

**Challengers State Basketball Tournament  
Medical Release Form**

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ S.S.# \_\_\_\_\_

Address: \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Emergency \_\_\_\_\_

Church Name \_\_\_\_\_ City \_\_\_\_\_

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

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

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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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