

# RELEASE AND MEDICAL AUTHORIZATION

\*\*\*\*\*No camper will participate until this form is completed\*\*\*\*\*

## RELEASE OF LIABILITY

In consideration of the All-American Wrestling granting the student permission to participate in this wrestling camp, I hereby assume all risks of personal injury (including death) that may result from any camp activity. As a guardian I do hereby release the All-American Wrestling, Harlem High School, and their officers, employees and agents, and all instructors and all participants in this camp 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 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

Camper'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 camp. (Each camper 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 student is attending the All-American Wrestling Camp.

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 camp activities, including a Physician's Authorization.

\_\_\_\_\_  
Parent's/Guardian Signature

\_\_\_\_\_  
Athlete's Signature

Camper \_\_\_\_\_  
(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**

Address \_\_\_\_\_

Office Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

**Please return to:**  
**All-American Wrestling Camps**  
**P.O. Box 206**  
**DeKalb, IL 60115-206**