

2010

# Byrnes Wrestling Camp

July 19, 20, 21, 22 & 23

8 AM to Noon

James F. Byrnes H.S.

Schofield Gym



## Registration Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: M F

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent /Legal Guardian \_\_\_\_\_ Other Phone \_\_\_\_\_

NUWAY CARD #: \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Wrestled last year? **Yes / No** - Team \_\_\_\_\_ Coach \_\_\_\_\_

Comments / list other sports played \_\_\_\_\_

### Authorization & Waiver by Parent(s) or Legal Guardian of Minor Child

I am aware that Wrestling is a very physical contact sport and participating in wrestling has certain risks and may cause injury to participants. However, I want my child, mentioned above, to participate in the Rebels Wrestling sponsored practices, games, and, tournaments (Activities). Knowing this, I give my permission and consent for my child to participate in Rebels Wrestling Activities.

I, and on behalf of my child, hereby indemnify, release, hold harmless, and forever discharge District Five Schools, James F. Byrnes H.S., Rebels Wrestling, the directors thereof, and its agents, employees, officers, directors, affiliates, successors, and assigns, of and from any and all claims, demands, debts, contracts, expenses, causes of action, lawsuits, damages, and liabilities, of every

kind and nature, whether known or unknown, in law or equity, that I or my child ever had or may have, arising from or in any way related to my child's participation in or transportation to and from any Activities conducted by, on the premises of, or for the benefit of, Rebels Wrestling.

In the event I cannot be reached, I authorize and direct any adult Rebels Wrestling representative to make emergency medical decisions for my child. My child is subject to the following allergies or medical conditions, and I authorize Rebels Wrestling to disclose such allergies or medical conditions to a physician in the event my child should require emergency medical care.

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

**Please provide detailed description on known allergies or medical conditions.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Send \$50 check payable to Byrnes Wrestling to:

James F. Byrnes H.S.

Attn: Coach Russ Howard

PO Box 187

150 E. Main Street

Duncan, SC 29334

Phone: 864-949-2364

Fax: 864-949-2342

E-mail: russ.howard@spart5.net