

Select _____
General _____

PAID Yes/No



Cobras Wrestling And Development Club

Wrestler: _____ USA CARD# _____

Weight: _____ Age: _____ B.D. ____/____/____

Address: _____ City: _____ Zip: _____

Print Parent(s)/Guardian(s) Name

Print Parent(s)/Guardian(s) Name

Work# _____ Home _____ Cell# _____

Health Insurance: _____ Policy# _____ Group# _____

If injury is serious, do you wish to have your family physician care for your child? Yes _____ No _____

If the physician can't be reached immediately, I authorize paramedics/ER physician(s) to treat my child and take any necessary action if injury is serious or life threatening. Yes _____ No _____

Name of Physician _____ Phone: _____

Address: _____ City: _____ Zip: _____

I am aware of the potential dangers of California USA Wrestling state and local events. I realize that the risk of injury may be severe including varieties of sprains, fractures, contusions, brain injuries, paralysis or even death. I further realize that my son/daughter needs to follow carefully all the guidelines given by the coaching staff and tournament/event organizers regarding training rules, safety procedures, proper use of equipment, legal and safe playing techniques and any and all other safety procedures. I understand that even if all the above is done, my son/daughter may still incur injury through participation in wrestling.

I have read and understand the above statement:

Participant Signature: _____ Date: _____

I have read and understand the above statement and give my son/daughter permission to participate in California USA Wrestling as a member of the Cobras Wrestling Club.

I also give permission for the above named minor to be transported to and from wrestling events, clinics and practices by team staff and coaches.

Parent/Guardian Signature: _____ Date: _____

EMAIL: _____ @ _____