PERTINENT MEDICAL INFORMATION (Please Print)

Athlete's Name _____

Parent or Guardian _____

Work Phone _____

Home Phone _____

Address _____

City _____

State _____ Zip _____

☐ Permission for medical treatment, release of medical information and payment of medical expense.

☐ We authorize the staff of the California Gold Wrestling Camp to render emergency medical care for my child. We further authorize the staff to obtain medical care at a hospital or by a private physician should, in the judgement of the staff, it be deemed necessary. The staff will use the 911 emergency care if deemed necessary.

☐ I AUTHORIZE release of any medical information to the mediacl staff and emergency workers that is required to treat the above named participant.

☐ I UNDERSTAND that any changes resulting from this medical treatment will be billed to me at my address or to my medical insurance carrier which is:

Medical Insurance Co. _____

Policy # _____

Address _____

City _____

State _____ Zip _____

Please bring this medical sheet to the first day of wrestling camp.