Club Administration

Waiver	
USAW Card	

Wrestler Information & Medical Release

Date: ____________

Last Name: ________________ First Name ________________

Birthday: ________________ School Year: (Circle) K 1 2 3 4 5 6 7 8 9 10 11 12

Month/Day/Year

Weight: ________________ Shirt Size: (Circle) YM YL S M L XL XXL

Parent or Guardian Information

Last Name: ________________ First Name: ________________

Last Name: ________________ First Name: ________________

Mailing Address: ________________________________

Telephone: ________________ Email: ________________

Medical Release

As the parent/guardian of ____________________________________, I request that in my absence the above player be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named wrestler.

Please use the back of this form to describe any drug allergies or pertinent health concerns that the club should be aware of

_______________________________ ________

Parent/Guardian Signature Date

Medical Insurance Information:

Insurance Company:__________________________________ Policy # ________________________________

Emergency Contacts

Name: ________________________ __ Phone:_________________ Relationship:___________________

Name: ________________________ __ Phone:_________________ Relationship:___________________

Modified: 11/23/13
By: BW