

Wichita Wrestling Club Inc.

Parental Instruction Concerning Medical Treatment

Card No. _____

Wrestler's Name _____ Date of Birth _____

Parent/Guardian Name _____

Address _____

Telephone Numbers: Home _____
Work _____

Please indicate another person to contact in the event of an accident and we are unable to reach you:

Name _____ Telephone _____

Policy Holder _____

Insurance Company _____

Policy Number _____

Is this athlete presently on medication? _____

If yes please list medication(s) _____

Drug Sensitivities _____

Other Allergies _____

Please read the alternative statements below and sign under the one that you choose.

Do not sign more than one!

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

Signature of Parent or Guardian _____

Date _____

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

Signature of Parent or Guardian _____

Date _____

Gavin Jonas _____

Wichita Wrestling Club

(316) 768-0350