



Resurrection Catholic School Intramural Sports Parent/Student Contract

1. Philosophy

The goal of the Resurrection Athletics is to provide students an opportunity to participate in practices and drills in order to develop their athletic skills.

2. Eligibility

All athletes must attend Resurrection Catholic School and **MUST MAINTAIN A 2.0 GRADE POINT AVERAGE.**

3. Medical Release

All athletes must turn into the school office, a statement of good health signed by their doctor stating they were seen within the last year. Athletes must also turn in the attached registration and release forms.

4. Conduct and Discipline

Conduct in Intramurals is expected to be that stipulated in the Resurrection handbook. Discipline will be handled on an individual basis with parental consultation.

5. Athletic Department

Any questions or concerns about the athletic program can be addressed by contacting Athletic Director, Cindy Stanford at 644-3931, voice mailbox #123.

I have read and understand the above items and agree to abide by the guidelines, rules, and regulations of the Resurrection Athletics Program.

Please sign and return to the school office.

Athlete

Parent/Guardian

Date

Date



**DIOCESE OF ORLANDO ATHLETICS PERMISSION FORM AND
RELEASE OF LIABILITY FOR RESURRECTION CATHOLIC SCHOOL**

Soaring to Excellence

www.rcslakeland.org

NAME OF STUDENT: _____ CLASS: _____ COURIER # _____

ATHLETIC EVENT: INTRAMURALS DATE: _____

I am the parent/guardian of _____, and give my permission for my child to participate in Resurrection Catholic School Athletics. I acknowledge that the (SCHOOL/PARISH) is not responsible for transportation to or from athletic competitions or practices. I understand that I must pick my child up after the event within a reasonable period of time. My child must comply with the (SCHOOL/PARISH'S) rules and procedures. By granting this permission, I also waive any claims against, and release and hold harmless, (SCHOOL/PARISH) the diocese of Orlando, and any of their coaches, religious, employees, volunteers, agents, and representatives from any harm that occurs to my child while participating in school athletics.

In the event my child requires medical treatment or transportation for medical care, (SCHOOL/PARISH) will attempt to contact me at the number(s) listed below. If they are unable to reach me, (SCHOOL/PARISH) may contact the designated emergency contact at the number(s) listed below. If the coaches, chaperones, volunteers, or other adult supervisors are unable to reach the designated emergency contact, I authorize them to take appropriate measures to provide care and treatment for my child, to transport my child to the nearest emergency room or physician's office, or to call any emergency paramedic ambulance service.

Parent/Legal Guardian (Signature)

Date

MEDICAL INFORMATION

In the event the Student becomes ill, I authorize the directors, coaches, or chaperones to obtain medical attention at a physician's office or hospital. The Student is covered by the following medical insurance:

Insurance Co. _____ Group# _____ Toll Free Phone # _____
Allergies _____ Inhaler needed _____
Chronic/Acute Illnesses _____
Doctor's Name _____ Phone: _____

Does your child have a medical condition that limits them from participating in any athletic activities?
Yes _____ No _____ If Yes, you must provide documentation from a physician advising of the limitations before your child may participate in athletics. All athletes must turn into the school office, a statement of good health signed by their doctor before the student may participate in athletics.

I UNDERSTAND THAT EVERY EFFORT WILL BE MADE TO REACH ME BEFORE MEDICAL PERMISSION IS GIVEN TO TREAT MY CHILD.

Parent/Guardian (Print Name)

Emergency Contact (Print Name)

Home _____
Cell _____
Work _____
E-Mail _____

Home _____
Cell _____
Work _____
E-Mail _____



RESURRECTION CATHOLIC SCHOOL ATHLETE MEDICAL CERTIFICATE

PATIENT: _____

This is to certify that the above mentioned patient was examined by me on (date):_____.

This person was found to be in general good health. (**Exam needs to be completed annually if a student plans to participate in sports**)

Signed: _____, M.D. Date: _____

Office address: _____

Comments: _____

All RCS athletes must turn in a signed medical release once a year before they may participate in athletic games or practices. Please submit your release to the Resurrection Catholic School Athletic Director.