

Shamrock Wrestling Club Registration Form

ATHLETE

Athlete's Name: _____
Home Address: _____
Phone: _____ Birth Date: _____
Grade School you attend: _____ Grade you are in: _____

PARENTS

Mother's Name: _____
Mother's Email: _____ Cell Phone: _____
Father's Name: _____
Father's Email: _____ Cell Phone: _____

EMERGENCY CONTACTS

List two persons to contact in case of an emergency. (If both parents reside at the same address, list as one contact)

Name of Contact #1: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Relationship: _____

Name of Contact #2: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Relationship: _____

INSURANCE

Insurance Company: _____
Address: _____
Phone Number: _____
Name of Policy Holder: _____
Policy Number: _____ Group Number: _____

MEDICAL INFORMATION

Are you allergic to any medications? Yes No
If so, please specify: _____

Do you have any allergies? Yes No
If so, please specify: _____

Are you taking any medications? Yes No
If so, please specify: _____

Physicians Name: _____ **Phone Number:** _____

PLEASE READ THE ALTERNATIVE STATEMENTS BELOW AND INITIAL IN THE BOX NEXT TO THE ONE THAT YOU CHOOSE. INITIAL ONLY ONE!

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.

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.

Signature Parent / Guardian: _____ **Date:** _____