

**Pierce County Junior Wrestling League and  
Franklin Pierce Jr. Wrestling Medical Waiver**

Wrestler's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School: \_\_\_\_\_ Grade \_\_\_\_\_ Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_ Drug sensitivities: \_\_\_\_\_

Is child presently on medication? **Yes No** List Medications: \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_ Cell phone (emergency): ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_ Cell phone (emergency): ( ) \_\_\_\_\_

**HOLD HARMLESS AND INDEMNITY AGREEMENT**

*I, Parent or Guardian of the above named child, hereby give my consent to such child's participation in the authorized activities of the Franklin Pierce Junior Wrestling Program. I understand that wrestling is an activity which involves bodily contact and that occasionally participants suffer some injuries. In consideration of the organization's permitting my child to participate in its programs, I agree to hold it, its coaches, officers or referees harmless from any claims for personal injuries that may result to the above named child in the course of his/her participating in the organization's activities, and to indemnify it in the event it is compelled to pay any claim thereon.*

*I, Parent or Guardian of the above named child, agree to provide or arrange transportation for my wrestler to all wrestling matches/tournaments, and to release the Franklin Pierce Junior Wrestling organization from any responsibility for my child during transportation.*

**Signature of Parent/Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PARENTAL INSTRUCTIONS CONCERNING MEDICAL TREATMENT**

Please read the 2 statements below and **sign ONLY the 1** that you choose.

1. If my child needs medical attention, it is my wish that I be contacted before any medical procedures are done on my child unless immediate treatment is necessary to save my child's life or to prevent permanent damage. I accept responsibility for all costs related to such treatments.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OR**

2. If my child needs medical treatment while participating, it is my wish that treatment begin while efforts are being made to contact me. I accept responsibility for all costs related to such treatments.

**Signature of Parent/Guardian** \_\_\_\_\_ **Date:** \_\_\_\_\_