



### SFPAL Waiver of Liability Form

Sport:

Team Name:

Division:

Player's Last Name:

Player's First Name:

Init.:

School:

Grade:

DOB:

Parent/Guardian Name:

Email:

Address:

City:

Zip Code:

Home Ph:

Cell Ph:

Work Ph:

Emergency Contact (NOT listed above):

Phone:

Insurance Company of Youth Participant:

Policy #:

Existing medical condition/medications\* - SFPAL requires a PAL Medical Clearance Form signed by a doctor—when existing conditions/medications are listed. Call 415.401.4666 for Medical Form.

Existing Medical Conditions\*

#### Consent to Rules and Regulations

As the parent/legal guardian of the above named participant, I agree that the participant and I will abide by the rules of the SFPAL, its affiliates and sponsors. I understand that SFPAL participants must reside or go to school in San Francisco and I certify that my child meets this requirement. I hereby release, discharge and/or otherwise indemnify SFPAL, the San Francisco Police Department, the City and County of San Francisco, its affiliated organizations and sponsors, their employees and associated personnel against any claim by or on behalf of the participants as a result of participation in the program and/or being transported to or from the same, which transportation I hereby authorize.

All boxes must be checked and your signature below in order for your child to participate in the SFPAL program:

- I have read and agree to adhere to the "Coach/Parent/Spectator Code of Conduct".
- I give SFPAL my permission to use my child's photo in promotional material.
- My child resides in and/or attends school in the City of San Francisco

#### Consent of Medical Treatment

As the parent/legal guardian of the above named participant, I hereby give consent for emergency medical care prescribed by a duly licensed Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb, or well-being of my dependent.

Parent/Legal Guardian Name (please print)\*: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**ONE MORE THING**

We very much appreciate your participation in the San Francisco Police Activities League (SFPAL). Unfortunately, your \$100 fee does not cover the real cost of the program. And it doesn't cover the cost of kids whose families can't pay at all. So, if you can afford it, we'd like to ask you to increase your \$100 payment to a round \$150. Of course, we'd be delighted if you could contribute even more, but the extra \$50 would get us a long way toward breaking even. Not all the way, especially not in these tough economic times when so many of our corporate and foundation funders have had their own budgets cut. But that extra \$50 would still be a tremendous boost. So mark yourself down for a \$150 total payment to SFPAL and help us ensure that all children – without regard to their ability to pay – can participate in this program that you, and thousands of others like you, have found so worthwhile. **Please round up to \$150.**

Please check one:

- \_\_\_\_\_ I want to help other children participate in SFPAL. I'll round up my payment to \$150.
  - (For your tax records, an acknowledgement letter with SFPAL's tax ID# will be provided for your generous donation).
- OR**
- \_\_\_\_\_ I'll just pay the regular \$100 SFPAL judo registration fee.

**Pay By:** Check/money order (payable to SFPAL): \_\_\_\_\_ Cash: \_\_\_\_\_ Credit Card: \_\_\_\_\_

Credit Card information:

Name on card: \_\_\_\_\_

Billing address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Visa/MC Card number: \_\_\_\_\_ Exp: \_\_\_\_\_ CCV Code: \_\_\_\_\_

Email address: \_\_\_\_\_ Phone: \_\_\_\_\_

In order for SFPAL to apply for foundation and individual support to underwrite our programs and keep costs at a minimum, we ask that you please respond to the following demographic information. *(This information is optional and confidential. We appreciate your assistance.)*

- Ethnicity of Youth: (please circle all that may apply or write in your response).

African American    Asian    Latino/a    Multi-Ethnic    Other Non-White    Pacific Islander    Native/American Indian

White    Other: \_\_\_\_\_

- Income Level (Please circle your annual household income):

Less than \$30,000    \$30,001-\$40,000    \$40,001-\$55,000    \$55,001-\$75,000    over \$75,001

# United States Judo Federation, Inc. (USJF)

Print

Reset

## Individual Membership Application

Use This Application To Join Or Renew Membership In United States Judo Federation

1. Application Date		2. Last Name		3. First Name		4. Middle Initial	
5. Address							
6. City		7. State	8. Zip Code		9. Home Phone ( ) ( )		10. Work Phone ( ) ( )
11. FAX ( ) ( )		12. Mobile ( ) ( )		13. E-Mail			
14. Date of Birth		15. Age	16. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		17. Citizenship <input type="checkbox"/> U.S.A. <input type="checkbox"/> Non-U.S.A.		18. Judo Rank & Rank #
19. USJF Life #		20. USJF ID #		21. Club/Dojo			
22. Yudanshakai							
23. Name & Address of Insurance Beneficiary							
24. Membership Fees <small>Choose Regular/Primary, Secondary, or Booster Membership • Excess Accident Medical Insurance is included with the Regular/Primary Membership NO INSURANCE with Secondary or Booster Membership • Secondary Membership expires with USJA/USA Judo primary expiration date Life Members &amp; President's Club Life Members should call the National Office or check with their Yudanshakai for the correct renewal fee.</small>							
Regular/Primary <input type="checkbox"/> \$50.00		Secondary <input type="checkbox"/> With USJA primary \$25.00 <input type="checkbox"/> With USA Judo primary \$25.00		Life Members <input type="checkbox"/> Life Member \$ _____ <input type="checkbox"/> President's Club \$ _____		Booster <input type="checkbox"/> \$15.00	
25. Donations <small>The USJF is a non-profit tax exempt charity. Depending on your tax circumstance, donations may be tax deductible. Please consult with your tax professional. Balch, Fukuda, Lee, Kitaura, &amp; Palacio are all scholarship/grant programs. Please contact the National Office for more information.</small>							
<input type="checkbox"/> Balch \$ _____ <input type="checkbox"/> Lee \$ _____		<input type="checkbox"/> Fukuda \$ _____ <input type="checkbox"/> Kitaura \$ _____		<input type="checkbox"/> General \$ _____ <input type="checkbox"/> Palacio \$ _____		<input type="checkbox"/> Development \$ _____ <input type="checkbox"/> Other \$ _____	
27. Cash or Check Payment Please DO NOT MAIL CASH  <input type="checkbox"/> Cash _____  <input type="checkbox"/> Check # _____ <small>120 RETURNED CHECK FEE</small> Amount _____  Initials _____		28. Credit Card Payment <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover  Name On Card _____ Issuing Bank _____  Account # _____ Exp Date _____ V-Code _____  Card Billing Address _____  Cardholder Signature _____					
29. I certify that the above information is true and I am eligible to be a member in accordance with the rules of the United States Judo Federation, Inc. (USJF).							
<input checked="" type="checkbox"/> Signature of APPLICANT (REQUIRED FOR EVERYONE) _____ Date _____				<input checked="" type="checkbox"/> Signature of Parent/Legal Guardian (Required if Applicant under 18) _____ Date _____			

### WAIVER AND RELEASE OF LIABILITY AGREEMENT - SIGNATURE(S) REQUIRED

I, the Applicant, state that I am 18 years of age or over. In consideration of being permitted to participate in any way, I acknowledge and agree to release, waive and discharge, to the greatest extent permitted by law, United States Judo Federation, Inc. (USJF) from or for all claims, demands and causes of actions or any other liabilities which may arise or be caused in whole or in part by the negligence of USJF in conjunction with or arising out of membership with USJF, and the action or lack thereof of USJF and agree that I know and understand the risks involved in the sport of Judo and do hereby assume these risks and accept the responsibility for any damages or injuries by engaging in the contact sport of Judo.

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
APPLICANT SIGNATURE <small>(Signature required if Applicant over 18)</small>	PRINTED NAME	DATE

### PARENTAL INDEMNIFICATION

I state that I am the parent/legal guardian of \_\_\_\_\_ (the Applicant), a minor. I agree to indemnify and hold harmless the USJF for any expenses incurred, claims made, or liabilities assessed against them as a result of any injury, death, or insufficiency of legal capacity. I consent to the Applicant's becoming a member of USJF & participating in Judo practices, clinics, & events sanctioned or sponsored by USJF.

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PARENT/LEGAL GUARDIAN SIGNATURE <small>(Parent/Legal Guardian signature required if Applicant under 18)</small>	PRINTED NAME	DATE

\*\*\* RELEASE MUST BE SIGNED FOR THIS APPLICATION TO BE VALID • MAKE A COPY FOR YOUR RECORDS \*\*\*  
 Submit to Yudanshakai or Mail to: USJF, P. O. Box 338, Ontario, OR 97914-0338 • Phone: (541) 889-8753 • www.usjf.com



# San Francisco Police Activities League

350 Amber Drive, San Francisco, CA 94131

415.401.4666 | fax: 415.401.4670

[www.sfpal.org](http://www.sfpal.org)

## MEDICAL CLEARANCE FORM

(Only for players with an existing medical condition)

### SFPAL Judo Medical History Form

Medications, Please List & Why:

Allergies, Please List:

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Has the applicant had any of the following conditions? Please circle response.

#### General Conditions:

- |                               |       |     |    |
|-------------------------------|-------|-----|----|
| 1. Headaches                  | _____ | YES | NO |
| 2. Fainting Spells            | _____ | YES | NO |
| 3. Visual/Hearing Deficit     | _____ | YES | NO |
| 4. Seizures / Convulsions     | _____ | YES | NO |
| 5. High Blood Pressure        | _____ | YES | NO |
| 6. Heart Disease / Conditions | _____ | YES | NO |
| 7. Lung Disease / Asthma      | _____ | YES | NO |
| 8. Kidney Problems            | _____ | YES | NO |
| 9. Gastrointestinal Disorders | _____ | YES | NO |
| 10. Hernias                   | _____ | YES | NO |
| 11. Back Problems             | _____ | YES | NO |
| 12. Diabetes                  | _____ | YES | NO |
| 13. Dental / Plates           | _____ | YES | NO |
| 14. Wear Glasses / Contacts   | _____ | YES | NO |
| 15. Skin Problems             | _____ | YES | NO |
| 16. Surgeries                 | _____ | YES | NO |
| 17. Anemia                    | _____ | YES | NO |
| 18. Last Tetanus              | _____ |     |    |

#### Injuries/Trauma:

- |                              |       |     |    |
|------------------------------|-------|-----|----|
| 1. Head / Concussion         | _____ | YES | NO |
| 2. Neck                      | _____ | YES | NO |
| 3. Chest Ribs                | _____ | YES | NO |
| 4. Abdomen                   | _____ | YES | NO |
| 5. Shoulders                 | _____ | YES | NO |
| 6. Clavicles / Collar Bones  | _____ | YES | NO |
| 7. Arms                      | _____ | YES | NO |
| 8. Elbows                    | _____ | YES | NO |
| 9. Wrists                    | _____ | YES | NO |
| 10. Hands                    | _____ | YES | NO |
| 11. Fingers                  | _____ | YES | NO |
| 12. Pelvis / Hips            | _____ | YES | NO |
| 13. Knees                    | _____ | YES | NO |
| 14. Ankles                   | _____ | YES | NO |
| 15. Feet                     | _____ | YES | NO |
| 16. Toes                     | _____ | YES | NO |
| 17. Fractures / Broken Bones | _____ | YES | NO |
| 18. Sprains                  | _____ | YES | NO |

Immunization: \_\_\_\_\_

Please explain "YES" Answers.

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Athlete / Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# San Francisco Police Activities League

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415.401.4666 | fax: 415.401.4670

[www.sfpal.org](http://www.sfpal.org)

## MEDICAL CLEARANCE FORM

(Only for players with an existing medical condition)

### SECTION A (to be completed by parent/guardian) PLEASE PRINT OR TYPE

Name of Participant	Date of Birth
Sport /Activity/Program	Team Name

### SECTION B (to be completed by physician) PLEASE PRINT OR TYPE

I have cleared the above named youth to participate in the activity listed above for games/practices/classes.

NAME OF MEDICAL PROBLEM :

This clearance is valid for the following time period:

to

\_\_\_\_\_  
Month/Day/Year

\_\_\_\_\_  
Month/Day/Year

Physician's Name (printed)

State License Number

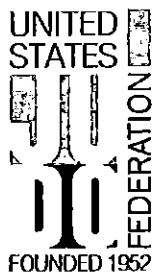
Physician's Signature

Today's Date

Address

City/State/Zip

Telephone Number



# UNITED STATES JUDO FEDERATION

## Membership Assistance For Minors Program

**Mailing Address:**  
P. O. Box 338  
Ontario, OR 97914 0338

**Telephone:**  
(541) 889-8753

**Faxes:**  
(541) 889-5836  
(413) 502-4983

**Internet:**  
[www.usjf.com](http://www.usjf.com)  
[na@usjf.com](mailto:na@usjf.com)

## USJF Membership Assistance For Minors Program General Information

### Purpose:

To provide access to the benefits of membership in the United States Judo Federation (USJF) to those minors who have financial hardship.

### Eligibility:

Any minor who is having difficulty joining the USJF due to financial hardship may apply for the appropriate category of membership that will meet their requirements.

1. Full Membership
2. Short Term Membership For Schools

The Assistance will NOT cover the entire cost of the membership. It is expected that there will be some contribution on behalf of the minor from his/her family.

### Procedure:

1. An eligible person shall complete an application form for individual membership in USJF
2. The individual membership application shall be accompanied by an assistance for minors application form, explanation of the hardship, & the amount of assistance requested
3. The instructor or responsible party in the USJF club or Yudanshakai shall sign the assistance for minors application form to verify the hardship
4. The individual membership application, assistance for minors application form, and individual contribution shall be forwarded to the USJF National Office:  
USJF National Office • P. O. Box 338 • Ontario, OR 97914-0338
5. Applications shall be reviewed on a first come, first considered basis

### Duration of the Program:

The program shall continue as long as budgeted funds are available. When the program has depleted all available budgeted funds, a notice will be posted on the USJF website and the program will have been concluded.



# UNITED STATES JUDO FEDERATION

## Membership Assistance For Minors Program

**Mailing Address:**

P. O. Box 338  
Ontario, ON N7B 9T9 97914-0338

**Telephone:**

(541) 889-8753

**Faxes:**

(541) 889-5836  
(413) 502-4983

**Internet:**

[www.usjf.com](http://www.usjf.com)  
[info@usjf.com](mailto:info@usjf.com)

## USJF Membership Assistance For Minors Program Application Form

(Please use Adobe Acrobat to complete & printout form)

\_\_\_\_\_  
Minor Applicant's Name (printed)

\_\_\_\_\_  
Date

### Category of Membership Requested:

Full Membership

Short-Term School Membership – four months, \$25.00

Short-Term School Membership – eight months, \$40.00

### Explanation of Need:

(May include financial, multiple family members hardship etc.)

### Amount of Member Contribution:

\$ \_\_\_\_\_

\_\_\_\_\_  
Applicant's Parent/Legal Guardian Signature

\_\_\_\_\_  
Name of USJF Chartered Judo Club

\_\_\_\_\_  
Yudanshakai

I hereby declare that this student has genuine financial hardship and would benefit from USJF assistance.

\_\_\_\_\_  
Signature of Club/YDK Representative & Title

\_\_\_\_\_  
Date

It is expected that there will be some contribution on behalf of the minor from his/her family. A completed membership application form along with a check covering the member contribution amount, made out to "USJF", must accompany this application. Please mail all forms & payment to the USJF National Office.