



LAST NAME _____

FIRST NAME _____

Circle appropriate camp
you are attending

Colorado Camp

New York Intensive

Technique

Team

MEDICAL INFORMATION FORM

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 (Please Check if Applicable)

Asthma: Mild Moderate Severe Exercise Inducer

Allergies: Medication Food Seasonal Other _____

Anaphylactic Reaction: Insect Food Latex

EPI Penn/EPI Pen Jr.: If yes, please include a doctor's order stating emergency use of pen.

Diabetes: Type I Type II

Seizure Disorder

(Please Check)

Restrictions: The following restrictions apply to this individual –

Dietary

Does not eat red meat Does not eat pork Does not eat eggs Does not eat dairy products

Other *(describe)* _____

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

INJURY OR ILLNESS JOURNAL

a. Description of injury/illness: _____

b. Description of how incident occurred if applicable: _____ c. Date: _____

d. Date parents were initially called: _____ e. Date parents were called on follow-up: _____

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



(Child's Name)

Parent/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 PHONE # _____ 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 _____



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Prescription and Non-Prescription Medication Permission Form

(To be completed by Parent/Guardian)

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*



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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 Paleface Athletics, LLC, its insurers, its affiliated clubs, administrators, agents, directors, officers, state organizations, members, committees, volunteers, all employees of Paleface Athletics, LLC, 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 Paleface Athletics, LLC. 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 Paleface Athletics, LLC 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 Paleface Athletics, LLC 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 Paleface Athletics, LLC 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 Paleface Athletics, LLC 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)