ONONDAGA WRESTLING CLUB

Authorization for Medical Treatment of Minors

I (We) being the parent(s) or legal guardians(s) of the below named minor(s), do hereby appoint: **Onondaga Wrestling Club Coach's and Coordinators** to act in my (our) behalf in authorizing unexpected medical, dental or hospital care for the below named minor(s) during the period of my (our) absence, for the **2024-2025 Onondaga Wrestling Club Season.** This document shall be presented to a physician, dentist or appropriate hospital representative at such time as unexpected medical, dental or hospital care may be required.

Name(s) of Minor(s):	Birthdate:	Special Conditions or Allergies:

PARENT / GUARDIAN:

Name:		Insurance Carrier:
Phone:		
Cell 1:		ID or Contract Number:
Cell 2:		

Signature: _____ Date: _____

Witnessed By: _____ Date: _____

Received By: _____ Date: _____