Glen Este Youth Wrestling
Emergency Medical Authorization

I hereby give my permission for my son/daughter _____ to participate in Glen Este Youth Wrestling activities. I also certify that I will not hold the organization or any personnel associated with the organization liable for damages in case of accident or injury.

_____	_____	_____
Parent/Guardian Name – please print	Parent/Guardian Signature	Date

EMERGENCY MEDICAL AUTHORIZATION

Child's Name _____ Date of Birth _____

Address _____

Purpose: To enable parent/guardian to authorize the provision of emergency treatment for children who become ill or injured while under organization authority, when parent/guardian cannot be reached.

Part 1 – TO GRANT CONSENT

Residential Parent/Guardian

Mother's Name _____ Home Phone _____ Cell Phone _____

Father's Name _____ Home Phone _____ Cell Phone _____

Other Family Name _____ Home Phone _____ Cell Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Doctor _____ Phone _____ Dentist _____ Phone _____

Medical Specialist _____ Phone _____ Preferred Hospital _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above named doctor or in the event the designated preferred physician is not available, by another licensed physician or dentist and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning my child's medical history including allergies, medications and medical conditions to which a physician should be alerted

_____

Date _____ Signature of Parent/Guardian _____