**HIGH SCHOOL TRAINING CAMP**

**Registration**

**NAME:**

**ADDRESS:**

**HIGH SCHOOL:**

**PHONE:**

**EMAIL:**

**Register Online at:**

[**www.Fingerlakeswrestlingclub.com**](http://www.Fingerlakeswrestlingclub.com)

**PLEASE BRING THIS WITH YOU TO REGISTRATION**

In the event of an injury or illness, I give permission for my child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be treated by the FLWC, Cornell Sports Medicine Staff at Cayuga Medical Center, or Convenient Care Center. I give permission for medical staff to administer any medications as indicated on the Providers use and disclose my child’s protected health information for payment, treatment, and health care operations purposes. Protected health information includes but is not limited to, medical, billing, and demographic collected and or created by the FLWC or above service providers. I understand that I will be responsible for all charges for health services by FLWC or off Campus providers.

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**Signature of Parent/Guardian DATE**

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**Signature of Wrestler DATE**