

DIOCESAN ATHLETIC INTERSCHOLASTIC PROGRAM - REGISTRATION FORM
PHYSICIAN'S CERTIFICATE

I hereby certify that _____ (NAME OF ATHLETE) has been examined by me
and

found physically fit to engage in all Diocesan interscholastic athletics for the school year 20____ - 20_____

PHYSICIAN'S SIGNATURE _____ DATE _____

GENERAL INFORMATION: NAME OF
ATHLETE _____

SEX: M _____ F _____

ADDRESS _____

PHONE _____

GRADE _____ AGE _____ DATE OF BIRTH _____
SS# _____

PARENT(S)/LEGAL GUARDIAN(S) _____

ADDRESS _____ PHONE(H) _____

PHONE(W) _____

FATHER'S SS# _____ MOTHER'S
SS# _____

ANOTHER PERSON TO CONTACT _____

RELATIONSHIP _____ PHONE # _____

ALLERGIES AND OTHER MEDICAL CONCERNS _____

MEDICAL INSURANCE:

NAME OF INSURANCE COMPANY _____

POLICY NUMBER _____ GROUP
NUMBER _____

ELIGIBILITY - CCD STUDENTS

This student is an active member of

(NAME OF PARISH) CCD Program. He/She will be participating all year in the CCD Program.

(signature of pastor or designee)

(date)

PARENT CONSENT STATEMENT

By signing this form, I _____ (NAME OF PARENT/GUARDIAN)
certify that I

request and give my permission for _____ (NAME OF CHILD) to
engage in the

Diocesan interscholastic athletic program. I release the participating schools, principals, coaches, Knights of Columbus, the
Diocese of

Nashville and their representatives from any and all liability and waive claims against them.

(signature of parent or legal guardian)

(date)

NOTE TO PRINCIPALS AND COACHES:

COACHES MUST HAVE A COPY OF THIS FORM FOR EACH ATHLETE AND SHOULD KEEP IT ON HAND FOR ALL GAMES AND PRACTICES. A COPY OF THIS FORM FOR EACH ATHLETE MUST BE ON FILE IN THE PRINCIPAL'S OFFICE BEFORE HE/SHE CAN PARTICIPATE IN ANY FORM OF THE DIOCESAN INTERSCHOLASTIC PROGRAM