

**MEDICAL EMERGENCY FORM**

WRESTLER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

HOME PHONE \_\_\_\_\_ Cell Phone Father: \_\_\_\_\_ Cell Phone Mother: \_\_\_\_\_

**PRIMARY INSURANCE**

INSURANCE COMPANY NAME \_\_\_\_\_

POLICY # \_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE COMPANY NAME \_\_\_\_\_

POLICY # \_\_\_\_\_

**FAMILY PHYSICIAN**

PHYSICIAN \_\_\_\_\_ Address \_\_\_\_\_

PHONE \_\_\_\_\_

**PERSON TO CONTACT IF PARENTS ARE NOT AVAILABLE**

NAME \_\_\_\_\_ Address \_\_\_\_\_

PHONE: \_\_\_\_\_

**IS YOUR CHILD PRESENTLY ON MEDICATION? YES or NO (circle One)**

**IF YES, PLEASE LIST MEDICATION (S)** \_\_\_\_\_

**ALLERGIES / HEALTH PROBLEMS** \_\_\_\_\_

**PLEASE READ THE STATEMENTS BELOW AND SIGN THE ONE THAT YOU CHOOSE.**

**SIGN ONLY ONE!**

If my child needs medical attention, it is *my* wish that I be 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/GUARGIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**OR**

If my child needs medical treatment while participating, it is *my* wish that the treatment be 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/GUARGIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_