

SCHOOL Seton-La Salle High School

P.I.A.A.

PHYSICIAN RELEASE

RELEASE FORM

\_\_\_\_\_ 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.

SPORT \_\_\_\_\_ Physician/Date \_\_\_\_\_

PARENT'S RELEASE

In consideration of \_\_\_\_\_, being allowed to participate in  
(Son/Daughter's Name)  
competitive 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 \_\_\_\_\_ a 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.

PARENTS OR GUARDIANS SIGNATURES:

\_\_\_\_\_  
(Father's Signature/Date) (Mother's Signature/Date)

Father's Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother'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 or DPA Coverage \_\_\_\_\_

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

However, the Diocese will provide payment up to \$1,000.00 toward 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.

We have read the foregoing release and explanation of payments and understand the same. We agree to accept the limited additional coverage pursuant to the terms set forth herein and agree to forego any additional claim.

\_\_\_\_\_  
(Father's Signature/Date) (Mother's Signature/Date)

Approved: \_\_\_\_\_  
Principal