

# GOMEZ WRESTLING ACADEMY

WRESTLER'S FULL NAME \_\_\_\_\_  
LAST FIRST M.I.

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ GRADE \_\_\_\_\_

HAVE YOU WRESTLED BEFORE? \_\_\_\_\_ YEARS OF EXPERIENCE \_\_\_\_\_

TYPE: FOLKSTYLE \_\_\_\_\_ FREESTYLE \_\_\_\_\_ GRECO ROMAN \_\_\_\_\_

CLUBS/SCHOOLS WRESTLED FOR \_\_\_\_\_

DO YOU PLAY ANY OTHER SPORTS? Please List \_\_\_\_\_

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APPROXIMATE HEIGHT \_\_\_\_\_ APPROXIMATE WEIGHT \_\_\_\_\_

MOTHERS NAME \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CAN WE CALL YOU AT WORK? Y N

E-MAIL ADDRESS \_\_\_\_\_

FATHERS NAME \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CAN WE CALL YOU AT WORK? Y N

E-MAIL ADDRESS \_\_\_\_\_

EMERGENCY CONTACT NAME \_\_\_\_\_

PHONE # 1 \_\_\_\_\_ PHONE # 2 \_\_\_\_\_

RELATIONSHIP TO WRESTLER \_\_\_\_\_

INSURANCE CARRIER \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ ID NUMBER \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

HOSPITAL YOU PREFER \_\_\_\_\_

DOES YOUR CHILD HAVE ANY MEDICAL CONDITIONS? \_\_\_\_\_

IF YES, PLEASE LIST \_\_\_\_\_

IS YOUR CHILD TAKING ANY MEDICATIONS? \_\_\_\_\_

IF YES, PLEASE LIST \_\_\_\_\_

IS YOUR CHILD ALLERGIC TO ANY MEDICATIONS OR HAVE ANY OTHER ALLERGIES? \_\_\_\_\_

IF YES, PLEASE LIST \_\_\_\_\_

DATE OF YOUR CHILDS LAST PHYSICAL EXAM \_\_\_\_\_

PLEASE CHECK IF ANY OF THE FOLLOWING APPLY:

\_\_\_\_\_ CONTACT LENSES \_\_\_\_\_ FRACTURE IN THE LAST 2 YEARS

\_\_\_\_\_ SHOULDER DISLOCATION, SEPARATION OR OTHER INJURY IN THE LAST 2 YEARS.

\_\_\_\_\_ JOINT SURGURY \_\_\_\_\_ BACK INJURY

\_\_\_\_\_ ANY JOINT INJURY IN THE LAST 2 YEARS

PLEASE GIVE DETAILS BELOW FOR ANY CONDITIONS CHECKED ON THE PREVIOUS PAGE.

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DOES THE WRESTLER HAVE ANY MEDICAL CONDITIONS THAT HAVE NOT BEEN MENTIONED ABOVE? If YES, PLEASE EXPLAIN \_\_\_\_\_

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**THE QUESTIONS ON THIS FORM HAVE BEEN ANSWERED COMPLETELY AND TRUTHFULLY TO THE BEST OF MY KNOWLEDGE.**

WRESTLERS SIGNATURE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

## **MEDICAL/SURGICAL RELEASE**

IN THE EVENT MY CHILD/WARD REQUIRES MEDICAL TREATMENT, IT IS MY WISH THAT TREATMENT BE STARTED WHILE EFFORTS ARE BEING MADE TO CONTACT ME. SO THAT TREATMENT NOT IS 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 THAT TREATMENT.

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SIGNATURE OF PARENT/GUARDIAN

DATE

**WAIVER AND RELEASE  
HOLD HARMLESS AGREEMENT**

PLEASE READ THIS FORM CAREFULLY AND BE AWARE THAT IN REGISTERING YOUR CHILD/WARD FOR PARTICIPATION IN PROGRAMS OFFERED BY GOMEZ WRESTLING ACADEMY THAT YOU WILL BE WAIVING AND RELAEASING ALL CLAIMS FOR INJURIES YOUR CHILD/WARD MAY SUSTAIN IN PARTICIPATING IN INSTRUCTION AND COMPETITION THRU GOMEZ WRESTLING ACADEMY.

I RECOGNISE AND ACKNOWLEDGE THAT THERE ARE CERTAIN RISKS OF PHYSICAL INJURY TO PARTICIPANTS IN WRETLING AND I AGREE TO ASSUME THE FULL RISK OF ANY SUCH INJURIES, DAMAGES OR LOSS, REGARDLESS OF SEVERITY THAT MY CHILD/WARD MAY SUSTAIN AS A RESULT OF PARTICIPATING IN ANY ACTIVITIES ASSOCIATED OR CONNECTED WITH GOMEZ WRESTLING ACADEMY. I WAIVE OR RELINQUISH ALL CLAIMS I OR MY CHILD/WARD MAY HAVE AGAINST GOMEZ WRESTLING ACADEMY, IT'S COACHES, OFFICES EMPLOYEES OR VOLUNTEERS, AS A RESULT OF PARTICIPATING IN ANY OF ITS PROGRAMS OR ACTIVITIES. I HEARBY FULLY RELEASE AND DISCHARGE GOMEZ WRESTLING ACADEMY AND ITS OFFICERS, COACHES AND VOLUNTEERS FROM ANY AND ALL CLAIMS RESULTING FROM INJURIES, DAMAGES AND LOSSES SUSTAINED BY MY CHILD/WARD AND ARISING FROM, CONNECTED WITH, OR IN ANY WAY ASSOCIATED WITH THE ACTIVITIES OF GOMEZ WRESTLING ACADEMY.

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SIGNATURE OF PARENT/GUARDIAN

DATE

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SIGNATURE OF PARENT/GUARDIAN

DATE

# **GOMEZ WRESTLING ACADEMY SPRING/SUMMER 2010 TUITION AGREEMENT**

SPRING AND SUMMER SEASON  
APRIL 1, 2010 TO AUGUST 31, 2010

\$900.00

IKWF CARD FEE – ONLY IF NEEDED (PAYABLE TO IKWF) \$35.00

TUITION IS DUE ON THE 1<sup>ST</sup> DAY OF THE MONTH DURING THE OFF SEASON.

A DEPOSIT OF \$300.00 IS DUE AT THE TIME OF REGISTRATION TO GUARENTEE YOUR CHILD’S SPOT. THE BALANCE WILL BE DUE IN 4 MONTHLY PAYMENTS OF \$150.00 DUE THE FIRST DAY OF MAY, JUNE, JULY AND AUGUST. THE FULL BALANCE MUST BE PAID NO LATER THAN AUGUST 31<sup>ST</sup>.

A LATE FEE OF \$15 PER WEEK WILL BE ASSESSED ON ALL LATE PAYMENTS.

NO REFUNDS WILL BE ISSUED AFTER 14 DAYS.

I, \_\_\_\_\_ AGREE TO THE TERMS OUTLINED ABOVE. I AGREE TO MAKE ALL PAYMENTS ON A TIMELY BASIS, AND I AGREE THAT IN THE EVENT THAT I MISS A PAYMENT DUE DATE THAT I WILL BE ASSESSED A LATE PAYMENT CHARGE. IN THE EVENT THAT A PAYMENT IS RETURNED BY MY BANK, I AGREE TO PAY ALL COSTS ASSOCIATED IN COLLECTING THE PAYMENT AS WELL AS A \$35.00 RETURNED CHECK FEE. AFTER THE REFUND PERIOD HAS PASSED, I UNDERSTAND THAT I AM LIABLE FOR PAYMENT IN FULL REGARDLESS OF MY CHILDS ATTENDANCE AND PARTICIAPATION.

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SIGNATURE OF PARENT/GUARDIAN

DATE

