RELEASE AND MEDICAL AUTHORIZATION

********No athlete will participate until this form is completed********

RELEASE OF LIABILITY

In consideration of Northern Illinois Wrestling Academy & Club, All-American Training & Fitness, Shooters Elite Wrestling Club, and All-American Wrestling Camps granting the athlete permission to participate in this wrestling club/academy, I hereby assume all risks of personal injury (including death) that may result from any club activity. As a guardian I do hereby release Northern Illinois Wrestling Academy & Club, All-American Training & Fitness, and its officers, employees, agents, and instructors and all participants in this club/academy from all liabilities, including claims and suits at law or in equity, for injury, fatal or otherwise which may result from the student taking part in any club, academy or camp activity.

MEDICAL AND SURGICAL AUTHORIZATION

I hereby authorize and give my consent to the health authorities or any licensed health professional to perform upon or administer to

Athlete's Name____

any reasonable necessary surgical or medical treatment. This authorization is intended to cover emergency treatment, immunization, injections, and minor operations and procedures. Parental authorization for treatment beyond that responsive to the emergency will be requested. I agree to assume all cost related to such treatment.

MEDICAL CHARGES AND INSURANCE

I understand that I will be responsible for any medical or other charges in connection with student's attendance at this club. (Each athlete must provide his/her own medical insurance) Also, I authorize the disclosure of medical information to my insurance company for the purpose of claim. This permission is good only while the athlete is attending Northern Illinois Wrestling Academy & Club, All-American Wrestling Camp, Practices and Camps Activities.

Name(Parent/Guardian) ____

Address ____

State____________Zip_____________Phone (H) _______________(W) ____________

Insurance Company ____

Insurance Co. Address ____

Policy No. ______________________________Policy Holder ____________________

My signature indicates agreement and acceptance of the terms previously described: *Release of Liability, Medical and Surgical Authorization, Medical Charges and Insurance*. I understand that this form must be completed in order for student participation in club activities, including a Physician's Authorization.

____Date__________________

Parent's/Guardian Signature (*Required*)

____

Athlete's Signature

Athlete ____

(Please print full legal name)

Social Security Number _______________________________________

Birthday ___________________________________ **M**_____ **F**_____

Physician's Authorization

(School physical form acceptable if valid within one year, attach copy)

This is to certify that _________________________ was examined by me on __________________________(valid if within one year) and that I found this individual to be physically able to participate in vigorous physical activity and competitive athletic sports.

Date of last tetanus immunization_______________________________________

Allergies ____

Drug Sensitivities ____

Other Medical Problems ____

Current Medications ____

What accommodations should be made to ensure proper administration and storing of the medication?____

Signed **X** ____

Physician's Signature (*Required*)

Address ____

Office Phone ____

Home Phone ____

Please return to:
All-American Training & Fitness
P.O. Box 15074
Loves Park, IL 61111