



## MEDICAL INFORMATION FORM

CAMP:  
 1: \_\_\_\_\_  
 2: \_\_\_\_\_

FULL NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

ADDRESS \_\_\_\_\_ Male  Female

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE: Home # \_\_\_\_\_ Work # \_\_\_\_\_

CELL PHONE Dad # \_\_\_\_\_ Mom # \_\_\_\_\_

IMMUNIZATIONS: <i>(Dates for each dose)</i>	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                       | <i>(Please Check if Applicable)</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Asthma:</b> <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Exercise Inducer   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Allergies:</b> <input type="checkbox"/> Medication <input type="checkbox"/> Food <input type="checkbox"/> Seasonal <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Anaphylactic Reaction:</b> <input type="checkbox"/> Insect <input type="checkbox"/> Food <input type="checkbox"/> Latex                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>EPI Penn/EPI Pen Jr.:</b> If yes, please include a doctor's order stating emergency use of pen.   |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Diabetes:</b> <input type="checkbox"/> Type I <input type="checkbox"/> Type II  |
| <input type="checkbox"/> | <input type="checkbox"/> | <b>Seizure Disorder</b>  |
- (Please Check)*

**Restrictions:** The following restrictions apply to this individual –

**Dietary**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Does not eat red meat   | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat eggs           |
| <input type="checkbox"/> Does not eat red meat   | <input type="checkbox"/> Does not eat pork | <input type="checkbox"/> Does not eat dairy products |
| <input type="checkbox"/> Other <i>(describe)</i> |  |  |

**General Health History** that applies to this individual

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

***Please explain any "YES" answers on next page***

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 Journeymen Wrestling permission to provide medical care for conditions which arise during participation in Journeymen 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. Journeymen Wrestling is not responsible for participants who arrive sick or injured. (See Policy Letter)



(Child's Name)

(Parent or 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 P HONE #: \_\_\_\_\_ 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: \_\_\_\_\_



## Prescription and Non-Prescription Medication Permission Form

(To be completed by Parent/Guardian)

Camp \_\_\_\_\_

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**

Yes  No

### Non-Prescription Medication

Allowed to take "over-the-counter" medications during camp stay (Advil, Tylenol, Tums, etc.).

Yes  No

### Prescription Medication

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



## 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 Journeyman Wrestling Club, Ltd., its insurers, its affiliated clubs, administrators, agents, directors, officers, state organizations, members, committees, volunteers, all employees of Journeyman Wrestling Club, Ltd, 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 Journeyman Wrestling Club, Ltd 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 Journeyman Wrestling Club, Ltd 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 Journeyman Wrestling Club, Ltd 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 Journeyman Wrestling Club, Ltd 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 Journeyman Wrestling Club, Ltd 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.

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)