

# Knights Wrestling Booster Club

## Wrestling Camp

### October 7, 8, 9, 10 – 2019

Wrestler Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ T-Shirt Size \_\_\_\_\_

#### Emergency Contact in the event we are unable to contact you directly:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Insurance Co. (required) : \_\_\_\_\_ Policy No (required): \_\_\_\_\_

#### Instructions for Medical Treatment

Please read the following alternative statements below. Check the one that you desire. Endorse **ONE** with your signature below.

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

\_\_\_\_\_ If my son/daughter needs medical attention; it is my wish that I be contacted before any medical procedures are initiated, unless immediate treatment is necessary to save life or prevent permanent injury. I accept responsibility for all costs related to such treatment.

This is to certify that as parent/guardian of this athlete, I do release the organizers of the Little Grapplers Wrestling Camp from any and all liabilities incident to their involvement at this event.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**Please bring the completed registration form to camp.**