

## TEAM TEXAS CADET DUAL TEAM REGISTRATION FORM

WRESTLERS NAME: \_\_\_\_\_

PARENTS/GUARDIANS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

USA CARD NUMBER: \_\_\_\_\_

### **PARENT/GUARDIAN RELEASE**

I, the undersigned, hereby certify that I am the parent or legal guardian of the wrestler. I hereby give permission for the staff of Best Trained Wrestling/Team Texas Cadet Duals Staff to seek, during the season, appropriate medical attention for the wrestler and for the wrestler to receive medical attention in the event of accident, injury or illness. I will be responsible for any and all medical costs for treatment and or attention. I, the undersigned for ourselves, our heirs, executors and administrators, waive, release and forever discharge Best Trained Wrestling, Team Texas Cadet Dual Staff, Jerry Best and Allen Independent School District, the camp and its staff, officers, agents, employees, representatives, successors, and assign of and from all rights and claims for damages, injury or loss to person or property which may be sustained during participating in camp activities or while at camp, whether or not damages, injury or loss is due to negligence.

Wrestler's Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name (please print) \_\_\_\_\_

Best Trained, Team Texas and Allen ISD does not discriminate on the basis of race, color, sex, age, national origin, religion, sexual orientation, or disability in matters affecting employment or in providing access to programs. Inquiries related to the policies of Best Trained Wrestling should be directed to Jerry Best (214)244-9037.

# MEDICAL CONSENT FORM

Athlete: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Permission is hereby granted to the attending physician to proceed with any medical or surgical treatment, x-ray examinations and immunizations for the above named athlete. In the event of serious illness, the need for major surgery, or significant injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me, the treatment necessary for the best interest of the above named athlete may be given.

In the event that an emergency arises during a practice session, an effort will be made to contact the parents or guardians as soon as possible. Permission is also granted to the athletic trainer to provide the needed emergency treatment to the athlete prior to his/her admission to the medical facilities.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

Phone numbers where parent/guardian can be reached:

Name: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Health Insurance, if any: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Phone # of this company: \_\_\_\_\_

## HEALTH HISTORY

Kidney injuries: \_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

Heart condition: \_\_\_\_\_ Diabetes: \_\_\_\_\_

Asthma: \_\_\_\_\_ While competing do you wear contacts: \_\_\_\_\_

Allergic so any medication: \_\_\_\_\_

Currently taking any medication on a regular basis? \_\_\_\_\_ If yes, what?

\_\_\_\_\_