

**2024/2025 STUDENT/PARENT ATHLETIC HANDBOOK  
SIGNATURE PAGE**

**MUST SIGN EACH YEAR & RETURN TO SCHOOL OFFICE**

*Please read the Student Parent Athletic Handbook, which can be accessed electronically on the school's FACTS SIS homepage,*

***PLEASE PRINT AND SIGN THIS RELEASE FOR EACH STUDENT PARTICIPATING IN DIOCESE OF SCRANTON CATHOLIC SCHOOL CATHOLIC YOUTH ORGANIZATION ATHLETIC TEAM ACKNOWLEDGING:***

- YOU HAVE READ, UNDERSTAND, AND WILL ABIDE BY THE CONTENTS OF THIS ATHLETIC HANDBOOK.***
- YOU UNDERSTAND THAT PARTICIPATION ON AN ATHLETIC TEAM AT A DIOCESAN SCHOOL IS A PRIVILEGE AND AS SUCH, THIS PRIVILEGE CAN BE TAKEN AWAY EITHER TEMPORARILY OR PERMANENTLY IF ANY OF THE POLICIES STATED WITHIN ARE NOT FOLLOWED.***
- YOU GRANT PERMISSION FOR YOUR STUDENT-ATHLETE TO PARTICIPATE IN THE SPORT OR SPORTS FOR WHICH HE/SHE IS REGISTERED.***

The Diocese of Scranton Catholic Schools CYO developed rules, regulations, and procedures in conjunction with policies stated in the Diocese of Scranton Elementary School Athletic Guidelines Policy Handbook.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Parent(s)/Guardian Name

\_\_\_\_\_  
Parent(s)/Guardian Signature

\_\_\_\_\_  
Date

**This Form must be completed and turned into the Athletic Director in order for the student to be eligible to participate.**

# Diocese of Scranton Catholic School System

## Student-Athlete Medical and Insurance Certificate

Student's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone No. \_\_\_\_\_  
\_\_\_\_\_  
Mother's Name \_\_\_\_\_  
Telephone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Grade: \_\_\_\_\_

### MEDICAL INFORMATION

Physician's Name:

\_\_\_\_\_

Physician's Address:

\_\_\_\_\_

Physician's Telephone No.:

\_\_\_\_\_

Preferred Hospital:

\_\_\_\_\_

Medical Insurance:

\_\_\_\_\_

Emergency Contact Person:

\_\_\_\_\_

Telephone No. \_\_\_\_\_

Physician's Release: \_\_\_\_\_ has been examined

(Name of Student)

on this date \_\_\_\_\_ and I hereby certify that he/she may participate in competitive sports. (Please identify any physical conditions which may limit participation, or which should be known by coaching staff or trainers.)

\_\_\_\_\_

Date

Physician's Signature

**This Form must be completed and turned into the Athletic Director in order for the student to be eligible to participate.**