AVE MARIA ACADEMY

BETHEL PARK CAMPUS
134 FORT COUCH ROAD
PITTSBURGH, PA 15241

MT. LEBANON CAMPUS
401 WASHINGTON ROAD
PITTSBURGH, PA 15216

MEDICAL RELEASE FORM

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's Signature/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, South Regional Catholic Elementary Schools, and **Ave Maria Academy** of Bethel Park and Mt. Lebanon and/or the Ave Maria Academy Athletic Association, their agents, and their successors, from any/all actions or suits in laws 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/Guardian's Signature/Date) (Father's/Guardian'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 #: _____ Agreement #: _____

Please check if you **do not** have Medical Insurance: _____

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: _____
(Parent or Guardian's Signature)

BACK OF FORM MUST BE COMPLETED BY PHYSICIAN

MEDICAL DATA FORM

NAME: _____

ALLERGIES:

PREVIOUS SURGERY:

MEDICAL PROBLEMS:

CURRENT MEDICATIONS:

HEIGHT AND WEIGHT:

BLOOD PRESSURE:

PHYSICIAN'S COMMENTS: