

# 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 No. \_\_\_\_\_