Williamstown Mighty Braves Youth Wrestling

Medical Release Form

**Note: To be carried by any regular season or tournment coach or board member

Wrestler:_____ Date of Birth:_____ Gender: M F

Parent/Guardian Name:_____ Relationship_____

Parent/Guardian Name:_____ Relationship_____

Wrestler's Address_____ City:_____ State:___ Zip:_____

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Email:_____

Parent/Legal Guardian Authorization:

In case of emergency, I hereby authorize my child to be treated by Certified Emergency Personnel (i.e. EMT, First Responder, E.R. Physician)

Family Physician:_____ Phone: _____

Address:_____ City:_____ State:_____

Hospital Preference:_____

Wrestlers Insurance Company:_____ Policy Number:_____

If parent/legal guardian cannot be reached in case of emergency, contact:

Name:_____ Phone:_____ Relationship to wrestler:_____

Name:_____ Phone:_____ Relationship to wrestler:_____

Please list any allergies/medical problems, including those requiring maintenance medication (i.e. diabetic, asthma, seizure disorder).

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Toxoid Booster: _____

The purpose of the above information is to ensure that medical personnel have details of any medical problem with may interfere with or alter treatment.

Authorized Parent/Guardian Signature:_____ Date:_____