***Team Red Devil Wrestling Club Registration***

## Player Registration

**Player Name:** ____________________ **Phone:** ____________ **Date of Birth:** ____________

**Address:** ____________________ **City:** ____________ **State:** ____________

____________________ **Zip Code:** ____________ **Email:** ____________

**Years of Experience( Do not include this year)** ______

**Gender:** ☐ Male ☐ Female **Height:** ____________ **Weight:** ____________

**Gaurdian Name:** ____________________ **Phone:** ____________ **Relationship:** ____________

**Gaurdian Name:** ____________________ **Phone:** ____________ **Relationship:** ____________

**Emergency Contact:** ____________________ **Phone:** ____________ **Relationship:** ____________

## Clothing Sizes

| | | | |
|---|---|---|---|
| **Shirt Sizes:** | ☐ Youth Small<br>☐ Youth Medium<br>☐ Youth Large | ☐ Adult Small<br>☐ Adult Medium<br>☐ Adult Large | ☐ Adult X- Large<br>☐ Adult XX-Large<br>☐ Other |
| **Pant Sizes:** | ☐ Youth Small<br>☐ Youth Medium<br>☐ Youth Large | ☐ Adult Small<br>☐ Adult Medium<br>☐ Adult Large | ☐ Adult X- Large<br>☐ Adult XX-Large<br>☐ Other |

## Fundraiser

**Boxes of Candy Bars:** ________ **boxes** **Elect $25 buyout** ________
**1 box required or buyout**

## Parent Participation

It will be mandatory for one parent of each child, except for coaches, to work the home meet and one away meet. More information will be provided at the mandatory parents meeting.

Please print name if you would be willing to help coach. ______________________________

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## Medical Information

**Preferred Doctor Name:** ______________________ **Phone:** ______________________

**Preferred Dentist Name:** ______________________ **Phone:** ______________________

**Insurance Carrier** ______________________ **Phone:** ______________________

| **Medical History** |
| --- |
| (Please specify any allergies, medications, special conditions, etc: |

## Medical Information

| **Part 1 - Grant of Consent** | | |
| --- | --- | --- |
| In the event reasonable attempts to contact the parents or guardians have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by preferred Dr. (2), or preferred Dentists or in the event designated Dr. or Dentist is not available, by another licensed physician or dentist; and (3) the transfer of the child to preferred hospital or any hospital reasonably accessible.<br><br>Note: This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in necessity for such surgery are obtained before the surgery is performed. | | |
| **(Print)**<br>**Paticipant Name:** | **(Signature)**<br>**Parent/Gaurdian:** | **Date:** |

| **Part 2 - Refusal of Consent (Do not complete if Part 1 has been completed)** | | |
| --- | --- | --- |
| I do NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish that Team Red Devil Wrestling Club to take no action, or perform the following actions:<br><br>Actions to be Performed: | | |
| **(Print)**<br>**Paticipant Name:** | **(Signature)**<br>**Parent/Gaurdian:** | **Date:** |

## Release

| The above enrollee or legal guardian of said enrollee in consideration of the activity indicated hereby releases and discharges Team Red Devil Wrestling Club, Tipp Monroe Community Services, Inc., the City of Tipp City, the Monroe Twp Trustees and the Tipp City Exempted Village School Board of Education and their assignees from any liability whatever, and will hold them harmless from judgement brought against them. | |
| --- | --- |
| **Parent/ Guardian Signature:** | **Date:** |

| **Medical release on file (Good for 12 Months)** | **Date:** |
| --- | --- |