

Elizabeth PAL Wrestling



Elizabeth PAL Wrestling registration is now open for the 2024-2025 Season

Ages 5-14 boys and girls welcome!

Contact Lateef Banks at 908-531-1261 or visit the website at www.elizabethPAL.org





Elizabeth P.A.L. Wrestling



2024-2025 Application

PLEASE PRINT NEAT & LEGIBLE

Child's Name: _____

Child's Home Address: _____ Home Phone: _____

Sex: F _____ M _____ Date of Birth: ____/____/____ Grade: _____ Age: _____ Shirt Size: _____

Mother's/Guardian's Name: _____ Father's Name: _____

Mother's Work Place: _____ Father's Work Place: _____

Mother's Work #: _____ Father's Work #: _____

Mother's Pager/Cellular Phone: _____ Father's Pager/Cellular Phone: _____

Email Address: _____ Email Address: _____

MANDATORY THREE EMERGENCY CONTACTS: Three local people to be called if your child is ill or injured and parents are unavailable. These people have parent's permission to take responsibility for the child, and to take him/her home. If any information is found to be false or phone numbers are not working/disconnected, your child will be dismissed from the program until the correct information is provided!

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Name: _____ Home Phone: _____

Address: _____ Work Phone: _____

Consent

I hereby release the City of Elizabeth, the Officers, Directors and Employees of participating agencies, the Elizabeth Police Department and/or businesses from any liability whatsoever arising out of the transport and/or participation of my child in this program. This Includes, but is not limited to, claims and expenses incurred in traveling to and from any destination. I have read, understood, and accepted the above.

Parent/Guardian Signature: _____ Date: _____



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MEDICAL INFORMATION FORM

PLEASE PRINT NEAT & LEGIBLE: This form must be completed in its entirety, please complete and return to the Office of Youth or A Program site.

Child Name: _____

Sex: F _____ M _____ Date of Birth: _____ Grade: _____

Mother/Guardian's Name: _____

Father's Name: _____

Home Address: _____

Home Phone: _____ Cellular Phone: _____

CHILD'S PREFERRED SOURCE OF MEDICAL CARE

Physician's Name: _____ Phone: _____

Dentist Name: _____ Phone: _____

Hospital: _____ Phone: _____

Does your child have any allergies to:

Medication: Yes _____ No _____ **Food:** Yes _____ No _____ **Substances:** Yes _____ No _____ If yes, please explain: _____

Does your child wear glasses or contacts? Yes _____ No _____

Does your child require prescribed medication? Yes _____ No _____ If yes, please explain (include dosage, schedule and duration): _____

Does your child have a history of:

Asthma/Breathing Problems: Yes _____ No _____ Diabetes: Yes _____ No _____

Epilepsy/Convulsion/Seizures: Yes _____ No _____ Sickle Cell Anemia: Yes _____ No _____

Heart Trouble: Yes _____ No _____ Fainting Spells: Yes _____ No _____ or other, if yes, please explain: _____

Does your child have any other special health problems we should know about? Yes _____ No _____ If yes, please explain: _____

May your child participate in all physical activities? Yes _____ No _____ If no, please explain, (doctor's note may be needed): _____

IF YOUR CHILD HAS ANY PHYSICAL RESTRICTIONS PLEASE LET US KNOW



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PHOTO/VIDEO RELEASE

RE: _____
(Print Child's Name)

IN CONSIDERATION FOR BEING ALLOWED TO PARTICIPATE IN THE ELIZABETH PAL SOCCER CAMP, I HEREBY RELEASE THE ELIZABETH POLICE DEPARTMENT FROM ANY LIABILITY FOR PAYMENT OR OTHER COMPENSATION FOR THE USE OF MY CHILD'S PICTURE OR LIKENESS, VOICE BIOGRAPHICAL INFORMATION, OR OTHER MATERIAL PROVIDED TO THE ELIZABETH POLICE DEPARTMENT. I ALSO AGREE TO ALLOW THE ELIZABETH POLICE DEPARTMENT TO USE THESE MATERIALS AS IT SEES FIT, INCLUDING ADVERTISING AND/OR PUBLIC RELATIONS.

Dated: _____

(Signature of Parent/Guardian)

(Print/Type Name of Parent/Guardian)

Child's Address

Phone Number