ACKNOWLEDGEMENT AND ASSUMPTION OF RISK

PARTICIPATION IN WRESTLING

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, wish to participate in wrestling, and I understand and agree to the following terms and conditions related to my participation**:**

Participation in the Activity will involve moderate to heavy exercise as well as the physical contact. Wrestling, similar to other sporting activities, is not without risk of physical injury. It is my responsibility to:

* determine that I am physically fit to participate in wrestling
* to advise of any and all medical conditions of which I am aware
* have parental approval to participate if under 18 years of age
* understand that despite its efforts, the University and the London-Western Wrestling Club may not be able to ensure my complete safety at all times from such risks and dangers of this activity

My signature below is given freely in order to indicate my understanding and acceptance of these realities and in consideration for being permitted by the Wrestling Program to participate in the above mentioned activity.

**For participants under the age of 18 years:**

I am the parent or legal guardian of the above student. I acknowledge that I have read the above and I have had the opportunity to seek clarification about any concerns and ask any questions I may have. I have discussed the above with my child and agree to accept the above terms on his/her behalf.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

or

**For participants 18 years and older:**

I acknowledge that I have read the above and I have had the opportunity to seek clarification about any concerns and ask any questions I may have.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_