

**CALIFORNIA AMATEUR WRESTLING FOUNDATION
WRESTLING CLUB – INFORMATION QUESTIONNAIRE**

Wrestler: _____ Date of Birth _____ Weight _____

Parent/Guardian

Address:

City _____ Zip Code _____

Home # _____ Work # _____ Cell # _____

E-mail address

Emergency contact if parents cannot be reached:

Name: _____ Relationship: _____

Home # _____ Work # _____ Cell # _____

Physicians Name: _____ Phone # _____

Physical condition of player: _____
Any allergies, illness or other medical or educational conditions. Please be specific and complete; this information is essential to medical personnel and coaches:

MEDICAL RELEASE:

The undersigned Parent/Guardian of wrestler hereby authorizes and consents to any X-ray, examination, anesthetic, medical or surgical diagnosis, procedure or treatment rendered under the general or specific supervision of any member of the medical staff licensed under the provisions of the Medical Practice Act and associated with any general hospital or other medical facility holding a current license to operate from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned, in the exercise of their best judgement, may deem advisable. It is understood that efforts shall be made to contact the undersigned prior to rendering treatment, but that any of the above mentioned treatments will not be withheld if the undersigned cannot be reached.

PARENT/GUARDIAN SIGNATURE