SY2526 Participation Forms

Acknowledgment of Risk, Waiver, and Release of Liability Agreement

IDEA Public Schools ("IDEA") requires participants of an athletic activity or sport ("Program") to agree to and to sign this release form in order to participate. By signing this agreement, you agree that it is your responsibility to consult with a medical professional prior to, and regarding your child's participation in physical and mentally challenging activities.

Participant Name: _____ Date: _____ Age: _____

Sport/Athletic Activity: _____ Grade: _____

ASSUMPTION OF RISK

I acknowledge that my participation in the Program involves the possible risk of serious bodily injury, death, and/or property damage. I assume and accept all risk of bodily injury, death, property damage and any and all other harm connected with or arising out of my participation in the Program. I acknowledge that I am responsible for any and all medical expenses resulting from my illness or injury in connection with or arising out of the Program.

ACKNOWLEDGMENT OF HAZARDOUS ACTIVITIES

I acknowledge that the Program may involve strenuous and hazardous physical activities. I certify that I am in excellent physical health and have no physical limitations that would prevent me from fully participating in the Program. I grant permission to IDEA Public Schools and its Agents (defined below) to provide me with emergency medical treatment if needed.

RELEASE AND INDEMNITY

I (on my behalf and on behalf of my heirs, personal representatives, executors, administrators, successors and assigns) hereby:

(A) Release IDEA Public Schools, any sponsor or corporate partner of IDEA or the Program or any other persons or entities associated with the Program, their representatives, successors, assigns, employees, and volunteers or any representatives (the "Agents") from and against any and all claims, demands, actions, costs, losses, expenses, damages or causes of action for injuries or illnesses (up to and including death), damages or other claims of any nature that I might suffer arising out of or in any way connected with or related to the Program, including, without limitation, any claims which may arise in respect of activities in which I participate related to the Program (the "Claims"), and;

(B) Will defend, indemnify, and hold harmless IDEA Public Schools and their agents from and against any and all Claims which may be brought against them by anyone claiming to have been

injured or damaged as a result of my participation in the Program, including Claims occasioned wholly or in part, by any act, omission or negligence of an Agent that may arise out of the organization, design, supervision and execution of the Program or any other activities related thereto.

IF PARTICIPANT IS 18 OR OLDER: I HAVE CAREFULLY REVIEWED AND VOLUNTARILY AGREE TO THE TERMS OF THIS ACKNOWLEDGMENT OF RISK, WAIVER, AND RELEASE OF LIABILITY AGREEMENT AND HAVE SIGNED BELOW OF MY OWN FREEWILL.

Participant Signature (Required): _____

Participant First/Last Name (Please Print): _____ Date: _____

IF PARTICIPANT IS UNDER 18: I CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE PARTICIPANT AND ACKNOWLEDGE THAT I HAVE CAREFULLY REVIEWED AND VOLUNTARILY AGREE TO THE TERMS OF THIS ACKNOWLEDGMENT OF RISK, WAIVER, AND RELEASE OF LIABILITY AGREEMENT.

Parent/Guardian Signature (Required): _____

Child's First/Last Name (Please Print): _____

Parent/Guardian (Please Print Full Name): _____ Date: _____

Authorization for Emergency Medical Treatment

In case of accident, illness, or other emergency, I request that IDEA Public Schools ("IDEA") personnel contact me. If IDEA personnel cannot reach a parent/guardian after conscientious effort, I give permission for IDEA personnel to call emergency service providers or medical or dental service providers. If a life-threatening emergency exists, I give permission for IDEA personnel to immediately call emergency personnel and then contact me as soon as possible thereafter.

In the event that I cannot be reached to give necessary medical consent, I grant permission for IDEA Public Schools to arrange for all necessary emergency care for my child. I will be financially responsible for such care and for emergency medical transport. I authorize and consent to any X-ray examination, anesthetic, medical, dental, or surgical diagnosis or treatment, and hospital care, which, in the best judgment of a licensed physician or dentist, is deemed advisable. I agree to assume the financial responsibility for expenses incurred as a result of those services being provided.

Emergency Information

Athletes Name: _____ D.O.B.: _____

1. Parent/Guardian: _____
   Contact Number: _____

2. Parent/Guardian (If Applicable): _____
   Contact Number: _____

Please provide two alternative Emergency Contacts:

1. Contact Name (First & Last Name): _____
   Contact Number: _____

2. Contact Name (First & Last Name): _____
   Contact Number: _____

List any known or suspected medical conditions:

1.
2.
3.
4.
5.

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

2020

This **MEDICAL HISTORY FORM** must be completed ***annually*** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____

Address _____ Phone _____

Grade _____ School _____

Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

Explain "Yes" answers in the box below**. Circle questions you don't know the answers to.

		Yes	No
1.	Have you had a medical illness or injury since your last check up or physical?	☐	☐
2.	Have you been hospitalized overnight in the past year?	☐	☐
	Have you ever had surgery?	☐	☐
3.	Have you ever had prior testing for the heart ordered by a physician?	☐	☐
	Have you ever passed out during or after exercise?	☐	☐
	Have you ever had chest pain during or after exercise?	☐	☐
	Do you get tired more quickly than your friends do during exercise?	☐	☐
	Have you ever had racing of your heart or skipped heartbeats?	☐	☐
	Have you had high blood pressure or high cholesterol?	☐	☐
	Have you ever been told you have a heart murmur?	☐	☐
	Has any family member or relative died of heart problems or of sudden unexpected death before age 50?	☐	☐
	Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelpathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm?	☐	☐
	Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
	Has a physician ever denied or restricted your participation in activities for any heart problems?	☐	☐
4.	Have you ever had a head injury or concussion?	☐	☐
	Have you ever been knocked out, become unconscious, or lost your memory?	☐	☐
	If yes, how many times? _____		
	When was your last concussion? _____		
	How severe was each one? (Explain below)		
	Have you ever had a seizure?	☐	☐
	Do you have frequent or severe headaches?	☐	☐
	Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
	Have you ever had a stinger, burner, or pinched nerve?	☐	☐
5.	Are you missing any paired organs?	☐	☐
6.	Are you under a doctor's care?	☐	☐
7.	Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler?	☐	☐
8.	Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)?	☐	☐
9.	Have you ever been dizzy during or after exercise?	☐	☐
10.	Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
11.	Have you ever become ill from exercising in the heat?	☐	☐
12.	Have you had any problems with your eyes or vision?	☐	☐

		Yes	No
13.	Have you ever gotten unexpectedly short of breath with exercise?	☐	☐
	Do you have asthma?	☐	☐
	Do you have seasonal allergies that require medical treatment?	☐	☐
14.	Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?	☐	☐
15.	Have you ever had a sprain, strain, or swelling after injury?	☐	☐
	Have you broken or fractured any bones or dislocated any joints?	☐	☐
	Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints?	☐	☐
	If yes, check appropriate box and explain below:		

☐ Head	☐ Elbow	☐ Hip
☐ Neck	☐ Forearm	☐ Thigh
☐ Back	☐ Wrist	☐ Knee
☐ Chest	☐ Hand	☐ Shin/Calf
☐ Shoulder	☐ Finger	☐ Ankle
☐ Upper Arm	☐ Foot	

16.	Do you want to weigh more or less than you do now?	☐	☐
17.	Do you feel stressed out?	☐	☐
18.	Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease?	☐	☐

Females Only

19. When was your first menstrual period? _____
When was your most recent menstrual period? _____
How much time do you usually have from the start of one period to the start of another? _____
How many periods have you had in the last year? _____
What was the longest time between periods in the last year? _____

Males Only

20. Do you have two testicles? _____
21. Do you have any testicular swelling or masses? _____

☐ An electrocardiogram (ECG) is not required. By checking this box, I choose to obtain an ECG for my student for additional cardiac screening. I have read and understand the information about cardiac screening. I understand it is the responsibility of my family to schedule and pay for such ECG.

EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):

It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____

PREPARTICIPATION PHYSICAL EVALUATION -- PHYSICAL EXAMINATION

Student's Name _____ Sex _____ Age _____ Date of Birth_____

Height _____ Weight_____ % Body fat (optional) _____ Pulse _____ BP____/____ (____/____, ____/____)
brachial blood pressure while sitting

Vision: R 20/_____ L 20/___ Corrected: ☐ Y ☐ N Pupils: ☐ Equal ☐ Unequal

As a minimum requirement, this **Physical Examination Form** must be completed prior to junior high participation and again prior to first and third years of high school participation. It ***must*** be completed if there are yes answers to specific questions on the student's MEDICAL HISTORY FORM on the reverse side. **** Local district policy may require an annual physical exam.***

	NORMAL	ABNORMAL FINDINGS	INITIALS*
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart-Auscultation of the heart in the supine position.			
Heart-Auscultation of the heart in the standing position.			
Heart-Lower extremity pulses			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
Marfan's stigmata (arachnodactyly, pectus excavatum, joint hypermobility, scoliosis)			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

*station-based examination only

CLEARANCE

☐ Cleared

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for:_____Reason: _____

Recommendations: _____

_____

The following information must be filled in and signed by either a Physician, a Physician Assistant licensed by a State Board of Physician Assistant Examiners, a Registered Nurse recognized as an Advanced Practice Nurse by the Board of Nurse Examiners, or a Doctor of Chiropractic. Examination forms signed by any other health care practitioner, will not be accepted.

Name (print/type) _____ Date of Examination: _____

Address: _____

Phone Number: _____

Signature: _____

Must be completed before a student participates in any practice, before, during or after school, (both in-season and out-of-season) or performance/ games/matches.

Concussion Acknowledgement Form

Definition of Concussion

A concussion means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may:

A. Include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and

B. Involve loss of consciousness.

Prevention Guidelines

- Teach and practice safe play and proper technique.
- Follow the rules of play.
- Make sure the required protective equipment is worn for all practices and games.
- Protective equipment must fit properly and be inspected on a regular basis.

Signs and Symptoms of Concussion

The signs and symptoms of concussion may include but are not limited to: Headache, Appears to be dazed or stunned, Tinnitus (ringing in the ears), Fatigue, Slurred speech, Nausea or vomiting, Dizziness, Loss of balance, Blurry vision, Sensitivity to light or noise, Feeling foggy or groggy, Memory loss Confusion

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Concussion Oversight Team (COT)

Each district shall appoint and approve a **Concussion Oversight Team (COT)**. The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include an Advanced Practice Nurse, neuropsychologist, or a physician assistant. The COT is charged with developing the **Return to Play** protocol based on peer-reviewed scientific evidence.

Immediate Action and Return to Play

The student-athlete shall be **removed from practice or competition immediately** if suspected to have sustained a concussion. Every student-athlete suspected of sustaining a concussion shall be seen by a **physician** before they may return to athletic participation. The treatment for concussion is **cognitive rest**. This includes avoiding external stimulation such as: Watching television, Playing video games, Sending text messages, Use of computer, Bright lights. When all signs and symptoms of concussion have cleared and the student has received **written clearance from a physician**, the student-athlete may begin their **Return to Play** protocol as determined by the Concussion Oversight Team.

IDEA Public Schools

Texas Education Code, Section 38.157

A student removed from an interscholastic athletics practice or competition under Section 38.156 may not be permitted to practice or play again following the force or impact believed to have caused the concussion until:

1. The student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student's parent or guardian or another person with legal authority to make medical decisions for the student;

2. The student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;

3. The treating physician has provided a **written statement** indicating that, in the physician's professional judgment, it is safe for the student to return to play; and

4. The student and the student's parent or guardian or another person with legal authority to make medical decisions for the student:

    A. Have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;

    B. Have provided the treating physician's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and

    C. Have signed a consent form indicating that the person signing:

        (i) Has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;

        (ii) Understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;

        (iii) Consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and

        (iv) Understands the immunity provisions under Section 38.159.

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*Parent or Guardian Signature*_____ *Date* _____

Student Signature _____ *Date*_____

Sudden Cardiac Arrest

What is Sudden Cardiac Arrest?

- Occurs suddenly and often without warning.
- An electrical malfunction (short-circuit) causes the bottom chambers of the heart (ventricles) to beat dangerously fast (ventricular tachycardia or fibrillation) and disrupts the pumping ability of the heart.
- The heart cannot pump blood to the brain, lungs, and other organs of the body.
- The person loses consciousness (passes out) and has no pulse.
- Death occurs within minutes if not treated immediately.

What Causes Sudden Cardiac Arrest?

Conditions Present at Birth

Inherited (passed on from parents/relatives) conditions of the heart muscle:

- Hypertrophic Cardiomyopathy – hypertrophy (thickening) of the left ventricle; the most common cause of sudden cardiac arrest in athletes in the U.S.
- Arrhythmogenic Right Ventricular Cardiomyopathy – replacement of part of the right ventricle by fat and scar; the most common cause of sudden cardiac arrest in Italy.
- Marfan Syndrome – a disorder of the structure of blood vessels that makes them prone to rupture; often associated with very long arms and unusually flexible joints.

Inherited conditions of the electrical system:

- Long QT Syndrome – abnormality in the ion channels (electrical system) of the heart.
- Catecholaminergic Polymorphic Ventricular Tachycardia and Brugada Syndrome – other types of electrical abnormalities that are rare but run in families.

Non-Inherited (not passed on from the family, but still present at birth) conditions:

- Coronary Artery Abnormalities – abnormality of the blood vessels that supply blood to the heart muscle. The second most common cause of sudden cardiac arrest in athletes in the U.S.
- Aortic valve abnormalities – failure of the aortic valve (the valve between the heart and the aorta) to develop properly; usually causes a loud heart murmur.
- Non-compaction Cardiomyopathy – a condition where the heart muscle does not develop normally.
- Wolff-Parkinson-White Syndrome – an extra conducting fiber is present in the heart's electrical system and can increase the risk of arrhythmias.

Conditions Not Present at Birth but Acquired Later in Life

- Commotio Cordis – concussion of the heart that can occur from being hit in the chest by a ball, puck, or fist.
- Myocarditis – infection/inflammation of the heart, usually caused by a virus.

- Recreational/Performance-Enhancing drug use.

Idiopathic

- Sometimes the underlying cause of the Sudden Cardiac Arrest is unknown, even after autopsy.

What Are the Symptoms/Warning Signs of Sudden Cardiac Arrest?

- Fainting/blackouts (especially during exercise)
- Dizziness
- Unusual fatigue/weakness
- Chest pain
- Shortness of breath
- Nausea/vomiting
- Palpitations (heart is beating unusually fast or skipping beats)
- Family history of sudden cardiac arrest at age < 50

ANY of these symptoms/warning signs that occur while exercising may necessitate further evaluation from your physician before returning to practice or a game.

What Is the Treatment for Sudden Cardiac Arrest?

- Time is critical and an immediate response is vital.
- CALL 911
- Begin CPR
- Use an Automated External Defibrillator (AED)

What Are Ways to Screen for Sudden Cardiac Arrest?

- The American Heart Association recommends a pre-participation history and physical including 12 important cardiac elements.
- The Pre-Participation Physical Evaluation – Medical History form includes ALL 12 of these important cardiac elements and is mandatory annually.
- Additional screening using an electrocardiogram and/or an echocardiogram is readily available to all athletes, but is not mandatory.

IDEA Public Schools

Where Can One Find Information on Additional Screening?

- American Heart Association (www.heart.org)
- AugustHeart (www.augustheart.org)
- Championship Hearts Foundation (www.championshipheartsfoundation.org)
- Cypress ECG Project (www.cypressecgproject.org)
- Parent Heart Watch (www.parentheartwatch.com)

Acknowledgment Section

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name (Print): _____

Student Signature: _____ **Date:** _____

Student Name (Print): _____

Parent and Student Agreement/Acknowledgement Form Anabolic Steroid Use and Random Steroid Testing

- Texas state law prohibits possessing, dispensing, delivering or administering a steroid in a manner not allowed by state law.
- Texas state law also provides that body building, muscle enhancement or the increase in muscle bulk or strength through the use of a steroid by a person who is in good health is not a valid medical purpose.

- Texas state law requires that only a licensed practitioner with prescriptive authority may prescribe a steroid for a person.
- Any violation of state law concerning steroids is a criminal offense punishable by confinement in jail or imprisonment in the Texas Department of Criminal Justice.

STUDENT ACKNOWLEDGEMENT AND AGREEMENT

As a prerequisite to participation in IDEA Public Schools athletic activities, I agree that I will not use anabolic steroids. I have read this form and understand that I may be asked to submit to testing for the presence of anabolic steroids in my body, and I do hereby agree to submit to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my high school. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject me to penalties as determined by IDEA Public Schools.

Student Name (Print): _____ Grade (9-12) _____

Student Signature: _____ Date: _____

PARENT/GUARDIAN CERTIFICATION AND ACKNOWLEDGEMENT

As a prerequisite to participation by my student in IDEA Public Schools athletic activities, I certify and acknowledge that I have read this form and understand that my student must refrain from anabolic steroid use and may be asked to submit to testing for the presence of anabolic steroids in his/her body. I do hereby agree to submit my child to such testing and analysis by a certified laboratory. I further understand and agree that the results of the steroid testing may be provided to certain individuals in my student's high school. I understand and agree that the results of steroid testing will be held confidential to the extent required by law. I understand that failure to provide accurate and truthful information could subject my student to penalties as determined by IDEA Public Schools.

Name (Print): _____

Signature: _____ **Date:** _____

Relationship to student: _____

A message to: Parents/Guardians & Student Athletes:

Extracurricular activities are conducted on a voluntary basis.

Having insurance is not mandatory for participation, but **HIGHLY RECOMMENDED** for families in case of medical expenses due to any sustained injuries.

IDEA Public Schools **DOES NOT** carry insurance policies for athletic-related injuries sustained in try-outs, practices and/or competitions; or while in the care of our staff.

Parents, please take the time to read over all literature in this packet regarding our network's approved private insurance policy options available to you all.

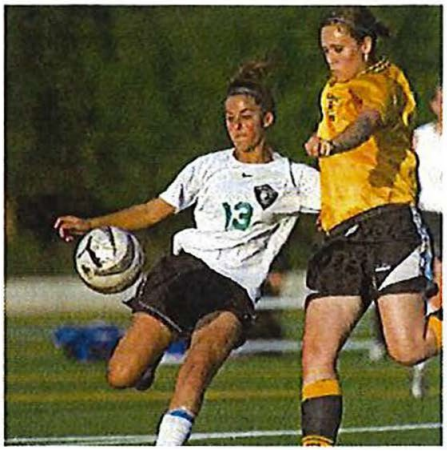
Insurance Waiver Acknowledgement: In providing my signature and contact information below, I hereby certify for the record that I was made aware of & acknowledge that IDEA Public Schools does not provide medical coverage, and I received the (Optional Student Insurance Information).

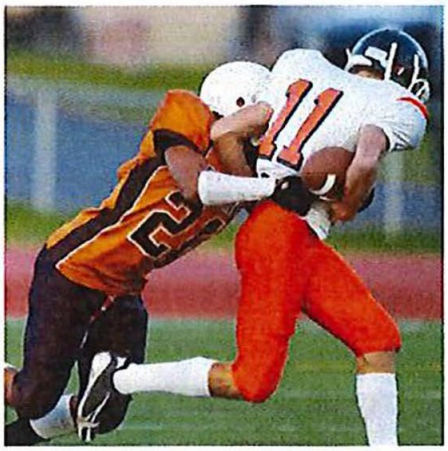
I therefore acknowledge that I will not hold IDEA Public Schools liable for any medical expense that may result from athletic(s) sport participation.

Parent Name: _____

Student Name: _____

Parent Signature: _____





STUDENT ACCIDENT INSURANCE

School-Time Coverage 24 Hour Coverage $5,000 Dental

This is an affordable, full excess, accident-only policy for students that will offset the rising medical costs and deductibles required by insurance carriers under your current health plans.

Enclosed is a brief detail of the plans currently available and enrollment form. Online enrollment is available via our website at www.studentinsuranceplans.com and coverage can be verified by calling 469-579-4139. A detailed master policy is available at the school district.

Underwritten by:

Catlin Insurance Company, INC.
1330 PC ST Oak BLVD, Ste 2325
Houston, Texas 77056

Marketed by:

Student Insurance Plans, LLC
PO Box 1447
Frisco, Texas 75034

Accident Plans

Description of Plan Benefits	**Standard Plan**	**Elite Plan**
Death	$10,000	$50,000
Dismemberment	$10,000	$100,000
Paralysis	**N/A**	$100,000
AME		

Benefit Maximum	**$25,000**	
Deductible (per accident)	**$0**	**$100**
inpatient		
Hospital Miscellaneous/Room & Board:	100% up to $2,500	100% up to Benefit Maximum
Physician's Visit	$50 per visit	100% up to Benefit Maximum
Outpatient:		
Day Surgery Misc: *(facility charge)*	100% up to $2,000	100% up to Benefit Maximum
X-Ravs, Diagnostic Testina:	100% UP to $300	100% up to Benefit Maximum
Physician’s Visits:	$50 per visit	100% up to Benefit Maximum
Physical Therapy:	$50/visit to $500	100% up to Benefit Maximum
Hospital Emergency Room:	100% UP to $300	100% up to Benefit Maximum
Emergency Room Physician:	$75 Per visit	100% up to Benefit Maximum
MRI/Cat Scan:	100% UP to $800	100% up to Benefit Maximum
Lab:	100% UD to $150	100% up to Benefit Maximum
Home Health Care:	$50/visit to $500	100% up to Benefit Maximum
Inpatient and/or Outpatient Surgeon's Fees:	100% up to $2,000 (limited to the primary procedure)	100% up to Benefit Maximum
Anesthetist:	25% of surgeon benefit	100% up to Benefit Maximum
Assistant Surgeon:	25% of surgeon benefit	100% up to Benefit Maximum
Ambulance:	100% UP to $600	100% up to Benefit Maximum
Orthopedic Braces & Appliance:	100% UD to $500	100% up to Benefit Maximum
Eyeglasses, Contact Lens, Hearing Aids:	**100% up to $400**	100% up to Benefit Maximum
Dental:	**100% up to $5000**	100% up to Benefit Maximum
Prescriptions	**100% Up to $100**	100% up to Benefit Maximum
Injections:	**100% Up to $100**	100% up to Benefit Maximum
MVA	**100% Up to $5000**	100% up to Benefit Maximum

Heart or Circulatory Malfunction	**N/A**	**$5,000**

Accident Coverages

School Time:

Coverage is in force for the hours and days when school is in session and while attending school sponsored and supervised activities on or off the school premises. This plan does not cover Athletics/UIL activities in grades 7-12.

24 Hour:

Coverage is in force around the clock, 24 hours a day, including summer, weekends, and vacation periods. Protected at home or while away anytime, anyplace, anywhere. The UIL/Sports coverage protects students while at practice or participating in school sponsored and supervised UIL activities and Sports for grades 7 – 12. Varsity Football is excluded.

How To Enroll Your Child

- Select a plan and coverage type from the options listed. Complete the application enclosed and make check payable to Student Insurance Plans. Please write your child's name on your check.
- Enrollment is also available online at www.studentinsuranceplans.com.
- Please keep a copy of the brochure and payment as your proof of insurance as you will not receive a policy or ID card. The master policy is issued to the district and can be obtained by contacting the District Administrator. Should you want an ID card for your child, you can print out the ID card from our website and fill in your child's information or contact us at 469-579-4139.

Claims Procedure

In case of an accident, notify the school immediately. Obtain a claim form from your school or at www.studentinsuranceplans.com and mail to the address indicated on the claim form. Notice of claim must be filled in within 90 days (about 3 months) from the date of the accident.

Exclusion and Limitations

This Policy does not cover any loss as a result of:

1.) Suicide or attempted suicide; intentionally, self-inflicted Injury; 2.) War or any act of war, whether

declared or not; active-duty service in the; military; naval or air force of any country or international organization; active participation in a riot, or insurrection; 3.) Sickness, disease; bodily or mental infirmity; bacterial or viral infection; or medical or surgical treatment thereof, except for any bacterial infection resulting from any accidental external cut or wound; 4.) Commission of or attempt to commit: a felony; an assault; or other illegal activity; being under the influence of drugs or intoxicants, unless taken under the advice of a doctor; 5.) Flight in; boarding; or alight in from an aircraft or any craft designed to fly above the Earth's surface, except as: a fare-paying passenger on a regularly scheduled commercial or charter airline, a passenger in a non-scheduled, private aircraft used for pleasure purposes with no commercial intent during the flight; 6.) Travel in or on; entering into or alighting from; or being struck by any on/off road motorized vehicle not requiring licensing as a motor vehicle; an Accident if the Covered Person is the operator of a motor vehicle and does not possess a valid motor vehicle license; participation

in any activity or hazard not specifically covered by the Policy; 7.) A cardiovascular malfunction or stroke caused solely and exclusively by exertion, as verified by a doctor, while the Covered Person participates in a Covered Activity; aggravation of an Injury the Covered Person Suffered before participating in that Covered Activity, unless We receive a written medical release from the Covered Person's Doctor. 8.) Treatment by any Immediate Family Member or member of the Covered Person's household. 9.) Treatment of hernia; Osgood-Schlatter Disease; osteochondritis; appendicitis; osteomyelitis; cardiac disease or conditions; pathological fractures; congenital weakness; detached retina unless caused by an injury or mental disorder or psychological or psychiatric care or treatment; whether or not caused by a Covered Accident. 10.) Pregnancy; childbirth; miscarriage; abortion; or any complications of childbirth; miscarriage; abortion; 11.) Cosmetic surgery, except for reconstructive surgery needed as the result of an injury; Any elective treatment, surgery, health treatment or examination; treatment of Injuries that result over a period of time; routine care or physicals; rest cures or custodial care; 12.) Sexually transmitted diseases or immune deficiency disorders and related conditions; 13.) Covered medical expenses for which the Covered Person would not be responsible for in the absence of the Policy; 14.) Damage to or loss of dentures or bridges; or damage to existing orthodontic equipment (except as specifically covered by the Policy).

Enrollment Application

School District Name: _____ School Name: _____

Student Last Name: _____ Students First Name: _____

Address: _____ City: _____ State: _____Zip: _____

Student ID: _____D.O.B. _____Grade: _____

Parent Name: _____ Parent Email: _____

Plans: (Coverage dates are listed within the master policy and are based upon the school district's calendar.) Circle the one you choose.

School Time Coverage:	**Standard Plan:**	**Elite Plan:**
Grades K-6	$20.00	$30.00
Grades 7 – 12	$30.00	$50.00
24 Hour Coverage:	**Standard Plan:**	**Elite Plan:**
Grades K-6	$35.00	$45.00
Grades 7-12	$90.00	$100.00

Amount Enclosed: _____ (make checks payable to Student Insurance Plans)

Online enrollment is available via Visa or Mastercard at www.studentinsuranceplans.com

Mail to: Student Insurance Plans, PO Box 1447, Frisco, Texas 75034