



CONTACT INFORMATION (Please Print)

Wrestler Name _____

Birthdate ____/____/____ Age Bracket ____ Weight ____

Parent(s) Name(s) _____

Home Address _____

City _____ State ____ Zip ____

Cell Phone _____ Email Address _____

EMERGENCY INFORMATION

Emergency Contact _____ Phone Number _____

Allergies/Conditions _____

Insurance Company _____ Policy # _____

ID # _____

Doctor's Name _____ Doctor's Phone Number _____

USA Wrestling Card # _____

PARENTS WAIVER OF LIABILITY AND PERMISSION

I give permission for Coach Samuel Henson to take my child to get medical care if needed.

Parent/Legal Guardian Signature

Date

Coach Samuel Henson