

**Challengers State Basketball Tournament
Medical Release Form**

Name: _____ Birthdate.: _____

Address: _____

Phone Numbers: Home _____ Emergency _____

Church Name _____ City _____

List below any allergies, medications currently being taken or medical information.

Insurance information: (Please list the insurance name and policy number)

By signing my name to this form, I give permission to the Emergency Medical Services of the Challengers State Basketball Tournament to administer treatment and/or permit my youth to be treated by a physician and hospital for injury or illness. I have provided insurance coverage information and a number where I can be reached in case of an emergency.

Parent/Guardian's Signature _____ Date _____

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