Golden Cross Wrestling Academy

www.GoldenCrossWrestling.com

***PLEASE ☑ CHECK THE APPROPRIATE BOXES**

Practice Starts Nov. 3rd

Continues through Mar 13th

CLUB COST OPTIONS:

***Checks payable to La Salle HS**

☐ **Per Session: $10**

☐ **Part Time: $225**
(Any 2 Days each week)
38 Sessions

☐ **Full Time: $425**
(3-4 days a week)
77 Sessions
1st half Due: Nov. 10
2nd half Due: Jan. 12

MAIL APPLICATION:

Avery Zerkle's
Golden Cross Wrestling, LLC
3651Millville Shandon Rd
Hamilton, OH 45013
937-631-2099
averyzerkle@hotmail.com

Elementary Gold

K-6th Grade

☐ **Part Time**

☐ **Full Time**

Your elementary wrestler has two options.

First, use Golden Cross 4 days a week to train and compete at an elite level. We have an extensive competition schedule of Duals and Open Tournaments for you to choose from.

Second, join your local Youth program and practice with them twice a week. Then use Golden Cross to get your wrestler one or two advanced practices each week.

Jr. High

7-8th Grade

☐ **Part Time**

☐ **Full Time**

All Jr. High wrestlers have two options.

First, train with the most advanced wrestlers in the Tri-State 4 days a week. We have full schedule designed so you can choose the type of competition that you are looking for. The schedule will range from average local tournaments to the toughest tournaments in the country.

Second, if your Jr. High has a wrestling program you can choose to participate on their team and use Golden Cross for more advanced supplemental training. Keep in mind that using this approach will limit your potential with restricted matches and competition.

High School

9-12th Grade

Sundays Only

SUNDAYS ONLY
As a high school wrestler you need to use the Golden Cross practices to out train your competition. You have the opportunity to train with the best wrestlers in the Tri State. The level of competition and intensity of each practice is what you need to achieve your full potential!
Don't miss this opportunity!

Name: _____Age: _____Weight: _____Grade:_____ School:_____

Last season accomplishments:_____

Cell Phone:_____email:_____Name on Facebook account: _____

***You must also complete Medical Form to participate**

ARCHDIOCESE OF CINCINNATI

PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 6-2006)

1. I, the lawful parent or guardian of _____(the "Child"), give permission for my Child to participate in the La Salle Sports Camps and release from all liability and indemnify the Archbishop of Cincinnati ("the Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati and all parishes and schools within the Archdiocese (the "Archdiocese"), La Salle High School, and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost and expenses, including attorneys' fees, arising out of any injury or illness incurred by my Child while participating in or traveling to or from the activity and further agree not to bring or prosecute or allow to be brought or prosecuted (including but not limited to prosecution through subrogation) in my name, or on behalf of my Child, any claims, lawsuits or actions against the Archbishop, the Archdiocese, La Salle High School, and their officers, agents, representatives, volunteers and employees.
2. I further understand that my Child's participation is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, elect to participate in spite of the risks.
3. I agree to instruct my Child to cooperate with the Archbishop or his agents in charge of the activity.
4. I appoint the Archbishop or his agents who are acting as leaders of the activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:
   (i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the child.
   (ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my Child.
5. This power of attorney shall lapse automatically upon completion of the activity and any related travel.
6. I agree that the Archbishop or his agents may use my Child's portrait or photograph for promotional purposes, website and office functions.
7. This acknowledgement and release is intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This acknowledgement and release shall be construed in accordance with the laws of the State of Ohio, except for the choice of law provisions thereof.

I have carefully read and understand and accept the terms and conditions stated herein and acknowledge that the Permission, Release, and Medical Power of Attorney shall be effective and binding upon me, my Child, and my own and my Child's personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Parent Email:_____

Signature of Parent or Guardian _____ Date ____/____/_____

Home Address _____ City _____ Zip _____

Place of Employment _____

Work Address _____ City _____ Zip _____

Parent or Guardian Phone No. (w) _____ _____ (c)_____

Emergency Contact _____ Phone No. (w) _____ (h) _____

Medical Information — Completed by Parent or Guardian — Please Print

Child's Name _____ Birth date ____/____/_____

Child's Soc. Sec. No. *_____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

Medical Insurance Co._____ Policy No. _____

Member's Name _____ Phone No. (h) _____ (w) _____

Member's Birth date ____/____/_____ Member's Soc. Sec. No. * _____

Family Doctor _____ Phone No. _____

*Social Security Number is optional. Please note that some hospitals WILL NOT treat without it.