

# USA Wrestling Entry Form

(Please Print Clearly)

## MEDICAL CONSENT

## Parent or Guardian of minor must read and complete the following:

EVENT NAME \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

USAW Card # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Birth Date \_\_\_\_\_

E-mail \_\_\_\_\_

Grade \_\_\_\_\_ Weight Class \_\_\_\_\_

School/Club \_\_\_\_\_

**Please enter the age-group, style and gender that you plan to participate at the listed Event above.**

Age-Group \_\_\_\_\_

Style \_\_\_\_\_

Gender \_\_\_\_\_

Name of Primary Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Address \_\_\_\_\_

Family Doctor \_\_\_\_\_

Phone \_\_\_\_\_

Presently on any medication? \_\_\_\_\_

\_\_\_\_\_

If yes, please list medication(s) \_\_\_\_\_

\_\_\_\_\_

Drug Sensitivities or Allergies \_\_\_\_\_

\_\_\_\_\_

Special Medical Conditions \_\_\_\_\_

\_\_\_\_\_

**Please indicate another person to call in case of emergency**

Name \_\_\_\_\_

Phone \_\_\_\_\_

Without this signed authorization from the parent/guardian, hospitals in many states are obligated by law to delay treatment of a contestant's injury or illness until the parents can be reached by telephone and their permission granted to begin treatment. Such a delay can prove unnecessarily painful and even dangerous to the athlete, particularly if the parents cannot be reached immediately. To avoid such delays, the parent/guardian should check one of the options below and endorse the selection with his/her signature.

**Check one:**

\_\_\_\_\_ If my child needs medical attention, it is my wish that I be contacted before any medical procedures are begun, unless immediate medical treatment is necessary to save my child's life or prevent permanent injury, in which event I authorize all necessary treatment.

\_\_\_\_\_ If my child, named above, needs medical treatment during this event, it is my wish that the necessary treatment be initiated while efforts are being made to contact me. So that treatment of my child will not be delayed, I consent to any medical procedures that the physician believes my child needs, on the understanding that efforts will continue to be made to reach me. I accept responsibility for all costs related to such treatment.

Adult athletes hereby authorize and consent to emergency medical treatment. Exceptions — List any medical procedures that you do not want performed unless specific approval is received:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PARTICIPANT ACKNOWLEDGES THAT PARTICIPANT HAS HAD SUFFICIENT OPPORTUNITY TO REVIEW THE PROVISIONS OF THIS DOCUMENT AND UNDERSTANDS ITS PURPOSE, MEANING AND INTENT.**

Print Name of Participant \_\_\_\_\_

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

