FOX LAKE WRESTLING CLUB EMERGENCY MEDICAL INFORMATION

I hereby give my permission for my child to participate in Wrestling during the 200___ - 200___ season. Further, I authorize qualified medical personnel to provide emergency treatment of any injury or illness my child may experience if they consider treatment necessary, and perform the treatment. This authorization is granted only if I cannot be reached and a reasonable effort has been made to do so. My child and I are aware that participation in sports is a potentially dangerous activity. I assume all risks associated with participation in sports, including but not limited to falls, contact with other participants, and other reasonable risk conditions associated with wrestling. All such risks to my child are known and appreciated by me. I understand this informed consent and agree to its conditions on behalf of my child.

PLEASE PRINT

Child's Name: _____ Date of Birth: _____
(Last) (First) MI

Home Address: _____
(Street) (City) (Zip)

Home Phone #: _____

Mother's Name: _____ Father's Name: _____

Mother's Work #: _____ Father's Work #: _____

Mother's Cellular #: _____ Father's Cellular #: _____

Emergency Contact Name (other than parent):_____

Phone #: _____ Alternate Phone #: _____

Hospital Preference: _____

Child's Physician: _____ Phone #: _____

Allergies: _____ Asthma? θ Yes θ No Type of Inhaler:_____

How did you find out about our club? _____

Heart Condition	**Y**	**N**	
Concussion / Head Injury	**Y**	**N**	
Diabetes	**Y**	**N**	
Epilepsy	**Y**	**N**	
Tuberculosis / Bronchitis	**Y**	**N**	
High / Low Blood Pressure	**Y**	**N**	
Dizzy Spells / Fainting Spells	**Y**	**N**	
Skin Conditions / Diseases	Y	N	
Fractures / Sprains	Y	N	
Surgery or advised to have surgery	Y	N	
Contacts / Glasses	Y	N	

To the best of my knowledge the information on this form is accurate and up to date.

_____ _____
Parent / Guardian Signature Date

Payment Check for Registration $100 Yes/No Check for Singlet Deposit $35 Yes/No Check USA Wrestling $ 40 Yes/No