



USA WRESTLING
MEDICAL HISTORY / INSTRUCTION FOR MEDICAL TREATMENT



WRESTLER NAME _____

ALLERGIES LIST ALL KNOWN ALLERGIES (*MEDICATIONS, FOODS, BEE STINGS, LATEX, ETC.*)

HEALTH CONDITIONS LIST ALL KNOWN AND LIST MEDICATIONS CURRENTLY TAKING, IF ANY, PRESCRIBED FOR THAT CONDITION.

PARENT/GUARDIAN CONTACT INFORMATION LISTED PERSONS WILL BE CONTACTED IN EVENT OF AN EMERGENCY

NAME _____ RELATIONSHIP TO WRESTLER _____

HOME _____ CELL _____ OTHER _____

NAME _____ RELATIONSHIP TO WRESTLER _____

HOME _____ CELL _____ OTHER _____

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.

SIGNATURE _____

DATE _____

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.

SIGNATURE _____

DATE _____