

USA WRESTLING

PARENT'S INSTRUCTIONS ON MEDICAL TREATMENT

PLEASE PRINT IN CAPITAL LETTERS

Wrestler's Name _____ Date of Birth _____

Parent/Guardian Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Please indicate another person to call if an accident occurs and we are unable to reach you:

Name _____ Phone No. _____

Insurance Company _____ Policy No. _____

Family Doctor _____ Phone No. _____

Is your child presently on medication? _____ If yes, please list medication (s):

Drug Sensitivities _____

Other Allergies _____

Date of your child's last complete physical examination by a medical doctor _____

If this is more than one year ago, please complete the accompanying medical history questionnaire.

Please read the alternative statements below and sign under the one that you choose. Sign only one!

1. If my child needs medical attention, it is my wish that I am contacted before any medical procedures are taken on my child, unless immediate treatment is necessary to save my child's life or to prevent permanent injury.

Parent/Guardian Signature _____ Date Signed _____

2. If my child needs medical treatment while participating, it is my wish that the treatment is started while efforts are being made to contact me. So that treatment is not delayed, I consent to any medical procedures that the physician believes are needed, on the understanding that efforts to contact me will continue to be made. I accept responsibility for all costs related to such treatment.

Parent/Guardian Signature _____ Date Signed _____

Wrestler's USA Wrestling Card No. _____

Name of Club _____

Coach's Name _____ Phone Number _____