

SHARKS WRESTLING CLUB

MEMBERSHIP APPLICATION

Wrestler's Name: _____ Date of Birth: _____

Age: _____ Weight: _____ Shirt Size: S M L XL XXL (circle one)

Parent/Guardian Name: _____ Relationship: _____

Address: _____

City: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

E-Mail: _____

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

Name: _____ Phone: (_____) _____

The undersigned, _____, hereby expressly consents and
(Parent or Legal Guardian)

agrees that _____ may participate in the Sharks
(Wrestlers Name)

Wrestling Club from November 5, 2026 through September 1, 2027.

The undersigned further expressly agrees that in consideration of the foregoing and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledge, to indemnify, save and hold harmless and defend Main Township School District 207, Maine Township West High School, Sharks Wrestling Club, IKWF, and its Board, members, officers, and employees thereof, against all suits, actions, legal proceedings, claims and demands and against all damages, losses, costs and expenses and attorney's fees in any manner caused by, arising from, incidental to and/or connected with or growing out of such participation.

I HAVE SIGNED THIS _____ DAY OF _____, 2026.

SIGNATURE OF PARENT/GUARDIAN: _____

WELCOME TO THE SHARKS WRESTLING CLUB

Maine Township High School District 207

Waiver and Release From Liability

AS A CONDITION OF ENROLLMENT, THE FOLLOWING DISCLAIMER OF LIABILITY MUST BE SIGNED AND DATED BY THE PARTICIPANT'S PARENTS OR GUARDIAN. THE PARTICIPANT, IN ATTENDING THE **SHARKS WRESTLING CLUB**, DOES SO AT THE PARTICIPANT'S OWN RISK. THE **SHARKS WRESTLING CLUB**, THE BOARD OF EDUCATION OF MAINE HIGH SCHOOL DISTRICT 207, ITS MEMBERS, OFFICERS, EMPLOYEES, ATHLETIC DEPARTMENT, STAFF, AGENTS AND VOLUNTEERS (COLLECTIVELY "SCHOOL DISTRICT 207") SHALL NOT BE LIABLE FOR ANY DAMAGES ARISING FROM PERSONAL INJURY SUSTAINED BY THE PARTICIPANT WHILE PARTICIPATING OR ATTENDING THE **SHARKS WRESTLING CLUB**. THE PARTICIPANT AND HIS/HER PARENTS OR GUARDIAN ASSUME ALL RESPONSIBILITY FOR ANY DAMAGES OR INJURIES THAT MAY OCCUR TO THE PARTICIPANT WHILE PARTICIPATING OR ATTENDING THE **SHARKS WRESTLING CLUB** AND SO HEREBY FULLY AND FOREVER EXONERATE AND DISCHARGE SCHOOL DISTRICT 207 FROM ANY AND ALL CLAIMS, DEMANDS, DAMAGES, RIGHTS OF ACTION OR CAUSES OF ACTION, PRESENT AND FUTURE, WHETHER THE SAME BE ANTICIPATED, OR UNANTICIPATED, RESULTING FROM OR ARISING OUT OF THE PARTICIPANT'S ATTENDANCE OR PARTICIPATION IN THE PROGRAM. TO THE EXTENT PERMITTED BY LAW, THE PARENTS OR GUARDIAN SHALL INDEMNIFY AND HOLD HARMLESS SCHOOL DISTRICT 207 FROM ANY CLAIM, LOSS, OR EXPENSE WHATSOEVER, INCLUDING WITHOUT LIMITATION REASONABLE ATTORNEYS' FEES, BROUGHT AGAINST OR SUFFERED BY SCHOOL DISTRICT 207 DUE TO ANY INJURY OR LOSS IN CONNECTION WITH THE PARTICIPANT'S PARTICIPATION IN THE PROGRAM OR ARISING OUT OF A CLAIM DIRECTLY OR INDIRECTLY RELATED TO SUCH USE BROUGHT BY ANY OTHER PERSON AND ARISING OUT OF THE PARTICIPANT'S ACTS OR OMISSIONS.

STUDENT NAME _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____

PRINT NAME _____

DATE _____ (RELATIONSHIP TO PARTICIPANT) _____

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 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 _____

Date _____

USA WRESTLING

PARENT'S INSTRUCTIONS ON MEDICAL TREATMENT

PLEASE PRINT IN CAPITAL LETTERS

Wrestler's Name _____ Date of Birth _____

Parent/Guardian Name _____ Relationship _____

Address _____

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 Number _____