

CHRISTIAN LIFE CLUB WRESTLING

Emergency Information

NAME _____ BIRTHDATE _____ AGE _____ Grade _____

Parent/Guardian _____ Home Phone _____

Home Address: _____

Parent place of Employment(Father) _____ Work Phone _____

Parent place of Employment(Mother) _____ Work Phone _____

Cell Phone (Father) _____ Cell Phone (Mother) _____

Email Address _____

Family Physician _____ Phone _____

Name of Insurance Co. _____ Policy # _____

Hospital Preferred _____

Does your child have a life threatening medical condition that could require immediate treatment? YES NO
If YES, a Medical Emergency Plan will need to be filled out ~ please contact athletic office

In an Emergency, if parents cannot be notified, please contact:

_____ Phone _____

_____ Phone _____

We give consent for our child to use the CLS Fitness Center for weight training and physical fitness with adult supervision provided by CLS coaches and staff. _____ YES _____ NO

The team trainer and coach may apply first-aid treatment until the family physician can be contacted. _____ YES _____ NO

We give our consent for coaches, trainers, and team physicians to use their own judgment in securing medical aid and ambulance service in case the parents cannot be reached. _____ YES _____ NO

We agree to facilitate the return of all emergency medical treatment apparatus, or will make full restitution financially.

_____ Date _____ Parent/Guardian Signature

Please indicate if your child has any medical conditions (i.e. asthma, allergies) or medications needed (i.e. inhalers, epipen) that you feel would be beneficial for the coach and/or emergency personnel to be aware of. Please indicate if the child has said medication on their person or in the team med kit.

I have chosen not to provide any method of treatment for my child's allergies, asthmatic condition or any other condition that might warrant medical intervention. Parent Signature: _____

Christian Life does not provide any medical insurance for participants in club wrestling.