South Kitsap Wrestling Club "Medical Release" Form

Participant First Name	Participant Last Name	Date of Birth
Address	City	Zip Code

Parent or Guardian Authorization:
In case of emergency, if family physician cannot be reached, I hereby authorize my child to be treated by Certified Emergency Personnel.

Family Physician		Phone
Hospital Preference		
Insurance Company	Policy Number	Group ID #

If parent/guardian cannot be reached in case of emergency, contact:

Name	Phone	Relationship
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Please list any allergies/medical problems, including those requiring maintenance medications (i.e. Diabetes, Asthma, Seizure Disorder). The purpose of the listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of Last Tetanus Toxoid Booster:_____

Authorized Parent/Guardian Signature:_____Date:_____