SPRINGFIELD WRESTLING SCHOOL

HEALTH/MEDICAL INFORMATION FORM

Name of wres	stler:			Date of Birth:	
Gender: (Circ	cle one) Male Female				
Parents/Guard	dians that live with child (f	irst emergency conta	icts)		
1.	Name:		Relati	on to child:	
	Work Phone:		_ Home	Phone:	
2.	Name:		_ Relati	on to child:	
	Work Phone:		_ Home	Phone:	
Additional En	marcanari aantaata				
1.	nergency contacts Name:		_ Relati	on to child:	
	Work Phone:		_ Home	Phone:	
2.	Name:		Relati	on to child:	
	Work Phone:		_ Home	Phone:	
Please list at camp. K		ng/bottle that identifies		ion drugs) taken routinely. Bring enough medication to last the entire ribing physician (if a prescription drug), the name of the medication,	
	takes medications on a routin		YES	NO	
If yes, this p Med #1	person takes medications as for			Specific times taken each day	_
Med #2		Dosage		Specific times taken each day	_ - -
Reason Med #3	for taking	Dosage		Specific times taken each day	_
	for taking	20050			_
Atta	ch additional pages for more		at the par	ticipant does/may not take during the summer	
	uestions: (Explain "yes"	_	-		
Has/does the pa		Yes	No	Yes No	

1 Had any recent injury, illness or infectious disease? 2. Have a chronic or recurring illness/condition 3. Ever been hospitalized? 4. Ever had surgery? 5. Have frequent headaches? 6. Ever had a head injury? 7. Ever been knocked unconscious? 8. Wear glasses, contacts or protective eye wear? 9. Ever had frequent ear infections? 10. Ever passed out during or after exercise? 11. Ever been dizzy during or after exercise? 12. Ever had seizures/convulsions? 13. Ever had chest pain during or after exercise? 14. Ever had high blood pressure? 15. Ever been diagnosed with a heart murmur/defect? 16. Ever had problems with joints (e.g., knees, ankles)?	 25. Have problems with sleepwalking? 26. If female, have an abnormal menstrual history? 27. Have a history of bed wetting? 28. Ever had an eating disorder? 29. Ever had emotional difficulties for which professional help was sought? 30. Have a bleeding/clotting disorder? 31. Has the child ever had any of the following diseases? (please give dates where applicable) 	
	German measles	
18. Have an orthodontic appliance being brought to camp?	Mumps	
21. Have asthma? 22. Have any dietary restrictions?	Measles	
	Hepatitis (A,B,or C)	
INSURANCE AND PHYSICIAN INFORMATION	<u>DN</u>	
Child's Medical Insurance Carrier:		
Policy/Group Number:		
Name of policy holder:	Relationship to participant:	
Social Security number of policy holder or insurance ID numb	er:	
Name of Dentist/Orthodontist:	Phone:	
Name of Family Physician:	Phone:	

Please Include a Copy of the wrestler's recent physical exam (within last two years) with doctor's signature and immunization form when returning this form. This will help registration process go more smoothly

General Appraisal:

Is camper capable of participating in an active wrestling school program? (please circle)

	YES	NO		
	Please explain any restric	ctions to activity (e.g. what	at cannot be done, what adaptations or limitations ar	e necessary)
	this space to provide and the about which the came		tion about the participant's behavior and pl	iysical, emotional, or mental
		•		
Parent/G	Guardian Authorization:			
	I understand and certify th		n in the Springfield Wrestling School and its activit my child will be participating.	ies is completely voluntary and I have
	I recognize that certain ha	zards and dangers are inh	nerent in this program and I acknowledge that althou	igh the Springfield Wrestling School
Springfie	eld College cannot insure or	r guarantee that the partic	nize the risk of injury to school participants, the Spr ipants, equipment, premises and/or activities will be	e free of hazards, accidents, and/or
injuries.	I further recognize and havafety of school participants.	re instructed my child in the health history for m	the importance of knowing and abiding by the school y child is correct and he/she has permission to engage	ol's rules, regulations and procedures age in all camp activities except as
	me and/or the examining p	hysician.	ant or supervisor selected by the School Director to	
	ed medicine, and seek emer	gency medical treatment	including ordering x-rays, and routine tests for the	health of my child. In the event that I
insuranc	e, secure proper treatment f		to the physician selected by the School Director to and/or anesthesia and/or surgery for my child as nan	
applicati	ion/registration form.			
Studer	nts name:			
Parent	/guardian signature			
Please	print name:		Date:	
Witnes	ss signature:			
Please	print name:		Date:	
i aiso u	inaerstana and agree to) abide by any restric	tions placed on my participation in Spring	neia wrestling School

Activities: