

BETHEL COLUMBUS DAY TOURNAMENT
Medical Release Form
October 11th & 12th, 2025
(One Per Player)

Player Name _____ Birth Date _____

Address _____

_____ Telephone _____

Player's Age _____ Years Height _____ Ft _____ Inches Wgt _____ Lbs

Emergency Contacts:

Parents / Guardian Name _____

Address (if different from above) _____

Telephone (Home) _____ (Cell) _____

Other Contact (Relative/Friend) _____ Telephone _____

Medical Info:

Physicians Name _____ Telephone _____

Hospital Preference _____

Insurance Company _____ Policy # _____

Known Allergies or Other Pertinent Medical Information _____

Parent / Guardian Consent:

I am the parent or legal guardian of _____
And I do hereby give my permission for the above named child to receive any and all medical treatment, assistance or care administered by any duly licensed physician or hospital in the event of an accident, injury or sickness while he / is at the Bethel Columbus Day Tournament until such time as I may be contacted. This release is in effect for the tournament dates above plus one week. I also hereby assume the responsibility for the payment of any such treatment and agree not to hold the BYSA, it's Board of Directors or members of the Tournament Committee responsible for the injury.
Parent / Guardian Signature _____

Date _____