MEDICAL INSURANCE / USA WRESTLING CARD INFO
Favia Wrestling Camps, LLC.

Please fill out form and email it back to Coach Favia prior to the clinic at joe.favia165@gmail.com or bring it with you to camp. Wrestlers without the completed form will not be permitted to participate.

Participant's Name: _____

Parents/Guardians: _____

Home Phone #:_____Work Phone #:_____

Emergency Contact: _____ Phone#_____

Coverage for accidental injury is required by all participants. Please indicate your family health insurance below, as well as your valid USA Wrestling Card Number:

_____ _____
(Name of Participant) **(Name of Policy Holder)**

_____ _____
(Health Insurance Company) **(Policy Number)**

_____ _____
(Name of Participant) **(USA Wrestling Card Number)**

Parent's approval and medical release:
Recognizing the possibility of physical injury associated with Wrestling and/or sudden illness at an event, and in consideration for Favia Wrestling Camps LLC. Accepting the registrant for its wrestling camps, I hereby release, discharge and/or otherwise indemnify Favia Wrestling Camps LLC. and its affiliates, associated personnel, including the owners of the facilities utilized for the programs against any claim by or on behalf of the registrant as a result of the registrant's participation in the programs.

My son has received a physical examination by a physician and has been found physically capable of participating in the programs. I herby give my consent to have an athletic trainer, emergency personnel, and/or doctor of medicine or dentistry provide my son with medical assistance and/or treatment and agree to be responsible financially for the reasonable cost of such assistance and/or treatment.

_____ _____
Signature of Parent/Guardian **Date**

MEDICAL INFORMATION FORM

Name: _____

Medical History
Is there a known history of:
A. Birth Deformities (one eye, one kidney, etc.) Yes _____ No _____
B. Medical conditions currently under treatment Yes _____ No _____
C. Pre-existing injury currently under treatment Yes _____ No _____
D. Fracture or other disability type injuries Yes _____ No _____
E Allergy (drugs, food, asthma, etc.) Yes_____ No _____
F. Mental disorders or convulsions Yes_____ No _____

Explain above answered "yes"_____

_____

IMMUNIZATION DATE (Please Provide Date)

1. Tetanus _____
2. Polio _____
3. Measles _____
4. Mumps _____
5. Diphtheria _____
6. Rubella _____
7. Pertussis_____

(If there is a religious objection to immunization of a child, a written statement should be signed and submitted by the parents/guardians)

Name of Physician: _____

Phone Number of Physician: _____

I hereby certify that the above information is correct to the best of my knowledge.

_____ _____
Signature of Parents/Guardians Date