TUSCALOOSA CITY SCHOOLS ATHLETICS

ATHLETIC PERMISSION AND INSURANCE VERIFICATION FORM

I HEREBY GIVE PERMISSION FOR MY SON/DAUGHTER _____
NAME OF PARTICIPANT
TO PARTICIPATE IN THE INTERSCHOLASTIC ATHLETIC PROGRAM _____ **SCHOOL** DURING THE **SCHOOL YEAR _____.**

IT IS UNDERSTOOD BY ME THAT NEITHER THE TUSCALOOSA CITY BOARD OF EDUCATION NOR THE SCHOOL CARRIES LIABILITY OR MEDICAL PAY INSURANCE WHICH COVERS PARTICIPATION IN THE ATHLETIC PROGRAM. SCHOOL FUNDS MAY NOT BE USED TO PAY FOR MEDICAL TREATMENT FOR PERSONAL INJURIES SUSTAINED WHILE PRACTICING FOR OR PLAYING OR OTHERWISE PARTICIPATING IN SUCH ATHLETIC PROGRAMS OR EVENTS OR WHILE ON TRIPS IN CONNECTION THEREWITH. IT IS FURTHER UNDERSTOOD THAT I WILL ASSUME FULL RESPONSIBILITY FOR ALL MEDICAL TREATMENT THAT THE ABOVE NAMED STUDENT MAY NEED OR REQUIRE FOR SUCH INJURIES.

CASTASROPHIC INSURANCE IS PROVIDED BY THE AHSAA FOR EACH ATHLETE WITH A DEDUCTABLE AMOUNT OF $25,000.

I DO HEREBY RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS THE TUSCALOOSA CITY SCHOOL DISTRICT, ITS AGENTS, SERVANTS, AND EMPLOYEES FROM ALL CLAIMS AND LOSS ON ACCOUNTS OF INJURIES, MEDICAL EXPENSES AND DAMAGES OF WHATEVER KIND WHICH MAY BE SUSTAINED BY ME OR SAID STUDENT ON ACCOUNT OF ANY INJURY RESULTING FROM PARTICIPATION IN SUCH ACTIVITIES.

I HEREBY GIVE THE COACH IN CHARGE MY PERMISSION TO SEND THE ABOVE NAMED FOR MEDICAL CARE IN AN EMERGENCY SITUATION.

□ I CERTIFY THAT I HAVE INSURANCE WHICH PROVIDES MEDICAL COVERAGE FOR SAID PARTICIPANT.

□ I CERTIFY THAT I DO NOT HAVE INSURANCE WHICH PROVIDES MEDICAL COVERAGE FOR SAID PARTICIPANT

_____ _____ _____
PARENT NAME PARENT SIGNATURE DATE

_____ _____
ADDRESS PHONE

MEDICAL INSURANCE VERIFICATION

NAME OF STUDENT:_____ AGE:_____ BIRTHDAY:_____
PARENT(S) PLACE OF EMPLOYMENT:_____
PARENT(S) WORK PHONE NUMBER:_____CELL:_____
INCASE OF EMERGENCY, CONTACT:_____PHONE:_____

MEDICAL INSURANCE INFORMATION:

NAME OF MEDICAL INSURANCE COMPANY:_____
MEDICAL INSURANCE POLICY NUMBER:_____
INSURANCE COMPANY ADDRESS:_____
INSURANCE COMPANY PHONE:_____

EMERGENCY STATEMENT:
I AUTHORIZE THE COACHING STAFF TO MAKE EMERGENCY STEPS TO OBTAIN MEDICAL ASSISTANCE FOR MY CHILD IN THE EVENT OF AN EMERGENCY WHERE A DECISION MUST BE MADE QUICKLY AND THERE IS NOT TIME AVAILABLE TO CONTACT THE PARENT(S) OR GUARDIAN(S) OR WHEN THE PARENT(S) OR GUARDIAN CANNOT BE CONTACTED IN A REASONABLE LENGTH OF TIME.

_____ _____ _____
PARENT NAME PARENT SIGNATURE DATE