

**EAST PROVIDENCE SCHOOL DEPARTMENT
EAST PROVIDENCE ATHLETICS
PARENT PERMISSION FORM**

STUDENT'S NAME: _____ **YEAR:** _____

SPORT: _____ **SCHOOL:** _____

Dear Parent or Guardian:

Your permission must be given in order for your child to participate in any sport in East Providence. Your signature on this form indicates your permission for your son or daughter to take part in the listed activity and your agreement with the policies relating to medical coverage outlined below. You should be aware of the school policy concerning any medical expenses arising from injuries sustained while participating in athletics:

1. Private coverage must be used whenever it can be applied.
2. School insurance, available to your child and purchased by you may pay part of the bill. It is required that you purchase school insurance in order for your child to participate in athletics. Also in the event of an injury claim it is the responsibility of the parent to complete all necessary forms properly and on time so that claims may be paid promptly.
3. The Rhode Island Interscholastic Injury Fund will, as a rule, consider any balances which may remain after the coverage provided by those above have been exhausted. The Injury Fund requires that you have some primary coverage. School insurance, purchased by you, qualifies as primary coverage.
4. Ordinarily the combined coverage outlined in 1, 2 and 3 above will be sufficient to cover the cost of most injuries sustained by an athlete. In the event that a balance is still due, the parent must assume the responsibility of these medical costs.
5. Any visit to a hospital, doctor, dentist or therapist must be reported to the Athletic Director within three (3) days of said visit or the parent may have to assume all financial responsibilities in connection with the injury.

Do you have private coverage which covers athletic injuries?

(please check) YES _____ **NO** _____

If YES please indicate the name of the insurer _____

And the policy number _____

Have you purchased school insurance for your child?

YES _____ **NO** _____

If NO please attach a note indicating that you understand that you as a parent will be responsible for all medical bills not covered by your insurer. If the purchase of school insurance is a financial hardship this will be verified and a waiver of the fee provided.

SIGNATURE OF PARENT OR : _____

GUARDIAN _____ **DATE** _____