



Season _____

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 _____