

Yutan Wrestling Club Medical Information Form

Wrestler's Name _____ Age _____
Sex M _____ F _____ Date of Birth ____/____/____
Home Address _____

Phone Num. (____) _____

Emergency contact _____

Street _____

City _____ State _____ Zip _____

Home Phone (____) _____ Office phone (____) _____

If unable to reach the above, name & phone number of another responsible person

_____ (____) _____

Family Physician: _____ Office Phone (____) _____

Date of most recent tetanus Booster _____ Others _____

Please list any allergies that your child may have: medications etc.)

Important note: If your son or daughter is currently taking medication, they must bring it with them to practices and meets. They must also inform the head coach about all aspects of taking the medication including the reason. (It would be best to have this documented and provide this to the head coach)

Has your child had any of the following? If yes, please attach a brief explanation and treatment if necessary.

Asthma _____ Bleeding Disorder _____ Diabetes _____ Head Injuries _____ Fractures _____

Epilepsy _____ Heart condition _____ Surgeries _____ Severe sprains/strains _____

Check / Skin Disorders

Ring Worm _____ Cold Sores _____ Herpes _____ Impetigo _____

Include all pertinent Medical information - Explain below:

- 1) _____

- 2) _____

- 3) _____

- 4) _____

Insurance Information

Insured Name _____

Name of company _____

Address

Policy # _____ Phone Number _____

Important: Please notify the Yutan Wrestling Club if this student has been exposed to any communicable diseases.

Restrictions / Limitations while at Events / Please list

Parents Authorization

This health history is correct as far as I know, and the person herein described has permission to engage in all activities, except as indicated above. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Yutan Wrestling Club to hospitalize, secure proper treatment as deemed necessary, for my son/daughter while he/she is participating in activities under their supervision.

Physicians Signature _____ Date _____

Parents Signature _____ Date _____