



**Camden County High School Athletic Department
Insurance & Athletic Participation Permission**
(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.

_____ **I have personal insurance on my child**

Medical Insurance Company: _____ Policy #: _____
 Medical Insurance Phone Number: _____

_____ ***I wish to purchase athletic insurance for my child. Parents please chose from coverage shown:**

- School time coverage (valid until the last day of school)
 - Economy plan-\$30.00 _____ Basic plan-\$50.00 _____ Deluxe plan-\$92.00 _____
- Around the clock coverage (coverage thru summer sports)
 - Economy plan-\$119.00 _____ Basic plan-\$202.00 _____ Deluxe plan-\$287.00 _____
- Fall Football coverage (9th thru 12th grade - fall & spring football coverage)
 - Economy plan-\$205.00 _____ Basic plan-\$329.00 _____ Deluxe plan-\$399.00 _____
- Spring Football coverage (9th thru 12th grade - spring football only)
 - Economy plan-\$82.00 _____ Basic plan-\$132.00 _____ Deluxe plan-\$164.00 _____

***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 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: _____

****** COMPLETION OF BOTH SIDES OF THIS FORM IS MANDATORY ******