



# “Fall-Ball” Classic (Boys) Player Registration Form

(Please Make Copy For Each Player)

Player’s Name: \_\_\_\_\_ High School: \_\_\_\_\_

Sr./Jr./So./Fr. (circle one) Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Pos: \_\_\_\_\_ S.A.T. Score: \_\_\_\_\_  
The above information is used for scouting and recruiting purposes so please use the latest S.A.T. Scores

Parents Name: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Home # : \_\_\_\_\_ Work #: \_\_\_\_\_

**PARENTAL MEDICAL AUTHORIZATION:**

I, the parent and/or guardian of the above candidate, hereby give my permission for his/her participation in the HawksBasketball “Fall-Ball” Classic Tournament. I assume all risks and hazards incidental to the conduct of the activities, including transportation to and from the activities and do further waive, release, absolve, indemnify and agree to hold harmless, the HawksBasketball League, the organizers, sponsors, supervisor’s, participants, and persons transporting the child to and from activities from any claim arising out of an injury to the child. **MEDICAL EXPENSES WILL BE REIMBURSED ONLY IN THE AMOUNT COVERED BY SECONDARY COVERAGE ACCIDENT AND/OR LIABILITY INSURANCE HELD BY THE HAWKS BASKETBALL ORGANIZATION.**

I also grant permission to managing personnel and/or other HawksBasketball representatives to authorize and obtain medical care from any licensed physician, hospital or medical clinic, should the participant become ill or injured while participating in HawksBasketball activities away from home or at other times when neither parent/guardian is available to grant permission for emergency treatment. In view of the foregoing, the HawksBasketball Organization requires disclosures of any and all medical conditions or allergies which may affect athletic performance or which may have an adverse effect on emergency medical treatment (e.g. DRUG ALLERGIES, DIABETES, ALLERGIC REACTIONS TO BEE STINGS, etc.) Disclosure shall include any and all medical conditions or allergies.

\*By signing this agreement you, the parent/guardian, agree to all conditions here within this form.

**Medical Conditions**  
(Please print)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature\*: \_\_\_\_\_

(Print Name): \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact Number: \_\_\_\_\_