

# MASTER S.H. YU

MARTIAL ARTS & FITNESS ASSOCIATES

## CHILDREN'S PROGRAM APPLICATION

Welcome! Please complete this questionnaire to help us learn more about your child's motivation in studying Martial Arts. This will assist us in designing a rewarding training program for your child. Thank you.

		Date of Application
Student Name	Date of Birth	
Phones: Home	Alternate	
Address		
City	State	Zip
E-Mail		

### School History

Pre-school	
Kindergarten	
Current School	Grade

### Parental Information

Father	
Occupation	Employer
Mother	
Occupation	Employer
Who initiated child's study of Martial Arts?	<input type="checkbox"/> Parents <input type="checkbox"/> Child

How did you learn about us?	<input type="checkbox"/> Ad	<input type="checkbox"/> Sign	<input type="checkbox"/> Church/Temple
	<input type="checkbox"/> Friend Who?		<input type="checkbox"/> Other
Learning Objectives (check all that apply)	<input type="checkbox"/> Self-defense	<input type="checkbox"/> Personal training	<input type="checkbox"/> Physical conditioning
	<input type="checkbox"/> Discipline training	<input type="checkbox"/> Self-confidence	<input type="checkbox"/> Weight management/control
	<input type="checkbox"/> Coordination	<input type="checkbox"/> Sports/competition	<input type="checkbox"/> Art form study

Please indicate previous Martial Arts experience (school name, instructor, length of study, etc.)

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**Physical/Emotional Evaluation**

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1. Does your child take regular medication?  Yes  No If yes, please specify:

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2. Has your child had surgery in the past 2 years?  Yes  No If yes, please specify:

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3. Does your child experience difficulty in any of the following areas?  
(Check all that apply)

<input type="checkbox"/> Coordination	<input type="checkbox"/> Agility	<input type="checkbox"/> Mental or emotional instability
<input type="checkbox"/> Balance	<input type="checkbox"/> Self-confidence	<input type="checkbox"/> Neurological disorders
<input type="checkbox"/> Endurance	<input type="checkbox"/> Expressing feelings	<input type="checkbox"/> Interacting with other children

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4. Does your child have any chronic illnesses?  
(Check all that apply)

<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Nervous tension
<input type="checkbox"/> Heart condition	<input type="checkbox"/> Back problems	<input type="checkbox"/> Hernia	<input type="checkbox"/> HIV infection or AIDS
<input type="checkbox"/> Arthritis, bursitis	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> None of the aforementioned			

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5. Is your child goal/reward oriented?  Yes  No

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6. Do you experience discipline problems with your child?  Yes  No

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7. Has your child ever been attacked or abducted?  Yes  No

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I certify the above information is true and correct and give my permission for my child to study under the direction of Master S.H. Yu Martial Arts & Fitness Associates, Inc.

Parent signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

Date of First Class \_\_\_\_\_

Thank you. Please use the space below to share other relevant information that will help us work with your child.