

# CUMBERLAND ATHLETIC DEPARTMENT

## Parental Permission, Authorization for Treatment and Insurance Waiver Form

Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Sport: \_\_\_\_\_

Your permission must be given in order for your child to participate in any sport in Cumberland. Your signature on this form indicates permission to participate in the listed activity. Also, please be aware of the school department's policy concerning school insurance and any medical expenses arising from injuries sustained while participating in athletics.

1. All participants in football **MUST** purchase the football coverage offered by the school insurance carrier.
2. School insurance is available to your child, and all participants in school sports are strongly recommended to purchase this insurance.
3. If school insurance is not purchased, a waiver form declining the insurance must be signed by the parent or guardian. **There is no waiver for football.**
4. Private coverage must be used first whenever it can be applied.
5. School insurance will be submitted next after any private coverage.
6. The Rhode Island Injury Fund will, as a rule, consider any balance which may be left after the coverage afforded by the above agencies has been exhausted. The Injury Fund may not pay unless you have private coverage and/or school insurance.
7. Any injury or visit to a doctor, dentist, physical therapist or hospital as a result of an injury must be reported to the coach and an injury report must be filled out.

### Parental Permission and Authorization for Treatment

I hereby give my consent for \_\_\_\_\_ to represent his/her school in interscholastic athletics. In the event of injury or accident either en route to an event, at an event or en route back from an event, I also give consent for the school to obtain any and all medical care that is deemed reasonably necessary for the welfare of the student. I realize that all reasonable efforts will be made to contact me if the above does occur.

Name of Primary Medical Insurance: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
Parent or Guardian (Please Print): \_\_\_\_\_  
Signature of Parent or Guardian: \_\_\_\_\_  
School Insurance: \_\_\_\_\_ Yes \_\_\_\_\_ No (Must sign below) Date: \_\_\_\_\_

### Insurance Waiver Form (Only if NOT Purchasing School Insurance)

I am fully covered by our own insurance for any injury my child may receive. I do not wish to purchase school insurance.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_