



USA WRESTLING



PARENT'S INSTRUCTIONS ON MEDICAL TREATMENT

PLEASE PRINT IN CAPITAL LETTERS

Wrestler's Name _____ Date of Birth _____ Grade _____

Parent/Guardian Name _____ Relationship _____

Address _____ City _____ Zip Code _____

Home Phone _____ Work Phone _____

Please indicate another person to call if an accident occurs and we are unable to reach you:

Name _____ Phone No. _____

Insurance Company _____ Policy No. _____

Family Doctor _____ Phone No. _____

Is your child presently on medication? _____ If yes, please list medication (s): _____

Drug Sensitivities _____

Other Allergies _____

Date of your child's last complete physical examination by a medical doctor _____

If this is more than one year ago, please complete the accompanying medical history questionnaire.

Please read the alternative statements below and sign under the one that you choose. Sign only one!

1. If my child needs medical attention, it is my wish that I am contacted before any medical procedures are taken on my child, unless immediate treatment is necessary to save my child's life or to prevent permanent injury.

Parent/Guardian Signature _____ Date Signed _____

2. If my child needs medical treatment while participating, it is my wish that the treatment is started while efforts are being made to contact me. So that treatment is not delayed, I consent to any medical procedures that the physician believes are needed, on the understanding that efforts to contact me will continue to be made. I accept responsibility for all costs related to such treatment.

Parent/Guardian Signature _____ Date Signed _____

Wrestler's USA Wrestling Card No. _____

Name of Club _____

Coach's Name _____ Phone No. _____

High School _____



USA WRESTLING

MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT IN CAPITAL LETTERS

Wrestler's Name _____ USA Card No. _____

Emergency Contact _____ Phone No. _____

PLEASE CIRCLE THE CORRECT ANSWER, ALL INFORMATION WILL BE CONFIDENTIAL

Yes No 1. Are you allergic to any general medication (aspirin, sulfa, penicillin, etc.)? If so please indicate what medication(s) _____

Yes No 2. Are you now on any prescribed medication on a permanent or semi-permanent basis? If so, please indicate the name of the medication and why it was prescribed _____

Yes No 3. Have you ever had an epileptic seizure or been informed that you might have epilepsy? _____

Yes No 4. Have you ever been treated for diabetes? If so, please indicate the type(s) of insulin or pills you use. _____

Yes No 5. Has a medical doctor ever told you that you were anemic or had sickle cell anemia?

Yes No 6. Do you have or have you ever had high blood pressure? If so, list any medication for it that you take regularly _____

Yes No 7. Do you have or have you ever had any of the following diseases? If so, please circle the appropriate ones.

- | | |
|---------------------------------|---------------------------|
| Heart disease (rheumatic fever) | Liver disease (hepatitis) |
| Kidney disease (infections) | Lung disease (pneumonia) |

Yes No 8. Have you ever been informed by a medical doctor that you have asthma? If so, what medications, if any, do you take regularly _____

Yes No 9. Do you presently have an unrepaired hernia?

Yes No 10. Have you ever been "knocked out" or experienced a concussion during the past 3 years? If so, give the dates of each _____

Yes No 11. If the answer to No. 10 is "yes", did the attending physician have you stay overnight in a hospital? If yes, give the dates of each _____

Yes No 12. Have you ever had an injury to your neck involving nerves, vertebrae (bones), or Discs that incapacitated you for a week or longer? If yes, give the dates of each such injury. _____

Yes No 13. Do you wear any dental appliance? If yes, circle the appropriate appliance

- | | |
|--------------------|---------------------------|
| Permanent bridge | Permanent crown or jacket |
| Braces Full plate | Removable partial plate |
| Permanent retainer | Removable retainer |

PLEASE TURN THIS FORM OVER AND COMPLETE THE OTHER SIDE. THANK YOU.

- Yes No 14. Do you wear contact lenses during competition?
- Yes No 15. Have you had a fracture during the past 2 years? If yes, indicate which bone was broken and broken and the date if happened. _____
- Yes No 16. Have you had a shoulder dislocation, separation or other shoulder injury in the past 2 years That incapacitated you for a week or longer? If so, give the date of the injury.

- Yes No 17. Have you ever had surgery to correct a shoulder condition? If so, give the dates and what was done.

- Yes No 18. Have you ever had an injury to your back?
- Yes No 19. Do you experience Pain in your back? If yes, indicate frequency:
- | | | |
|------------------------|--------------------|------------|
| Seldom | Occasionally | Frequently |
| With vigorous exercise | With heavy lifting | |
- Yes No 20. Have you injured your knee during the past 2 years with severe swelling as a result?
- Yes No 21. Have you ever been told that you injured the ligaments and/or cartilage of either knee?
- Yes No 22. Have you ever been advised to have surgery to correct a knee problem?
- Yes No 23. If the answer to No. 22 is yes, has the surgery been completed? Date _____
- Yes No 24. Have you experienced a severe sprain of either ankle during the past 2 years?
- Yes No 25. Have you had any injury to your foot or toes in the past 2 years? If yes, explain:
- Yes No 26. Do you have any chronic conditions that have not been mentioned above? If so, explain:

The questions on both sides of this form have been answered completely and truthfully to the best of my knowledge.

Wrestler's Signature _____ Date _____

Parent/Guardian Signature _____

