DWC **USA WRESTLING** DWC

Medical History / Instructions For Medical Treatment

WRESTLER INFORMATION:

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

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

_____

_____

_____

_____

HEALTH CONDITIONS: LIST ALL KNOWN AS WELL AS ALL MEDICATIONS CURRENTLY TAKING, IF ANY, PRESCRIBED FOR THAT CONDITION

_____

_____

_____

_____

PARENT / GUARDIAN CONTACT INFORMATION: LISTED PERSON WILL BE CONTACTED IN THE EVENT OF AN EMERGENCY

NAME: _____ RELATIONSHIP TO WRESTLER: _____

HOME: _____ CELL: _____ OTHER: _____

NAME: _____ RELATIONSHIP TO WRESTLER: _____

HOME: _____ CELL: _____ OTHER: _____

MARK ONLY ONE

☐ 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:** _____ **Printed Name:** _____	☐ 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:** _____ **Printed Name:** _____