



Rob Hermann Wrestling Clinic

Brought to you by Team Washington

Emergency Medical Treatment Authorization & Implied Consent Form For Team Washington

Wrestler's Name: _____
Wrestler's Grade: _____ **Phone:** _____
Wrestler's Address: _____
Wrestler's City, State Zip: _____
Wrestler's Email Address: _____
Wrestler's School: _____

I, _____, grant permission to Kyle Foster, Steve Ice or David Saddler, who are coaches or team representatives of Team Washington to seek emergency medical treatment for my child, _____, in the case of an injury sustained while participating with one of the various Team Washington wrestling clinics. This permission is valid only during the current sport of Wrestling for the 2005/2006 playing season, with effective dates of November 19, 2005 through January 30, 2006.

Please note medical conditions or prescriptions that could affect proper treatment of your child: _____

Doctor's Name: _____

Parent's Signature _____

Doctor's Phone: _____

Print Parent's Name: _____

Preferred Hospital: _____

Parent's Address: _____

Medical Insurance Co.: _____

Date: _____

Parent's Home Phone: _____

Parent's Cell Phone: _____

Parent's email address: _____

Parent's Work Phone: _____

IMPLIED CONSENT

I am aware that wrestling is a dangerous activity, and I am voluntarily participating in this activity with knowledge of the danger involved and hereby agree to accept any and all risks of property damage, personal injury, or death.

In consideration of my participating, I hereby release Team Washington, and any of its coaches, instructors, officers, directors or agents, to include any school institutions providing facility usages from any present and future claims, including negligence, for property damage, personal injury, or wrongful death, arising from my participating in wrestling activities.

Furthermore, I hereby voluntarily waive any and all claims, both present and future, arising from my participation in wrestling activities, including, but not limited to negligence, property damage, personal injury and wrongful death.

I further understand that wrestling activities that I participate in may be conducted at sites that are remote from available medical assistance; and nonetheless agree to proceed with such activities in spite of possible absence of medical assistance. I also understand that any equipment provided for my protection may be inadequate in preventing serious injury.

I understand that Team Washington carries **NO** team medical insurance to cover players who are members of the team or who participate in their events, and that my/our personal insurance will be utilized first.

I have read this form and fully understand that by signing this form, I am giving up legal rights and/or remedies that may be available to me.

Parent/Guardian

Date

**Please print, sign and mail with payment to Team Washington prior to November 1, 2005 or payable at door.
 Mail to: Team Washington, 13706 69th Avenue Court East, Puyallup, Washington 98373**