Colony High School - August 2017
Reece Humphrey Freestyle Wrestling Camp

Wrestler Name: _____ Date of Birth: ___/___/___

Parent/Guardian: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

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

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Family Doctor: _____ Emergency Phone: _____

Insurance Company: _____ Policy No: _____

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 with 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 Colony High School Wrestling Camp and Coach Humphrey from any and all liabilities incident to their involvement at this event.

Parent/Guardian Signature: _____ Date: ___/___/___

Please bring the completed registration form to camp.