

**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 19\_\_\_\_ - 19\_\_\_\_\_.

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 \_\_\_\_\_ HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_ PHONE \_\_\_\_\_

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.