HOWLAND MAT CATS WRESTLING

SIGN-UP FORM

Wrestler's Name: ____

Birth Date: ____/____/____ Grade: _______ Age: _______ School: ____________________________

Home Address: ____

City: ____ State: _________ Zip: ______________

Home Phone: (_____) _________________ Email Address: _____________________________________

Parent/Guardian: ___________________________________ Cell Phone: (____) ___________________

Parent/Guardian: ___________________________________ Cell Phone: (____) ___________________

**Coaches will send updates and reminders via Remind (text # 81010 and message @howlandmc to join). Check the website weekly for schedules, forms, etc. at howlandmatcats.com.*

Wrestling Experience: ________________________________Approximate Weight: _________________

Other Sport Involvement: ____

____

Additional Information Regarding Wrestler (for coaches): _______________________________________

____

Sweatshirt Size: YSM YMD YLG AXS ASM AMD ALG AXL A2XL

(Program cost includes a sweatshirt. Circle size.)

--OFFICE USE ONLY—

Payment Information: CASH______________________ CHECK #___________________________

(Payable to Howland Tiny Tigers Wrestling Club)

Please complete both sides of this form.

HOWLAND MAT CATS PERMISSION SLIP AND EMERGENCY MEDICAL AUTHORIZATION

Student's Name____
Address____ Phone: (_____) ______________________________

*Please list the telephone number(s) to reach a parent/guardian during the time of this program:

____

I/We hereby give permission to (wrestler) ____ to participate in the following activity/program _______________________________________, as described on (date) ____/____/_______.
I/We shall not hold the school authorities liable for any injury incurred as a result of this activity/program.

DATE __________________ SIGNATURE OF PARENT/GUARDIAN____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

(PART I **OR** II MUST BE COMPLETED)

PART I TO ***GRANT*** *CONSENT:*

In the event reasonable attempts to contact me during this activity/program at (home or cell numbers) ____ or other parent or guardian at (home or cell numbers) ____ have been unsuccessful, I hereby give my consent for: (1) administration of any treatment deemed necessary by (preferred physician) Dr.____ or (preferred dentist) Dr.___________________________________, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of child to ____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. List any health condition, such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems or chronic conditions, etc. List any prescribed medication that your child is taking:
CONDITION(s):____
MEDICATION(s):____

DATE __________________ SIGNATURE OF PARENT/GUARDIAN____

Part II ***REFUSAL*** *TO CONSENT: (only if not completing the section above)*

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:____.

List any health condition, such as heart disease, diabetes, epilepsy, severe allergies, eye or ear problems or chronic conditions, etc. List any prescribed medication that your child is taking:
CONDITION(s):____
MEDICATION(s):____

DATE __________________ SIGNATURE OF PARENT/GUARDIAN____