

SCHOOL. _____

PHYSICIAN RELEASE

_____ has been examined by me on _____
 (name of student) (date)

and my examination has found no medical reason to preclude his/her participation in competitive sports.

 Physician/Date

PARENT'S RELEASE

In consideration of _____, being allowed to participate in competitive
 (son/daughter's name)
 sports, and intending to be legally bound, I do hereby release and forever discharge the Roman Catholic Diocese of Pittsburgh, the Bishop of the Diocese, Catholic Institute, and _____ Catholic School of the city of _____, and/or the School Athletic Association, their agents and their successors, from any/all actions or suits in law or equity which I/We might hereafter have, by reason of injuries sustained by my child participating in sports or in transit to or from participation in sports.

 Mother's signature/Date

 Father's signature/Date

Mother's Employer _____ Address _____ Phone _____

Father's Employer _____ Address _____ Phone _____

Hospitalization Covering Athlete: Blue Cross _____ Blue Shield _____ Major Medical _____

Other Coverage _____ Policy No. _____ Agreement No. _____

Please check if you do not have Hospitalization Coverage _____

Coverage for injury resulting from athletic participation is specifically excluded from the Diocesan Insurance Programs.

However, the diocese will provide payment up to \$1,000.00 toward the balance of athletic injury medical costs in excess of an individual's own coverage (Hospitalization, DPA, Blue Cross, Blue Shield, Major Medical, etc.). This payment is subject to strict limitations and no claim will be considered without full information required. As in the past, expenses beyond one year of accident date are not eligible expenses.

I have read the above and will comply.

Approved: _____
 (Principal)

 Parent or Guardian's Signature

DIOCESE OF PITTSBURGH
PROTECTED INSURANCE PLAN

REQUEST FOR MEDICAL COVERAGE INFORMATION
FORM "A"

Participating Student _____

Mother's Name _____ S.S.# _____

Father's Name _____ S.S.# _____

Mother's Employer: _____ Employer's Address: _____

Phone: _____

Father's Employer: _____ Employer's Address: _____

Phone: _____

Hospitalization Blue Blue Major Group #
Covering Athlete: Cross Shield Medical I.D. No. _____

Other Policy I.D.
Coverage Number Number _____

Proof of medical coverage is required for an athlete to participate in sports. If no coverage exists, the student CAN NOT participate in athletics.

A parent permitting a student to participate in school athletics after coverage has terminated or without coverage will assume full responsibility for any medical claim resulting from an injury while participating in the sport.

It must be understood that coverage for injury resulting from athletic participation is specifically excluded from the Diocesan Insurance Programs. It is for this reason that the preceding paragraphs must be strictly adhered to.

I/We, the undersigned, do attest to the accuracy of the information provided on this form. Furthermore, should there be a change, the school principal and coach will be notified immediately of any change.

Parent or Guardian's Signature

Approved: _____
(Principal)

Parent or Guardian's Signature

(Form Effective 07/01/94)

(PHOTOCOPY THIS FORM AS NEEDED)