13TH GOLDEN STATE OPEN TAEKWONDO CHAMPIONSHIP
OFFICIAL TEAM DEMONSTRATION ENTRY FORM

SATURDAY, MARCH 14, 2009
KELLOGG GYM @ CAL POLY POMONA
3801 WEST TEMPLE AVE, POMONA, CA 91768

SATURDAY	7:00 - 8:30 AM	CARD PICKUP
	8:30 AM	POOMSE COMPETITIONS BEGINS
	9:30—10:30 AM	14-32 BLACK BELT WEIGH-IN * (HOLDING AREA)

5 OR MEMBERS IN THE TEAM DEMOSTRATION COMPETITION MUST PARTICIPATE IN EITHER INDIVIDUAL POOMSE OR KYOROOGI COMPETITION.

TEAM DEMOSTRATION COMPETTION FEE: $100.00

PLEASE PRINT ALL INFORMATION IN CAPITAL LETTERS

TKD SCHOOL NAME

MASTER'S NAME

TEAM NAME

TEAM MEMBERS

	Full Name	Signature of Team Member Agreement to Liability (Parent/Guardian for those under 18)	Date
1.			
2.			
3.			
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12.			
13.			
14.			
15.			

PAYMENT TYPE:	*DEADLINES:*	*SEND TO:*
CASHIER'S CHECK OR MONEY ORDER MADE PAYABLE TO: **MASTER WUNG H. LEE** **(NO PERSONAL CHECKS ACCEPTED)**	POSTMARKED BY: **MARCH 10, 2009** **All Applications Must be on Date** **NO EXCEPTIONS**	**GSOTKD-Tournament Committee** **9569 E. LAS TUNAS DRIVE** **TEMPLE CITY, CA 91780** **TEL: 626-286-6500** **FAX: 626-286-7300**

LIABILITY WAVIER AND CONSENT TO MEDICAL TREATMENT

I hereby submit this registration and liability waiver form to participate in the Golden State Open Taekwondo Championship. I certify that above information is true and correct and hereby release, discharge, and waive any and all responsibility of the Kellogg Gym, California State Polytechnic University, Pomona, S.K. Taekwondo Center, California Taekwondo United, Tournament Organizing Committee, referees, instructors, agents, and other competitors from liability for any injury, including death, and for damage to or loss of property which may be suffered by myself arising out of, or in any way resulting from or attributable in whole or in part to my traveling to, training to, being coached in, using any sports equipment in, or participating in the Golden State Open Taekwondo Championship. As a competitor or parent/legal guardian of the competitor, I give consent to any x-ray exam, medical, chiropractic, dental or other treatment(s) deemed necessary for the safety and welfare of the contestant. I understand that this authorization is given prior to any diagnosis, treatments or hospital care being required, but is given to provide the medical/chiropractic/dental staff authority to render care as deemed advisable. In the case of minors, it is understood that efforts shall be made to contact the undersigned prior to rendering treatment, but treatment will not be withheld if the undersigned cannot be reached. **I understand that in case of injury, only basic first aid will be made available on site, and that I am fully responsible for any and all resulting medical or other expenses.**

MASTER'S SIGNATURE DATE

MASTER'S SIGNATURE ON THIS FORM IS MANDATORY. IF NOT SIGNED, TEAM WILL NOT BE PERMITTED TO COMPETE