



400 Swenson Drive, Kenilworth NJ 07033
WRESTLING MEDICAL RELEASE

I hereby give my permission for any and all medical attention necessary to be administered to my child,

(INSERT CHILD'S NAME)

In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted, this release is effective until rescinded. I also assume the responsibility for the payment of any such treatment, including, but not limited to transportation for required treatment.

Parent/Guardian: _____
Address: _____
Relationship: _____
City/State/Zip: _____
Home Phone: _____ Office Phone: _____ Cell Phone: _____
Name of Insurance Company: _____
Group Number: _____ Policy Number: Type: _____

In case I cannot be reached, any of the following people are designated to act on my behalf:

Apex Wrestling LLC. Coaches, Trainers and Personnel

In case I cannot be reached, please call at _____.
Our Physician's Name: _____ Address: _____
City/State/Zip: _____
Phone: _____ Hospital: _____
Known Allergies: _____
Known Disabilities: _____
Other Important Medical Information: _____

Apex Wrestling School LLC. is not responsible or liable in any way in the event of harm or injury occurring to the child. It is agreed that the parent or guardian will not hold Apex Wrestling School LLC. responsible for the welfare or whereabouts of the child. If the Parent or Guardian does file a complaint against Apex Wrestling School LLC. the Parent or Guardian agrees to pay for Apex Wrestling School LLC 's legal fees.

Signature of Parent/Guardian: _____ Date: _____

Staff
Signature: _____ Date: _____