AMERICAN WARRIOR WRESTLING
2909 Mansfield Blvd.
Wesley Chapel, Florida 33543
Office 813-365-1163
www.AmericanWarriorWrestling.com

CAMP - CLINIC REGISTRATION FORM

I. CAMP – CLINIC : ___________________________________ Clinic/Camp Fee:________

USAWrestling Member #________________________

II. ATHLETE/COACH INFORMATION

Name____
Last Name First Name MI

DOB:_____________Email:____________________________________Cell #:______________

Address____
Street City State Zip code

Current school of attendance: __________________________________ Current Grade_______

Social Media:________________________________ Veteran: ________________

III. PAYMENT METHODS: Camp/Clinic fee paid: ______________ Date paid_______
CashApp: $AmericanWrestling; Venmo: @Warrior_Wrestling;
PayPal:@WarriorWrestlingWC, 813-365-1163, AmericanWarriorWrestling@gmail.com
*NOTE: Registration is NOT confirmed until payment is received

ADMIN USE ONLY: Payment Confirmation#: How paid? Date Paid? Confirmation #?

Cash_________________ Venmo__________________ Paypal__________________ Cashapp_______________

IV. EMERGENCY CONTACT INFORMATION

#1 Name__________________________________ Phone:_______________ ______________

#2 Name__________________________________ Phone:_______________ ______________

The following information is voluntary information. It is used for the purposes to provide information to medical responders in the event the child/athlete/coach becomes injured or ill and needs emergency medical care in the absence of a parent or guardian.

Medical conditions/issues: