Emergency Medical Form -USA Wrestling

Parental Instructions Concerning Medical Treatment:

Wrestler's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Address: _____

Telephone Numbers: Home: _____ Work: _____ Cell: _____

Name of Primary Insurance Company: _____

Policy Number: _____

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

- Name: _____ Phone: _____ Cell: _____

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

Drug Sensitivities: _____

Other Allergies: _____

Special Medical Conditions: List here any physical impairments, hospitalization, injury, blackouts during competition, athletic participation restrictions, surgery or serious medical illness this athlete has had:

_____

Parent or Guardian of minor must read and complete the following:

- Without this signed authorization from the parent/guardian, hospitals in many states are obligated by law to delay treatment of a contestant's injury or illness until the parents can be reached by telephone and their permission granted to begin treatment. Such a delay can prove unnecessarily painful and even dangerous to the athlete, particularly if the parents cannot be reached immediately. To avoid such delays, the parent/guardian should check one of the options below and endorse the selection with his/her signature.
- 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 begun, unless immediate medical treatment is necessary to save my child's life or prevent permanent injury, in which event I authorize all necessary treatment.

   SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

2. If my child, named above, needs medical treatment during this event, it is my wish that the necessary treatment be initiated while efforts are being made to contact me. So that treatment of my child will not be delayed, I consent to any medical procedures that the physician believes my child needs, on the understanding that efforts will continue to be made to reach me. I accept responsibility for all costs related to such treatment.

   SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____