# Pierce County Junior Wrestling League and _____ Medical Waiver

Wrestler's Name:_____ Date of Birth _____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

School: _____ Grade _____ Weight: _____

*Allergies:* _____ *Drug sensitivities:*_____

Is child presently on medication? **Yes No** List Medications: _____

Notes: _____

_____

_____

Doctor's Name: _____ Phone: (  )_____

Parent(s)/Guardian(s):_____

Home phone: (  )_____ Work phone: (  )_____ Cell phone (emergency): (  )_____

Emergency Contact:_____

Home phone: (  )_____ Work phone: (  )_____ Cell phone (emergency): (  )_____

## HOLD HARMLESS AND INDEMNITY AGREEMENT

*I, Parent or Guardian of the above named child, hereby give my consent to such child's participation in the authorized activities of the _____Junior Wrestling Program. I understand that wrestling is an activity which involves bodily contact and that occasionally participants suffer some injuries. In consideration of the organization's permitting my child to participate in its programs, I agree to hold it, its coaches, officers or referees harmless from any claims for personal injuries that may result to the above named child in the course of his/her participating in the organization's activities, and to indemnify it in the event it is compelled to pay any claim thereon.*

*I, Parent or Guardian of the above named child, agree to provide or arrange transportation for my wrestler to all wrestling matches/tournaments, and to release the _____Junior Wrestling organization from any responsibility for my child during transportation.*

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

## PARENTAL INSTRUCTIONS CONCERNING MEDICAL TREATMENT

Please read the 2 statements below and **sign ONLY the 1** that you choose.

1. If my child needs medical attention, it is my wish that I be contacted before any medical procedures are done on my child unless immediate treatment is necessary to save my child's life or to prevent permanent damage. I accept responsibility for all costs related to such treatments.

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

**OR**

2. If my child needs medical treatment while participating, it is my wish that treatment begin while efforts are being made to contact me. I accept responsibility for all costs related to such treatments.

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