EL DORADO HILLS WRESTLING

MEMBERSHIP APPLICATION & MEDICAL & LIABILITY RELEASE WAIVER

2201 Francisco Dr. #140-200
El Dorado Hills, CA 95762
916-548-3838 or 916-220-7077
email: EDHwrestling@ymail.com

FALL & WINTER- FOLKSTYLE SEASON
SPRING & SUMMER - FREESTYLE & GRECO SEASON

www.EDHsports.com

NAME OF WRESTLER: _____DOB:_____AGE: ____ WT.___
SCHOOL: _____ GRADE: _____ YEARS EXPERIENCE? ____
PARENT/GUARDIAN NAME 1: _____
NAME 2: _____
HOME PHONE: _____ DAD CELL: _____
MOM CELL: _____ WRESTLER CELL: _____
DAD EMAIL: _____MOM EMAIL: _____
Important: Please print email addresses clearly
MAILING ADDRESS: _____
CITY/ STATE/ ZIP: _____
EMERGENCY CONTACT NAME: _____ PHONE: _____
PRIMARY PHYCIAN NAME: _____ PHONE: _____
PRIMARY DENTIST NAME: _____ PHONE: _____
HEALTH COVERAGE? Y/N ___ NAME OF PROVIDER: _____
POLICY # _____ GROUP #_____ PHONE: _____

I, the undersignhed parent or guardian do hereby grant permission for my son / daughter _____ to train at GHS or the El Dorado Hills Wrestling Club facility. I acknowledge, understand and agree that in that my son / daughter is assuming risk of such injury / illness by his / her participation. I assume full responsibility for my son / daughter's participation. I understand that membership in EDHWC may be revoked at any time without refund if my son / daughter fails to comply with club rules.

In order that my son / daughter / I many receive necessary medical treatment in the event of injury or illness, I hereby authorize the EDH Wrestling Club Staff / Coaches to facilitate medical treatment for my son / daughter for such illness or injury sustained during time in the wrestling room / gym. Furthermore, EDH Wrestling Club founders, principals, board members, owners and coaches and GHS staff will not be held responsible for any injury or illness incurred while my son / daughter is in the wrestling room, gym or traveling to or from and event.

Parent/Guardian Name: (Please Print) _____ (Participants 18 yrs of age may sign for self)

Parent/Guardian Signature: _____ Date: _____

Note: This information is only used for member identification and medical emergency.

Please check any known medical conditions that the coaches should be aware of:

Allergies: Food: _____ Bee Stings: _____ Antibiotics: _____ Other: _____
Does Child have Asthma? Y/N ___ Carrys Medication? _____
Any Orthopedic Conditions that will limit safe participation in any activity: (be specific) _____
_____

MEMBERSHIP TUITION DUES: FALL/WINTER SEASON: AGE 7-14 ____$245 ____ +$50 S.R. (Extra ½ hr)
FALL/WINTER SEASON: AGE 4 - 6 ____$195 Normal Season Rate
Checks Payable to: SPRING/SUMMER: AGE 8-19 ____$195 EARLY Rate ____$245 Normal Rate
EDH Wrestling SPRING/SUMMER: AGE 4-7 ____$145 EARLY Rate ____$195 Normal Rate

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_____ Check or Visa or Mastercard Accepted
Signature

Amount Paid?_____ Date:_____ BIRTH CERTIFICATE VERIFIED BY: _____
USA WRESTLING CARD #:_____ SCWAY CARD #: _____