

Check one

PATERSON PUBLIC SCHOOLS

_____ **JFK EDUCATIONAL COMPLEX, 61-127 PREAKNESS AVENUE, PATERSON, NJ 07522**

_____ **EASTSIDE HIGH SCHOOL, 150 PARK AVENUE, PATERSON, NJ 07501**

PERMISSION/ACKNOWLEDGEMENT FORM:

STUDENT NAME: _____ **GRADE:** _____ **DOB** _____ **AGE** _____

I hereby give permission for my son/daughter to participate in, travel with and be responsible for the return of all equipment in the following sports:

SPORT(S) _____

I release the school from all liability resulting from participation in these programs.

REALIZING THAT SUCH ACTIVITY INVOLVES THE POTENTIAL FOR INJURY WHICH IS INHERENT IN ALL SPORTS. I/WE ACKNOWLEDGE THAT EVENTHE BEST COACHING, USE OF THE MOST ADVANCED PROTECTIVE EQUIPMENT AND STRICT OBSERVANCE OF RULES, INJURIES ARE STILL A POSSIBILITY. ON RARE OCCASIONS THESE INJURIES CAN BE SO SEVER AS TO RESULT IN TOTAL DISABILITY, PARALYSIS OR DEATH. I/WE ACKNOWLEDGE THAT I/WE HAVE READ AND UNDERSTAND THIS WARNING.

I will be responsible for any athletic equipment loaned to my child by the school and will reimburse the school for any loss.

I also understand that only those medical expenses not covered by my own personal or group insurance are eligible for coverage by Paterson Public School District insurance policy up to the specified limits.

I understand that in the case of injury to my child, all medical bills must be submitted to my personal or group insurance first.

PLEASE NOTE: The Board of Education has purchased insurance coverage that protects all participants in interscholastic athletics against accidental injury. The following will explain the coverage. IN THE EVENT OF PHYSICIAN, HOSPITAL, AND/OR SURGICAL EXPENSES, THIS POLICY BECOMES EXCESS OVER ANY OTHER INSURANCE YOU MAY HAVE. **PARENTS MUST USE THEIR OWN INSURANCE FIRST. PATERSON BOARD OF EDUCATION'S INSURANCE WILL THEN PAY THOSE BILLS NOT COVERED BY YOUR OWN INSURANCE, UP TO THE LIMITS OF THE POLICY. PARENTS MUST SUBMIT ALL MEDICAL FORMS TO THE INSURANCE COMPANY.**

Although this coverage is very broad, there **are restrictions, limitations and exclusions in this policy.** In many situations **medical bills may not be covered in full.** Parents should understand that medical expenses are their own responsibility, not the Board of Education.

Please report any injuries immediately to the **ATHLETIC TRAINER OR YOUR CHILD'S COACH.** The school upon your request will provide claim forms and it will be the parent's responsibility to obtain all medical bills and submit them to the insurance company. Please be sure to obtain the insurance form from the school by the time you receive your medical bills. Bollinger, Co., telephone 866-267-0092, can best answer questions regarding the policy coverage or about specific claims.

I understand that I am liable for any medical bills remaining after the above procedures have been carried out.

I acknowledge receipt of the explanation of medical benefits, which describes the coverage, benefits and exclusions of the insurance program in force for the athletes and other participants in the athletic program in Paterson.

DATE: _____

PARENT/GUARDIAN NAME: (PRINT) _____

PARENT/GUARDIAN SIGNATURE: _____

PERSONAL/GROUP MEDICAL INSURANCE _____

POLICY# _____ **GROUP #** _____

PHONE (HOME) _____ **WORK** _____ **CELL** _____

In case of emergency contact: NAME _____ **PHONE** _____

Known Allergies to Medications _____