



# Fulton Youth Wrestling Clinic

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Participant \_\_\_\_\_ Coach \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Age: (as of Aug. 1) \_\_\_\_\_ Gender: Male Female  
School: \_\_\_\_\_ Experience (years) \_\_\_\_\_ SHIRT SIZE: \_\_\_\_\_ (YS, YM; YL; AS; AM; AL; AXL; AXXL)  
(Shirts tend to shrink - please order accordingly)  
Address: \_\_\_\_\_  
Parent/Gaurdian Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

You may purchase additional t-shirts for \$10. Pleas list size and quantity of any extra shirt you wish to purchase: \_\_\_\_\_

## Parent's Release and Indemnity Agreement

We (or I) hereby request that you accept the application for enrollment of \_\_\_\_\_ in the Wrestle with the Bull Wrestling Clinic. In consideration of your acceptance of the application, we (or I) hereby release the director, clinicians and counselors of the Wrestle with the Bull Wrestling Clinic along with the Fulton Parks and Recreation Department and all of its employees and the Fulton Kids Wrestling Club from all claims on account of injuries which may be sustained by our (or my) son or daughter while attending the Wrestle with the Bull Wrestling Clinic; and we (or I) agree to indemnify the director, clinicians, and counselors of the Wrestle with the Bull Wrestling Clinic along with the Fulton Parks and Recreation Department and all of its employees and the Fulton Kids Wrestling Club from any claim which may hereafter be presented by our (or my)son or daughter of any such injuries.

In the event of illness or injury , we (or I) hereby give our (or my) consent for medical treatment and permission to the attending physician to hospitalize , secure proper treatment, and order injections, anesthesia or surgery. We (or I) will be responsible for any medical and other charges in connection with our (or my) son's or daughter's attendance at this camp. (If there are any restrictions on his or her participation, please explain on a separate sheet.)

\_\_\_\_\_  
Signature of parent/guardian Date: \_\_\_\_\_  
Relationship to participant: \_\_\_\_\_  
Medical Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

FORMS SHOULD BE RETURNED ALONG WITH REGISTRATION FEE BY **OCTOBER 24th**, TO:

## ***FULTON PARKS AND RECREATION DEPT.***

P.O. BOX 130  
FULTON, MO 65251

PHONE: 573-592-3190

FAX: 573-592-3199

E-MAIL: [fpr@fultonmo.org](mailto:fpr@fultonmo.org)

CHECKS or MONEY ORDERS CAN BE MADE PAYABLE TO: **FULTON WRESTLING CLUB**