

Caveman School of Wrestling
Kagefit Clinic Waiver

Name _____

Age _____ Experience _____

What techniques do you want to see? _____

Parent Guardians Name _____

I/We the undersigned understand that all sporting and athletic participation comes with inherent risk of injury including catastrophic injuries. I/We accept all cost and responsibility for any injuries which might occur through participation in the Caveman Wrestling Clinic at Kagefit July 22nd. Furthermore I understand that wrestling is a strenuous and demanding activity and that my child is physically able to meet the demands of strenuous activity. I understand the Coach Adrian Anderson, The Caveman School of Wrestling and The Kagefit facility will work to ensure the safest experience possible and waive and claim against the aforementioned for liability.

Parents/Guardian Signature _____

Parent/Guardian Emergency Contact _____

Insurance Company _____

Group _____

Policy Number _____

Please list any medications, conditions, allergies or other conditions/situations the clinic staff should be aware of.
