DIOCESE OF PITTSBURGH
PROTECTED INSURANCE PLAN
REQUEST FOR MEDICAL COVERAGE INFORMATION
FORM "A"

Participating Student_____

Mother's Name _____ S.S.#_____

Father's Name_____ S.S.#_____

Mother's Employer: _____ Employer's Address: _____

Home Phone # _____ _____

Work Phone # _____ _____

Father's Employer: _____ Employer's Address: _____

Home Phone # _____ _____

Work Phone # _____ _____

Hospitalization Covering Athlete: Blue Cross _____ Blue Shield _____ Major Medical _____ Group # _____ I.D. # _____

Other Coverage: _____ Policy # _____ I.D. # _____

Proof of medical coverage is required for an athlete to participate in sports. If no coverage exists, the student **CANNOT** participate in athletics.

A parent permitting a student to participate in school athletics after coverage has terminated or without coverage will assume full responsibility for any medical claim resulting from an injury while participating for any medical claim resulting from an injury while participating in the sport.

It must be understood that coverage for injury resulting from athletic participation is specifically excluded from the Diocesan Insurance Programs. It is for this reason that the preceding paragraphs must be strictly adhered to.

I/We, the undersigned, do attest to the accuracy of the information provided on this form. Furthermore, should there be a change, the school principal and coach will be notified immediately of any change.

_____ _____
Parent or Guardian's Signature Parent or Guardian's Signature

Approved: _____
(Principal)