

EHWC Wrestler Medical History

CHECK ANY THAT APPLY TO YOUR WRESTLER

- | | | |
|---|---|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Do you use inhalers? | <input type="checkbox"/> Do you have a latex allergy? | |

Have there ever been any injuries to any part of the body? Please list what injuries and dates: _____

Are you now on prescribed medications? **Yes / No** Why: _____

Yes / No Do you wear contact lenses?

Yes / No Do you have dental appliances?

Yes / No Do you have any chronic conditions that have not been mentioned above?

If yes, please list them: _____

Wrestling is a reasonably safe sport as long as certain guidelines are followed. Wrestling is a contact sport and injuries to the neck, shoulders, arms, back, and other injuries related to a contact sport may result. If you have any physical condition that precludes you from such activities, please obtain a physician's consent to participate.

The questions on this form have been answered completely and truthfully to the best of my knowledge. I have read the proceeding and certify that I'm physically fit for the sport of wrestling. I fully understand the risks inherent in the sport of wrestling. I voluntarily participate in this activity.

Wrestler _____ Parent/Guardian _____

EHWC Wrestler Medical Release

Representatives of the Board of Directors and/or Coaching Staff **have my permission** to secure medical attention, hospitalization, ambulance transportation etc., for our child _____ while attending practice, traveling to and from scheduled meets, and during wrestling meets. We also give the above-mentioned representatives authority to consent to necessary surgery should hospital and surgeon not be able to contact me first.

Our child is allergic to these substances: _____

Other conditions that influence the medical treatment of my child: _____

Family Physician: _____ Phone: _____

Wrestler's Name: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

I do not consent to medical treatment and hereby release the above-mentioned representatives from any and all responsibilities.

Parent's Signature: _____ **Date:** _____