## OAK HARBOR AMATEUR WRESTLING CLUB APPLICATION

Wrestlers Name:		Home Telepho	one:
Address:	F	E-Mail Address:	
City:	Zip:	Emergency No:	
School:		Cell Phone:	
Age:Grade:	DOB:	Weight:	
Years of wrestling expe	erience:		
T-shirt size for wrestle	r: Child M-L-XL A	dult S-M-L-XL (plea	ase circle one)
Parent's Signature:			, 
			EDICAL TREATMENT
	<del>-</del>		or Amateur Wrestling Club)
Wrestlers Name:	P	'arent/Guardian Nai	me:
Address:		~	
Tel: Home:	Cell: person to contact in the event of an emergency and we are unable to		
	person to contact i	in the event of an em	ergency and we are unable to
reach you:			
Name:	Relationship	: Pho	one:
Insurance Co:	P	olicy No:	itivities:
Is your child presently	on medication?	Drug sens	itivities:
Other Allergies:			
	edical attention, it is n my child, unless ir		ontacted before any medical is necessary to save my child's life
			Date:
2. If my child needs me	dical treatment wh	ile participating, it is	s my wish that treatment begins
•			s not delayed, I consent to any
			inderstanding that efforts will
<u>-</u>			all costs related to such treatment
Signature of Parent/Gu			
Biddy Fees - \$50.00 per identification by the Biddy Fees - \$50.00 pe		h sibling thereafter) A	ND \$10.00 per individual (no sibling
Make Checks Payable	to: Oak Harbor An	nateur Wrestling Clu	ıb
DO NOT FILL IN- Tre	easurer will comple	te:	
Biddy Wrestling Fee pa	aid on this date:	Check No:	Cash: