CARDINAL WRESTLING CLUB

Cardinal Elite Preseason Segment 2017 Registration Form

PRACTICES: Sundays & Wednesdays from September 6, 2017 to October 29, 2017

TIMES: 11AM–1PM on Sundays & 6:30PM–8:00PM on Wednesdays

LOCATION: Stanford Wrestling Room--basement of Arrillaga Family Sports Center Located at 641 East Campus Drive, Stanford, CA 94305 (downstairs)

REQUIREMENTS:
Must live within 50 miles (as the crow flies) of the Stanford campus
Must have a current USA Wrestling Card (www.usawmembership.com)
Must be able to attend ALL scheduled practice sessions
Must have completed registration form on file (form below)

COST: Elite Fall Segment

- Initial CWC member – $400
- Returning CWC member – $350

**Families with multiple CWC members should contact the CWC staff regarding reduced rates*

Please bring (1) registration, (2) a copy of your current USA Wrestling Card & (3) payment to the 1st session

Name: _____ DOB: _____

Height: _____ Weight: _____ Athlete's Shirt Size: _____ Athlete's Shorts Size: _____

Address: _____

City: _____ Zip: _____ School: _____

Athlete's Email: _____ Parent's Email: _____

Athlete's Cell Phone: _____ Parent's Cell Phone: _____

Emergency Contact: _____ Phone: _____

USA Wrestling Card #: _____ (Mandatory)

I hereby acknowledge that participation in the Cardinal Wrestling Club (CWC) and related activities is at the sole discretion and judgment of the parent or guardian and involves an inherent risk of physical injury. I, on behalf of my child, hereby assume all such risk. I hereby release and agree to hold harmless Stanford University, its Board of Trustees, the CWC, and its founders from all claims, actions, damages, and liabilities for personal injury or damage relating to or arising out of any wrestling club activity. I authorize the CWC to act for me in any medical emergency according to their best judgment, including 911 emergency care if deemed necessary. In case of injury or illness, necessary emergency is authorized without the need to contact the parent or legal guardian. I understand that any and all charges resulting from this medical treatment will be billed to me at my address or to my medical insurance carrier. The CWC and Stanford University are not responsible for lost or stolen property.

Parent/Guardian Signature: _____ Date: _____

PERTINENT MEDICAL INFORMATION

Medical Insurance Company Policy #: _____

Full Name/Address of Insurance Company: _____