

The Ragin' Raisins Wrestling Club
**ASSUMPTION OF RISK, CODE OF CONDUCT, WAIVER AND RELEASE OF LIABILITY
 INSURANCE FORM & MEDICAL CONSENT**

Name _____
 Address _____
 City _____
 State _____ Zip Code _____
 Home phone _____
 Parent's cell phone _____
 Wrestler's cell phone _____
 Birthday ___/___/___ Grade _____
 School Affiliation _____
 USA Card # _____
 AAU Card # _____
 Father's name _____
 Mother's name _____
MEDICAL CONSENT
 Name of Primary Insurance
 Company _____

 Policy# _____
 Address _____
 Family Doctor _____
 Phone _____
 Presently on any medication? Yes / No

If yes, please list medication(s) _____

 Drug Sensitivities or Allergies _____

 Special Medical Conditions _____

Please indicate another person to call in case of an emergency:
 Name _____
 Phone _____

Parent or Guardian of minor must read and complete the following:

Without this signed authorization from the parent/guardian, hospitals in many states are obligated by law to delay treatment of a contestant's injury or illness until the parents can be reached by telephone and their permission granted to begin treatment. Such a delay can prove unnecessarily painful and even dangerous to the athlete, particularly if the parents cannot be reached immediately. To avoid such delays, the parent/guardian should check one of the following options and endorse the selection with his/her signature.

Check one:
 _____ If my child needs medical attention, it is my wish that I be contacted before any medical procedures are begun, unless immediate

medical treatment is necessary to save my child's life or prevent permanent injury, in which event I authorize all necessary treatment. _____ If my child, named above, needs medical treatment during this event, it is my wish that the necessary treatment be initiated while efforts are being made to contact me. So that treatment of my child will not be delayed, I consent to any medical procedures that the physician believes my child needs, on the understanding that efforts will continue to be made to reach me. I accept responsibility for all costs related to such treatment.

*Adult athletes hereby authorize and consent to emergency medical treatment. Exceptions-list any medical procedures that you do not want performed unless specific approval is received:

COMPETITOR ACKNOWLEDGES THAT COMPETITOR HAS HAD SUFFICIENT OPPORTUNITY TO REVIEW THE PROVISIONS OF THIS DOCUMENT AND UNDERSTANDS ITS PURPOSE, MEANING AND INTENT.

Print name of participant	Date
Signature of participant	Date
Signature of Parent/Guardian	Date

* A copy of your Birth Certificate is required to age verification at tournaments.