

OFFICE USE ONLY (do not mark in this box)

LITTLE REDSKINS WRESTLING CLUB WRESTLER APPLICATION 2008-2009

Wrestler's Name: _____ Phone # _____

Address: _____ City: _____ E-Mail _____

School: _____ Grade: _____ Date of Birth: _____

Weight: _____

Singlet Size: (circle one below) (weigh-in at registration):

Weight	40-60/YS	60-75/YM	75-90/YL	90-110/AXS	110-130/AS	130-155/AM	155-185/AL
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Wrestling Yr (circle): 1st 2nd 3rd 4th ___th T-Shirt Size: _____ Age (on 12-31-08): _____

\$50 Volunteer (refundable) Fee: Rcvd Check #

- Please note there will be a \$25 returned check fee -

Mother's Name _____ **Home#** _____

Work Ph# _____ **Cell#** _____ **E-Mail** _____

(Must check one)

Practice Coach (\$50) Competition Committee General Volunteer

Finance Committee Equipment Committee Registration Committee

Media Committee Coaches Committee Coach Shirt Size: _____

Father's Name _____ **Home#** _____

Work Ph# _____ **Cell#** _____ **E-Mail** _____

(Must check one)

Practice Coach (\$40) Competition Committee General Volunteer

Finance Committee Equipment Committee Registration Committee

Media Committee Coaches Committee Coach Shirt Size: _____

I, _____, understand that USAW registered wrestlers are provided with secondary, non-duplicating medical insurance in the event that my child gets injured during a team sponsored practice or activity. I hereby release Little Redskins Wrestling Club and its volunteers from any liability while my child is under their supervision should any such injury occur.

Parent Signature: _____

Date: _____

LITTLE REDSKINS WRESTLING CLUB

PARENT'S INSTRUCTIONS ON MEDICAL TREATMENT

(PLEASE PRINT IN CAPITAL LETTERS)

Wrestler's Name _____ Date of Birth _____

Parent/Guardian Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____

Please indicate additional persons to call if an accident occurs and we are unable to reach you:

Name _____ Phone No. _____

Name _____ Phone No. _____

Insurance Company _____ Policy No. _____

Family Doctor _____ Phone No. _____

Hospital Preference _____ Date of Last Exam by M.D. _____

Is your child presently on medication? _____ If yes, please list medication (s): _____

List all medical conditions, allergies & drug sensitivities: _____

Yes No Has a medical doctor diagnosed your child as having asthma? If so, what medications, if any, does your child take regularly _____

Yes No Has your child ever had an epileptic seizure or been informed he/she might have epilepsy?

Yes No Has your child ever had an injury to his/her neck involving nerves, vertebrae (bones), or discs that incapacitated him/her for a week or longer? If yes, give the date(s) of such injury.

Yes No Has your child ever had an injury to his/her back?

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

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

Parent/Guardian Signature _____ Date Signed _____

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

Parent/Guardian Signature _____ Date Signed _____