Team Braves Wrestling Club
Medical Release Form

Wrestlers Full Legal Name: _____ _____ _____
First Middle Last

_____ _____ _____ _____
Address City State Zip Code

Insurance Information: _____ _____
Insurance Company Name Insurance Policy Number

Parent/Guardian Name: _____ _____ _____
First Middle Last

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home Phone Work Phone Cell Phone

Parent/Guardian Name: _____ _____ _____
First Middle Last

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home Phone Work Phone Cell Phone

Is your child allergic to any medicines? Yes No

If yes, please list _____

Does your child have any medical conditions that might limit his/her abilities? Yes No

If yes, please describe _____

Is your child currently on any medications? Yes No

If yes, please list _____

If my child needs medical treatment while participating, be it at practice, at a tournament, or any other time my child is in the care of Team Braves or any of the team's representatives, it is my wish that 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 physicians or other medical personnel believe is needed, on the understanding that efforts will continue to be made to contact me. I accept responsibility for all costs related to such treatment.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (printed)