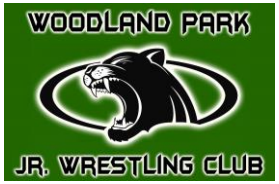

Health History Card

WRESTLER'S NAME _____ D.O.B_____ AGE _____

PARENT'S NAME_____ PHONE #_____

ALTERNATE PHONE_____ EMAIL_____

EMERGENCY CONTACT_____ PHONE_____

MEDICAL INFORMATION

FAMILY PHYSICIAN CONTACT INFORMATION: NAME_____PHONE_____

ADDRESS_____ HOSPITAL PREFERENCE_____

ALLERGIES AND/OR MEDICAL CONDITIONS (LIST):

_____

_____

_____

MEDICATIONS (LIST): _____

SURGICAL HISTORY:-

_____

CONSENT FOR TRANSPORT AND EMERGENCY TREATMENT:

PARENT SIGNATURE_____ PRINT_____