

# Iowa State Wrestling Camps Release Form

**Name of Participant** (print full legal name) \_\_\_\_\_  
**Birth Date** \_\_\_\_\_ **Gender** (circle one) **Male** **Female**  
**Camp Attending** \_\_\_\_\_  
**Parent/Guardian** \_\_\_\_\_  
**Emergency Phone Number** \_\_\_\_\_

## Physician Authorization, Release of Liability and Medical Authorization

These three segments must be filled out and signed by a parent or guardian. Students who are 18 years old or will become 18 years old before or during the camp must also sign. In order for students to participate in camp activities, we must have this signed form returned prior to the camp's start date. These forms can be delivered at Check-In.

### Physician's Authorization to Participate

This certifies that (name) \_\_\_\_\_ was examined by me on (date) \_\_\_\_\_ (valid within one year of camp) and I found him/her to be physically able to participate in vigorous physical and competitive athletic activities (School physical form accepted if valid within one year of camp). Allergies/Drug sensitivities \_\_\_\_\_  
Other medical problems/current medications \_\_\_\_\_  
Is an identification band or card carried to alert others to the allergies), medical conditions or medication use? Yes \_\_\_\_\_ No \_\_\_\_\_  
Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Office Phone \_\_\_\_\_

### Release of Liability to Participate

In consideration of Kevin Jackson's Iowa State Wrestling Camps of Iowa State University; In granting (name) \_\_\_\_\_ permission to participate in camp, I hereby assume all risks of his/her personal injury (including death) that may result from any Iowa State Wrestling Camp activity. As a Parent/Guardian, I do hereby release the Iowa State Wrestling Camp, it's officers, employees or agents from all liability, including claims and suits of law or in equity, for loss, damage or injury, fatal, or otherwise which may result from the student taking part in Iowa State Wrestling Camp activities.  
Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Medical and Surgical Authorization

In addition, I hereby authorize and give my consent to the health authorities of Iowa State University or any licensed health professional to treat or administer any reasonable, necessary surgical or medical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during the medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, and minor operations and procedures. In the case of psychiatric and/or psychological treatment; parent authorization for treatment beyond that responsive to the emergency will be requested. I agree to assume all costs related to such treatment. I authorize my insurance company to pay benefits to Iowa State University Theilen Student Health Center or other hospitals and clinics. Also, I authorize the disclosure of medical information to my insurance company for purpose of claim. I understand that I will be responsible for any medical expenses or other charges in connection with my child's attendance at this camp.  
Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

### Insurance Information (please print)

**Name of Insured** \_\_\_\_\_ **Policy Holder** \_\_\_\_\_  
**Insurance Company** \_\_\_\_\_  
**Insurance Co. Address** \_\_\_\_\_  
**Policy No.** \_\_\_\_\_ Does your insurance carrier require prior approval? Yes \_\_\_\_\_ No \_\_\_\_\_

This form must be on file for you to participate in the Iowa State Wrestling Camps. A copy of a current physical (within one year) may serve as the physician's authorization portion of this form. Please contact the camp office for any questions concerning the information in this document. (Each camper must provide his/her own medical insurance information.)

**Iowa State Wrestling Camps**  
**Jacobson Athletic Building - Wrestling**  
**Ames, IA 50011-1140**  
**Phone: 515-294-4872 - Email: [info@istatewrestlingcamps.com](mailto:info@istatewrestlingcamps.com)**

# Iowa State Wrestling Camps

## Medical History Form

Please Provide The Following Important Information:

Past Health (History): \_\_\_\_\_

\_\_\_\_\_

Past Injuries: \_\_\_\_\_

\_\_\_\_\_

Present Health (On Medication?): \_\_\_\_\_

\_\_\_\_\_

Drug Sensitivities: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Cty/St/Zip: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Other Health & Accident Coverage (Medicare, Welfare, etc.): \_\_\_\_\_

\_\_\_\_\_

Policy Holder: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**(Check Box)** I verify that my child has been checked by a licensed physician and is physically able to participate in Kevin Jackson's Iowa State Wrestling Camps. I agree to allow my child to be treated by a licensed physician while attending, if necessary, and to assume all costs related to such treatment. I authorize my insurance company to pay benefits to Student Health Services or University Hospitals. Also, I authorize the disclosure of medical information to my insurance company for the purpose of claim.

Camper Signature (if 18 years old): \_\_\_\_\_

Date: \_\_\_\_\_

Signature (Parent/Guardian): \_\_\_\_\_

Date: \_\_\_\_\_

Additional Room On Back (if needed)

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