

Beacon Wrestling Clinic Parent Consent

I give my son _____ permission to participate in the wrestling clinic held at Beacon High School. I hereby give my consent to have an athletic trainer, coach, emergency medical technician, nurse, medical treatment facility, and/or doctor of medicine or dentistry or associated personnel provide the applicant/participant with medical assistance and/or treatment and agree to be financially responsible for the cost of such assistance and/or treatment. I understand treatment for injury will be based on information provided herein. I hereby authorize emergency transportation of the applicant/participant to a medical treatment facility should an individual listed above consider it to be warranted. I recognize the possibility of physical injury associated with wrestling, and hereby release, discharge, and otherwise indemnify the team, Beacon High School, the employees and associated personnel of the organization, and affiliated organizations against any claim by or on behalf of the wrestler named above as a result of that wrestler's participation in the open mats. I hereby authorize the use of the above named individual's name and image in promotional publications for Beacon Wrestling. By signing below, I acknowledge that I have read, understand, and accept the above contractual agreements.

Signature Date: _____

Signature: _____

Relation to Wrestler: Father Mother Guardian

Emergency Contact: _____

Emergency Contact number: _____

Wrestlers info:

Name: _____