

# Roseville Wrestling Club

## Registration, Parent Authorization, Emergency Contact and Medical Release

Wrestler's Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Gender (Circle One): Male Female Weight: \_\_\_\_\_ Height: \_\_\_\_\_

SCWAY #: \_\_\_\_\_ USA Card #: \_\_\_\_\_

Years of Experience: \_\_\_\_\_

Mother/Guardian: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Father/Guardian: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Additional Contacts: In the event Parent/Guardian cannot be reached in an, please contact:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Medical Information:

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Hospital Affiliation: \_\_\_\_\_

Medical Insurance Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies: (medication, food): \_\_\_\_\_

In the event that I cannot be reached in an emergency, I hereby give my permission to Roseville Wrestling Club Staff to secure proper treatment for my child, \_\_\_\_\_ including, but not limited to; medical transport, hospitalization, injection, anesthesia, surgery.

\_\_\_\_\_  
Signature of Parent/ Legal Guardian

\_\_\_\_\_  
Date