LAST NAME _____ FIRST NAME _____

MEDICAL INFORMATION FORM

FULL NAME _____ D.O.B. _____

ADDRESS _____ ☐ Male ☐ Female

CITY _____ STATE _____ ZIP _____

TELEPHONE: Home # _____ Work # _____

CELL PHONE: Dad # _____ Mom # _____

IMMUNIZATIONS: *(Dates for each dose)*	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Hep B	_____	_____	_____		
DTP/DT/DT&P	_____	_____	_____	_____	_____
Td	_____	_____			
OPV/IPV	_____	_____	_____	_____	
MMR	_____	_____			
Varicella	_____	_____			
Haemophilus Influenza type b	_____ (date) _____				

☐ **Chicken Pox:** Age _____ *(Please check)*

Weight _____ Height _____ BP _____

Yes No (Please Check if Applicable)

☐ ☐ **Asthma:** ☐ Mild ☐ Moderate ☐ Severe ☐ Exercise Inducer

☐ ☐ **Allergies:** ☐ Medication ☐ Food ☐ Seasonal ☐ Other _____

☐ ☐ **Anaphylactic Reaction:** ☐ Insect ☐ Food ☐ Latex

☐ ☐ **EPI Penn/EPI Pen Jr.:** If yes, please include a doctor's order stating emergency use of pen.

☐ ☐ **Diabetes:** ☐ Type I ☐ Type II

☐ ☐ **Seizure Disorder**

(Please Check)

Restrictions: The following restrictions apply to this individual –

Dietary

☐ Does not eat red meat ☐ Does not eat pork ☐ Does not eat eggs ☐ Does not eat dairy products

☐ Other *(describe)* _____

General Health History that applies to this individual

	Yes	No		Yes	No
Any recent injury, illness or infectious disease?	☐	☐	Ever been diagnosed with a heart murmur?	☐	☐
Have a chronic or recurring illness?	☐	☐	Ever had back problems?	☐	☐
Ever been hospitalized?	☐	☐	Ever had problem with joints? (i.e. knee, ankle)	☐	☐
Ever had surgery?	☐	☐	Have an orthopedic appliance for camp?	☐	☐
Have frequent headaches?	☐	☐	Have any skin problems? (i.e. acne, rash)	☐	☐
Ever have a head injury:	☐	☐	Had mononucleosis in the past 12 months?	☐	☐
Ever been knocked unconscious?	☐	☐	Had problems with diarrhea/constipation?	☐	☐
Wear glasses, contacts?	☐	☐	Have problems with sleepwalking?	☐	☐
Ever had frequent ear infections?	☐	☐	Have a history of bed-wetting?	☐	☐
Ever passed out during or after exercise?	☐	☐	Ever had an eating disorder?	☐	☐
Ever been dizzy during or after exercise?	☐	☐	Ever had emotional difficulties for which		
Ever had seizures?	☐	☐	professional help was sought?	☐	☐
Ever had chest pains during or after exercise?	☐	☐			
Ever had high blood pressure?	☐	☐			

Please explain any "YES" answers on next page

INJURY OR ILLNESS JOURNAL

a. Description of injury/illness: _____

b. Description of how incident occurred if applicable: _____ **c.** Date: _____

d. Date parents were initially called: _____ **e.** Date parents were called on follow-up: _____

LAST NAME FIRST NAME

Explanation of "YES" answers from previous page. _____

_____

_____

_____

_____

I have examined this patient and in addition, the health history and immunization records have been reviewed. There are no apparent contraindications to participating in intense wrestling camp activities.

Date of Last Physical: _____ Physician's Name: _____

Physician's Address: _____

Physician's Telephone #: _____

Today's Exam Date: _____ _____

Physician's Signature

The Parent/Guardian by his/her signature denies that any significant health problems have occurred ***since the above date.***

Today's Date: _____ _____

Parent/Guardian Signature

CONSENT TO TREAT

I grant to medical personnel of Paleface Athletics, LLC permission to provide medical care for conditions which arise during participation in Paleface Athletics, LLC wrestling. Every effort will be made to contact parents for specific permission if general anesthetic is indicated. I hereby authorize the administration of whatever medical or surgical treatment may, in the judgment of the physician, be necessary and advisable for my child. Paleface Athletics, LLC is not responsible for participants who arrive sick or injured. (See Policy Letter)

_____

(Child's Name)

_____ _____

Parent/Guardian Signature (Date)

*****Is there anything else you think might be helpful to us in caring for this player? If yes, please attach an explanatory letter.**
PLEASE NOTIFY US IF ANY MEDICAL TREATMENT OR PROGRAM WILL CONTINUE DURING THIS STAY.

Required
MUST BE FILLED OUT

EMERGENCY INFORMATION: (If parents cannot be reached)

NAME _____ RELATIONSHIP _____

TELEPHONE: Home # _____ Work # _____

CELL PHONE # _____ EMAIL ADDRESS _____

Required
MUST BE FILLED OUT

INSURANCE INFORMATION:

Policy Holder _____ Policy Holder D.O.B. _____

Policy Holder Social Security # _____–_____–_____

Company Policy is held with _____

PO Box # and address of Insurance Company _____

800 # of Insurance Company _____

Additional Information _____

LAST NAME _____ FIRST NAME _____

Prescription and Non-Prescription Medication Permission Form

(To be completed by Parent/Guardian)

NAME OF PLAYER _____

NAME OF PARENT/GUARDIAN _____

TELEPHONE: Home # _____ Work # _____

CELL PHONE: Dad # _____ Mom # _____

EMERGENCY# _____ NAME _____

FOOD/DRUG ALLERGIES _____

Please list ALL medications (including over-the-counter or non-prescription drug) taken routinely. Bring enough medication to last the entire time at camp. Keep original packaging/bottle that identifies the prescribing physician (if prescription drug), the name of the medication, the dosage, and frequency of administration

Non-Prescription Medication

Yes ☐ No ☐ Allowed to take "over-the-counter" medications during camp stay (Advil, Tylenol, Tums, etc.).

Prescription Medication

Yes ☐ No ☐ Prescription medications will be taken during camp stay. Please list each drug separately in the boxes below (This includes inhalers/epi pens).

Name of Medication _____

Dose given at camp _____ (i.e. 1x/day, 2x/day) Duration of Order _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements _____

Name of Medication _____

Dose given at camp _____ (i.e. 1x/day, 2x/day) Duration of Order _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements _____

Name of Medication _____

Dose given at camp _____ (i.e. 1x/day, 2x/day) Duration of Order _____

Specific Directions (e.g., on an empty stomach/with meals/at bed time) _____

Special Storage Requirements _____

_____ _____

→ *Parent/Guardian Signature* → *Physician's Signature*

LAST NAME FIRST NAME

Participant's Waiver and Release from Liability

1. I,_____ , the undersigned, on behalf of myself, my heirs and next of kin, personal representatives, agents, insurers, successors and assigns (all hereinafter "Releasors") hereby FOREVER RELEASE, DISCHARGE AND COVENANT NOT TO SUE Paleface Athletics, LLC, its insurers, its affiliated clubs, administrators, agents, directors, officers, state organizations, members, committees, volunteers, all employees of Paleface Athletics, LLC, 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 Paleface Athletics, LLC 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 hereinafter 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 Paleface Athletics, LLC 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 Paleface Athletics, LLC 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 Paleface Athletics, LLC 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 Paleface Athletics, LLC 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 actions, inactions or negligence, but also from the actions, inactions or negligence of others 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.

4. As parent(s) or legal guardian(s), we have also been informed that various skin conditions are very preventable in the sport of wrestling and while strong measures will be taken to prevent the spread of skin conditions such as ring worm, herpes, and cold sores, 100% prevention cannot be guaranteed. Further, we the parent(s) or legal guardian(s) have been informed that there is an assumption of risk when anyone participates in the sport of wrestling.

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

_____ _____

Signature of Parent or legal guardian) (Date)

_____ _____

(Print Name) (Relationship to minor)