ATX Wrestling Registration
Parents Instructions on Medical Treatment
Please Print

Wrestler's Name:_____ Date of Birth:_____

Parent/Guardian Name:_____ Relationship:_____

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

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email:_____

Insurance Company:_____ Policy No._____

Doctor Name:_____ Phone Number:_____

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

Please indicate another Preston to call if an accident occurs and we are unable to reach you:

Emergency Contact Name:_____ Phone Number:_____

Does your child take medication regularly? Yes/No If yes, please list medication(s):_____

Drug Sensitivities:_____ Allergies:_____

Date of your child's last complete physical examination by a medical doctor:_____

Please check the box to consent to having pictures/videos of your child published on multimedia sites (Facebook, Instagram, team website), flyers, fundraising

☐ I Do Consent ☐ I Do not Consent

Please read the two alternative statements below and sign under the <u>one</u> that you choose. <u>SIGN ONLY ONE!!</u>

1. If my child needs medical treatment while participating, it's my wish that I am contacted before any medical procedures are taken on my child, unless immediate treatment is necessary to save my child's life or prevent permanent injury.

Parent/Guardian Signature:_____ Date:_____

2. If my child needs medical treatment while participating, it's my wish that the treatment is started while efforts are being made to contact me. So that treatment is not delayed, I consent to any medical procedures that the physician believes are needed, on the understanding that efforts to contact me will continue to be made. I accept responsibility for all cost related to such treatment.

Parent/Guardian Signature:_____ Date:_____