailed to:

Unified ITF

50 Bulkeley Hill Rd

Colchester, CT 06415

Please list any dietary restrictions or allergies

The information on this form is gathered to assist us with providing appropriate care in case of emergency. All of the information is kept confidential and is accessible only to those personnel that need to see it for safety purposes. Please type or print CLEARLY.

Name

Home Address

City  State  Zip Code

Country

Date of Birth  Age   Male  Female

Custodial Parent/Guardian

Daytime Phone  Cell/Evening

Second Parent/Guardian or Emergency Contact:

Relationship:  Daytime Phone  Evening/Cell

Address (if different from above):

City  State  Zip Code

Country

If not available in an emergency please notify:

Name  Relationship:

Daytime Phone  Cell/Evening

Is the participant covered by family medical/hospital insurance  Yes  No

Do you agree to cover any medical costs necessary in case of injury, illness or accident?  Yes  No

Insurance Carrier or Plan Name:  Phone Number

Name of Insured  Relationship to Insured:

Group #  Insurance ID:

Additional Information or Notes:

## Important- The following must be filled out by participant

Parent/Guardian Authorization: My permission is given to the medical personnel chosen by the UITF to order treatment, x-rays, routine tests, to release any records necessary for insurance purposes; and to provide or arrange unnecessary related UITF to secure and administer treatment, including hospitalization, for the person named above. The participant has my permission to engage in all activities except as noted.

By signing below I verify that this health report is complete and accurate.

Signature of Parent/Guardian or Adult Participant

Printed Name

Date/Time Field

Parent or Guardian Release

I authorize my son/daughter to participate fully in all UITF, LLC activities. Some of these activities involve risk of personal injury. I understand that the Unified ITF cannot safeguard against all such injuries and I expressly agree to assume such risk and waive and release the Unified International Taekwon-Do Federation, LLC, it's officers, agents and employees from any claim of liability, including the negligence of any officers for any loss, damage or injury incurred during the program in which I am participating.

I have read and understand the rules and regulations of Unified ITF and will comply with all health and safety measures and standards of conduct set by the Unified ITF.

Signature

Date/Time Field

Parent Signature (if minor)

Date/Time Field