



**Camden County High School Athletic Department  
Insurance, Athletic Participation & Permission, & Physical Forms**



**(PLEASE COMPLETE IN BLUE OR BLACK INK)**

Student Name: \_\_\_\_\_ Age: \_\_\_\_\_ School Year: 20\_\_\_\_ to 20\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Student Cell: \_\_\_\_\_

**PART 2 – EMERGENCY CONTACT/MEDICAL INFORMATION**

Parent Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Medical Conditions: \_\_\_\_\_

It is important that you understand that medical bills related to an athletic injury are the responsibility of the parents. Occasionally, student athletes are injured during practices or games and the school needs to ascertain that the parents have medical insurance in order to cover expenses if an injury occurs. Please check one of the following and complete the information related to your child's insurance coverage (you may opt to choose more than one).

**EVERY ATHLETE MUST HAVE INSURANCE TO PARTICIPATE. (PLEASE INITIAL ONE OF THE STATEMENTS BELOW)**

I have personal insurance on my child  
 Medical Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
 Medical Insurance Phone Number: \_\_\_\_\_  
 \*I wish to purchase athletic insurance for my child.  
 \*Contact Markel Student/Athletic Insurance at <http://markel.sevencorners.com/> or 1-877-444-5014.  
 (Payment must be made by credit or debit card) Policy #: \_\_\_\_\_

**PART 3 – RELEASE STATEMENT**

I understand that per The Georgia High School Association a **Pre-participation Physical Evaluation** must be performed by a physician to medically screen each student who participates in the athletic programs of the Camden County School System. I further understand that a basic medical screening (the required physical exam) is general in nature and limited in its scope and does not indicate or assure me that my child is completely free from impairments. If I wish for a more detailed physical exam to be performed upon my child/ward then it is my responsibility to arrange and pay for such an exam. If this more detailed exam is performed, it is my responsibility to notify the Camden County School System, and its appropriate employees, of any potential medical problems uncovered by any physical exam given to my child/ward other than the general physical required by the school system for athletic participation. I agree to fully waive any and all claims of whatever nature, fully and finally, now and forever, for my child/ward, for myself, my estate, my heirs, my administrators, my executors, my assignees, my agents, my successors, and for all members of my family, and to indemnify, release, defend, exonerate, discharge and hold harmless the Camden County School System, Camden County Board of Education, employees, agents, coaches, athletic trainers, physicians, and any other practitioner of the healing arts (an "Indemnified Party") from any and all liability, personal or property damages, claims, causes of action or demands brought against the Camden County School System or indemnified party arising out of any injuries to my child/ward or to his or her property or losses of any kind which may result from or in connection with his or her participation in any activity related to the athletic programs provided by the Camden County School System.

I also hereby give permission for my son/daughter to undergo medical treatment for any injury or illness he/she might sustain or acquire while engaged in interscholastic athletics in the Camden County School System. I understand that the athletic trainer will perform only those procedures which are within his training, credentials, and scope of professional practice to prevent, care for, and rehabilitate. In the event that more serious medical procedures are required, such as surgery or other invasive procedures, I understand that attempts will be made to contact me for consent. I understand that if my child suffers a potentially life threatening injury or illness, and in the event I am unable to be contacted within a reasonable period of time, I authorize any duly licensed medical practitioner to perform such procedures as he/she may medically deem necessary to alleviate the problem.

**HAVING UNDERSTOOD THIS AGREEMENT, I FREELY SIGN THIS PERMISSION FORM TO PROVIDE MEDICAL TREATMENT AND GIVE PERMISSION FOR MY CHILD TO PARTICIPATE IN ATHLETICS.**

PARENTS/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

EXPIRES:

FIRST NAME:

LAST NAME: