



CARDINAL WRESTLING CLUB

Winter Series 2011-12

Registration Form

- PRACTICES:** Scheduled Sundays from November 27, 2011 to February 19, 2012
- TIMES:** 5:30PM–7:30PM
- LOCATION:** Stanford Wrestling Room--basement of Arrillaga Family Sports Center
Located at 641 East Campus Drive, Stanford, CA 94305
- 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 have completed registration form on file (see below)
- COST:** Winter Series (8 sessions: 11/27, 12/4, 12/11, 1/1, 1/15, 1/22, 2/5 & 2/19)
- Initial CWC member – \$125 (or \$7.81/hour)
 - Returning CWC member – \$100 (or \$6.25/hour)
 - Single session – \$25 (or \$12.50/hour)

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

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

Name: _____ DOB: _____

Address: _____

City: _____ Zip: _____ School: _____

Height: _____ Weight: _____

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 this wrestling club 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, and 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: _____