



**USA WRESTLING**  
PARENT'S INSTRUCTIONS ON MEDICAL TREATMENT

Wrestler's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Please indicate another person to call if an accident occurs and we are unable to reach you:

Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone No. \_\_\_\_\_

Is your child presently on medication? \_\_\_\_\_ If yes, please list medication (s):  
\_\_\_\_\_

Drug Sensitivities \_\_\_\_\_

Other Allergies \_\_\_\_\_

Date of your child's last complete physical examination by a medical doctor: \_\_\_\_\_

*If this is more than one year ago, please complete the accompanying medical history questionnaire.*

*Please read the alternative statements below and sign under the one that you choose. Sign only one!*

1. If my child needs medical attention, it is my wish that I am contacted before any medical procedures are taken on my child, unless immediate treatment is necessary to save my child's life or to prevent permanent injury.

Parent/Guardian Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

2. If my child needs medical treatment while participating, it is my wish that the treatment is started while efforts are being made to contact me. So that treatment is not delayed, I consent to any medical procedures that the physician believes are needed, on the understanding that efforts to contact me will continue to be made. I accept responsibility for all costs related to such treatment.

Parent/Guardian Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

Wrestler's USA Wrestling Card No. \_\_\_\_\_

Name of Club: FREEBIRDS WRESTLING CLUB

Coach's Name: PATRICK HAYHURST

Phone No. HOME: (661)722-8773 CELL: (661)609-9057



## USA Wrestling MEDICAL HISTORY QUESTIONNAIRE

Wrestler's Name \_\_\_\_\_ USA Card No. \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**PLEASE SELECT THE CORRECT ANSWER, ALL INFORMATION WILL BE CONFIDENTIAL**

- |                                 |                           |     |  |                                 |                           |                             |                         |                    |                    |
|---------------------------------|---------------------------|-----|--|---------------------------------|---------------------------|-----------------------------|-------------------------|--------------------|--------------------|
| Yes                             | No                        | 1.  | Are you allergic to any general medication (aspirin, sulfa, penicillin, etc.)? If so please indicate what medication(s) _____  |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 2.  | Are you now on any prescribed medication on a permanent or semi-permanent basis? If so, please indicate the name of the medication and why it was prescribed.<br>_____   |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 3.  | Have you ever had an epileptic seizure or been informed that you might have epilepsy?  |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 4.  | Have you ever been treated for diabetes? If so, please indicate the type(s) of insulin or pills you use. _____   |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 5.  | Has a medical doctor ever told you that you were anemic or had sickle cell anemia?   |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 6.  | Do you have or have you ever had high blood pressure? If so, list any medication for it that you take regularly _____  |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 7.  | Do you have or have you ever had any of the following diseases? If so, please circle the appropriate ones.   |                                 |                           |                             |                         |                    |                    |
|                                 |                           |     | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Heart disease (rheumatic fever)</td> <td style="width: 50%;">Liver disease (hepatitis)</td> </tr> <tr> <td>Kidney disease (infections)</td> <td>Lung disease(pneumonia)</td> </tr> </table>   | Heart disease (rheumatic fever) | Liver disease (hepatitis) | Kidney disease (infections) | Lung disease(pneumonia) |                    |                    |
| Heart disease (rheumatic fever) | Liver disease (hepatitis) |     |  |                                 |                           |                             |                         |                    |                    |
| Kidney disease (infections)     | Lung disease(pneumonia)   |     |  |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 8.  | Have you ever been informed by a medical doctor that you have asthma? If so, what medications, if any, do you take regularly _____<br>_____  |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 9.  | Do you presently have an unrepaired hernia?  |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 10. | Have you ever been "knocked out" or experienced a concussion during the past 3 years? If so, give the dates of each _____  |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 11. | If the answer to No. 10 is "yes" did the attending physician have you stay overnight in a hospital? If yes, give the dates of each _____   |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 12. | Have you ever had an injury to your neck involving nerves, vertebrae (bones), or Discs that incapacitated you for a week or longer? If yes, give the dates of each such injury.  |                                 |                           |                             |                         |                    |                    |
| Yes                             | No                        | 13. | Do you wear any dental appliance? If yes, circle the appropriate appliance:  |                                 |                           |                             |                         |                    |                    |
|                                 |                           |     | <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Permanent bridge</td> <td style="width: 50%;">Permanent crown or jacket</td> </tr> <tr> <td>Braces Full plate</td> <td>Removable partial plate</td> </tr> <tr> <td>Permanent retainer</td> <td>Removable retainer</td> </tr> </table> | Permanent bridge                | Permanent crown or jacket | Braces Full plate           | Removable partial plate | Permanent retainer | Removable retainer |
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| Permanent retainer              | Removable retainer        |     |  |                                 |                           |                             |                         |                    |                    |



- Yes No 14. Do you wear contact lenses during competition?
- Yes No 15. Have you had a fracture during the past 2 years? If yes, indicate which bone was broken and the date it happened. \_\_\_\_\_
- Yes No 16. Have you had a shoulder dislocation, separation or other shoulder injury in the past 2 years that incapacitated you for a week or longer? If so, give the date of the injury.  
\_\_\_\_\_  
\_\_\_\_\_
- Yes No 17. Have you ever had surgery to correct a shoulder condition? If so, give the dates and what was done.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Yes No 18. Have you ever had an injury to your back?
- Yes No 19. Do you experience Pain in your back? If yes, indicate frequency:  
Seldom Occasionally Frequently  
With vigorous exercise With heavy lifting
- Yes No 20. Have you injured your knee during the past 2 years with severe swelling as a result?
- Yes No 21. Have you ever been told that you injured the ligaments and / or cartilage of either knee?
- Yes No 22. Have you ever been advised to have surgery to correct a knee problem?
- Yes No 23. If the answer to No. 22 is yes, has the surgery been completed? Date \_\_\_\_\_
- Yes No 24. Have you experienced a severe sprain of either ankle during the past 2 years?
- Yes No 25. Have you had any injury to your foot or toes in the past 2 years. If yes, explain:  
\_\_\_\_\_  
\_\_\_\_\_
- Yes No 26. Do you have any chronic conditions that have not been mentioned above? If so, explain:  
\_\_\_\_\_  
\_\_\_\_\_

*The questions on both sides of this form have been answered completely and truthfully to the best of my knowledge.*

Wrestler's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/ Guardian Signature \_\_\_\_\_



## USA Wrestling Waiver and Release from Liability

1. I, \_\_\_\_\_, the undersigned, on behalf of myself, my heirs and next of kin, personal representative, agents, insurers, successors and assigns (all hereinafter "Releasors") hereby FOREVER RELEASE, DISCHARGE AND COVENANT NOT TO SUE THE UNITED STATES OF AMERICAN WRESTLING ASSOCIATION, INC., its insurers, its affiliated clubs, administrators, agents, directors, officers, state organizations, members, committees, volunteers, all employees of USA Wrestling, and any and all participants, officials, referees, coaches, host clubs, sponsoring agencies, sponsors, advertisers, local organizing committees (and if applicable) owners, lessors and operators of premises used to conduct any USA Wrestling sanctioned event, meet, practice or activity (all hereinafter "Releasees") from any and all liabilities, claims, demands, causes of action or losses of any kind or nature, past, present or future, direct or consequential that I may hereafter have for PERSONAL INJURY, PERMANENT, TEMPORARY, TOTAL OR PARTIAL DISABILITY, DISFIGUREMENT, PARALYSIS AND ANY OTHER LOSSES OR DAMAGES TO PERSON OR PROPERTY OR DEATH, arising out of my participation in, attendance at or traveling to and from any USA Wrestling sanctioned event or activity including, but not limited to, LOSSES CAUSED BY THE PASSIVE OR ACTIVE NEGLIGENCE OF THE RELEASEES, or hidden, latent or obvious defects in the facilities or equipment used.
2. Releasor understands and acknowledges that USA Wrestling sanctioned activities and the sport of wrestling in general have inherent dangers that no amount of care, caution, training, instruction, supervision or expertise can eliminate. RELEASOR EXPRESSLY AND VOLUNTARILY ASSUMES ALL RISK OF PERSONAL INJURY, PERMANENT, TEMPORARY, TOTAL OR PARTIAL DISABILITY, DISFIGUREMENT, PARALYSIS AND ANY OTHER LOSSES OR DAMAGES TO PERSON OR PROPERTY OR DEATH, sustained while participating in, attending, preparing for or traveling to and from any USA Wrestling sanctioned event, meet, practice or activity, including the risk of PASSIVE OR ACTIVE NEGLIGENCE OF THE RELEASEES, or hidden, latent or obvious defects in the facilities or equipment used.
3. Releasor acknowledges and fully understands that each participant in any USA Wrestling sanctioned event, meet, practice or activity, including Releasor, will be engaging in activities that involve risk of serious injury, including permanent, temporary, total or partial disability, disfigurement, paralysis and any other losses to person or property, including death, and that severe social and economic losses may result not only from releasor's own action, inactions or negligence, but also from the actions, inactions or negligence of other notwithstanding the rules of play or the condition of the premises or of any equipment used. Further Releasor acknowledges and fully understands that there may be other associated risks with such activities which are not known or not reasonably foreseeable at this time.

I ACKNOWLEDGE THAT I HAVE HAD SUFFICIENT OPPORTUNITY TO REVIEW THE PROVISIONS OF THIS DOCUMENT AND UNDERSTAND ITS PURPOSE, MEANING AND INTENT.

\_\_\_\_\_  
(Participant's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)

The undersigned, \_\_\_\_\_ does hereby represent that he/she is, in fact, the parent or legal guardian of \_\_\_\_\_ and acting in such capacity agrees to the terms and conditions of the above stated waiver and release.

\_\_\_\_\_  
(Guardian's Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Relationship to minor)