



Annual Medical for CASK Passport/Sticker

Mail original form and payment to CASK. Email/fax not accepted.
 Submit to CASK at least 14 days before event. Rush fee applies if received less than 14 days before event.
 No applications accepted week of event.

1. Athlete completes Parts 1 and 2.
2. Athlete's doctor completes Part 3.
3. Club owner completes Part 4.
4. Club keeps a copy and mails original form with payment to the CASK office.
5. If application is approved, CASK mails the passport/sticker to club within 2 weeks of receiving application.

PART 1 ATHLETE INFORMATION To be completed by Athlete or Parent/Guardian

Have you already sent in your CASK membership form? Yes <input type="checkbox"/> No, it's attached <input type="checkbox"/>		Male <input type="checkbox"/> Female <input type="checkbox"/>
Club name:		Are you under 18? Yes <input type="checkbox"/> No <input type="checkbox"/>
First name:		Last name:
DOB: dd mm yy	Email:	
Phone:		Alt. phone:

Passport details

Are you applying for passport or a sticker? Passport (attach a labeled passport-size photo) Sticker

Age category? Jr.A (10-12) Jr.B (13-15) Intermediate (16-18) Sr.(19-39) Veteran (40 or older)

How many CASK bouts have you had? _____

How many *non-CASK full contact* bouts have you had? _____ What discipline? _____

Payment

Passport or sticker	<input type="checkbox"/> \$25
Rush fee	<input type="checkbox"/> \$75 <i>if applicable</i>
If CASK receives your medical at least two weeks (14 days) before the event, there is no rush fee. If CASK receives the medical the week before (14-7 days) before the event, a \$75 rush fee applies. <i>No medicals are accepted the week of the event.</i>	
<input type="checkbox"/> Cheque / money order	<input type="checkbox"/> Credit card Cardholder: _____
payable to CASK	Card #: _____ Exp date: _____

Office Use Only

Rec'd	Mailed	_____ - _____ - _____ - _____ - _____ - _____
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PART 2 MEDICAL HISTORY To be completed by Athlete or Parent/Guardian

	No	Yes, explain
1. Eye or ear impairment, infections or fever		
2. Rheumatic fever, T.B., pleurisy or asthma		
3. Kidney or urine disorder		
4. Problem or condition with a paired organ		
5. Diabetes Mellitus		
6. Indigestion, vomiting, abdominal cramps		
7. Nervous breakdown		
8. Acute infections or communicable disease (e.g. HIV/AIDS)		
9. Musculoskeletal Injuries		
10. Head injury or concussions		
11. Seizures or epilepsy in self		
12. Seizures or epilepsy in family member		
13. Suspensions from boxing/kickboxing for medical reasons		

Signature of Athlete or Parent/Guardian

Date

PART 3 MEDICAL EXAM To be completed by Physician

Patient name:		DOB: dd		mm	yy
Weight	Height	Expiration		Inspiration	
Vision right eye /20	Vision left eye /20	Color Vision		Field of Vision	
Ears (state of T.M.S. and Degree of Deafness)					
Teeth (any braces)			Hernia or organomegaly		
Abnormality in Chest, Heart, B.P., or C.N.S					
Male: Undescended testis, cryptorchidism					
Female: Breast lesions, bleeding, masses, other dysfunction, pain					
Abnormality in menstrual pattern, amenorrhea, lower pelvic pain					

➔ **Is this person fit to participate in amateur kickboxing?** Yes No (explain)

➔ **Physician's Signature:**

Date:

➔ Office stamp or
Physician name:
Office address:
Office phone:
Office fax:

PART 4 CLUB SIGN OFF To be completed by Club Owner

This person is a member of my club and I believe the information on this form is true and accurate. Yes

I have made a copy of this form and placed on file at my club. Yes

Club owner name:

Signature: