

Arsenal Wrestling Club Health Form

1. All information must be completed in order to participate in Arsenal Wrestling Club. A parent/guardian must provide all requested information, **print** the form, and a **parent/guardian must sign the form**. A doctor's signature is not required.
2. The Health Form **must be completed prior to practice**.

PROGRAM _____ AWC Mini + Spring _____ DATES(S) 2/13 – 5/27

NAME OF WRESTLER _____ WRESTLER'S AGE _____ DOB _____

MOTHER'S NAME _____ FATHER'S NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS: _____ CELL PHONE# _____

MOTHER'S WORK# _____ FATHER'S WORK# _____

LIST ADULT(S) WRESTLER IS AUTHORIZED TO BE RELEASED TO

NAME OF ALTERNATE CONTACT PERSON (OTHER THAN PARENT) _____

TELEPHONE # OF ALT. CONTACT _____ RELATIONSHIP TO WRESTLER OF ALT. CONTACT _____

LIST ANY **MEDICATION, FOOD, OR ENVIRONMENTAL ALLERGIES** _____

LIST ANY MEDICATION(S) BEING TAKEN. **PLEASE INCLUDE DOSAGE & REASON FOR MEDICATION** _____

LIST ANY ORTHOPEDIC INJURIES **WITHIN THE PAST YEAR** AND DESCRIBE NATURE & SEVERITY OF THE INJURY.
PLEASE GIVE DATE OF INJURY AND A BRIEF EXPLANATION _____

FAMILY PHYSICIAN _____ PHYSICIAN'S TELEPHONE # _____

DATE OF LAST PHYSICAL EXAM _____ DATE OF LAST TETANUS BOOSTER _____

HEALTH INSURANCE COMPANY _____

HEALTH INSURANCE GROUP AND POLICY #'s _____

NAME OF PERSON WHO IS PRIMARY HOLDER _____

WITH MY SIGNATURE BELOW:

- I verify that all of the above information is accurate to the best of my knowledge.
- I authorize Arsenal Wrestling Club and Athletic training staff to provide medical treatment for my child.
- I verify that my child may participate in any and all AWC-related activities and events, and that my authorization does not conflict with any medical advice or concerns expressed by my child's physician.

SIGNATURE OF PARENT/GUARDIAN

DATE