Note: If paying by check, please make the check out to the Kirtland Wrestling Club.

Wrestler Information

Full Name: _____ Preferred Name: _____

Grade Level: _____ Current Age: _____ Date of Birth: _____

Years Wrestling: _____ Previous Clubs: _____

T-Shirt Size (Youth XXS to Adult XXL): _____

Braces (Circle One): Top Bottom Both None

Email Updates

Which email address(es) would be best to send updates to?

_____

_____

Schedule Change/Cancellation Contact Information

If a practice or match has been cancelled or changed, the KWC should...

Circle One: Call Text Email

Name, Relationship, Phone/Email: _____

Note: If more than one person should be contacted, please list who and how.

_____

_____

_____

Proof of Insurance

My child, _____, is covered by the following medical insurance policy:

Name of Company: _____

Policy Number: _____

Insurance Agent: _____

Release of Responsibility

I represent that I am the parent or legal guardian of this child and hereby give my permission and assume full responsibility for my child while participating in the Kirtland Wrestling Club (KWC) activities.

I hereby release the KWC, the Kirtland Local School District, its members, volunteers and coaches from any and all liability whatsoever. I also understand that no insurance will be provided. I hereby agree to assume all risks and hazards incidental to the activities of the KWC. I understand that KWC may supply equipment to be used for the season and that I am responsible for returning the equipment to KWC and agree to be liable for the replacement cost of such equipment in the event it is not returned.

Signature: _____ Date: _____

Emergency Medical Authorization

In case of an emergency, the following person should be called:

Name, Relationship, Phone: _____

If there's no answer, the following person should be called:

Name, Relationship, Phone: _____

If there's no answer, the following person should be called:

Name, Relationship, Phone: _____

I hereby give consent for the following medical care providers and hospital to be called:

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Hospital: _____ Phone: _____

The following Part I or Part II must be completed.

Part I -- To Grant Consent

In the event reasonable attempts to contact me or other parent(s)/guardian(s) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by the previously-named physician or dentist, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist and (2) the transfer of the child to the previously-named hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Expires on June 1, 2015

Facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted:

_____

_____

_____

Signature: _____ Date: _____

Part II -- Refusal of Consent

(Do not complete Part II if you have completed Part I.)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the KWC authorities to take no action or to:

_____

_____

_____

Signature: _____ Date: _____