LAWRENCE PUBLIC SCHOOLS
ATHLETIC INSURANCE COMPLIANCE: School Year - 2021-2022

USD 497

Student's Name ____

(Last) (First) (Middle Initial)

Grade _______ School ______________________ Date of Birth ____/____/____ Date of Last Tetanus ______/______/______

Home Address ____ Telephone ______________________________

Zip code

Father's/Guardian's Name ____ Phone _________________________________

Mother's Name ____ Phone _________________________________

In case of emergency, if we cannot contact a parent:

Name ____ Phone _________________ Relationship

Family Physician ____ Business Phone ______________________

As required by the Kansas State School Athletic Association, all students participating in athletics and cheerleading must be protected by accident insurance for catastrophic injuries exceeding **$25,000**. This coverage is provided by the athletic participation fee paid by each participant.

In addition, *school policy requires* that all participants in school sponsored activities provide proof of medical insurance coverage for treatment up to **$25,000**.

Compliance with this regulation can be accomplished by one or both of the following options:

OPTION 1++ Provide the company name and policy number of the insurance carrier providing medical insurance protecting the student participant.

OPTION 2** Purchase individual, voluntary, student insurance coverage from the insurance plans made available to Lawrence Public Schools' students through an independent carrier. (Information provided by the insurance company is available in the school office)
Coverage is limited – you are encouraged to read the policy carefully and check with the company for details.

I have read the above policy and will comply with the conditions of self-acceptance for participation in school sponsored activities as follows:

++OPTION 1 I certify that ______________________________ is protected by medical insurance for treatment **up to at least $25,000**:

(**student name)**

Company Name ___________________________________ Policy/Group Plan Number____

(**required information)** **(required information)**

COMPLETE OPTION TWO <u>ONLY</u> IF YOU PURCHASED INSURANCE PLAN AVAILABLE TO LAWRENCE PUBLIC SCHOOL STUDENTS THROUGH AN INDEPENDENT CARRIER

****OPTION 2** I certify that ______________________________ (student name) is protected for medical treatment **up to at least $25,000** through an individual, voluntary, student insurance plan and that application has been submitted **to the Company** with the required premium for this coverage. ***PROOF OF COVERAGE REQUIRED FOR OPTION 2***

MEDICAL AUTHORIZATION

In the event that my child becomes ill or is injured, and I, or the authorized physician listed above, cannot be immediately contacted at the time of an emergency, and if in the judgment of the staff of Lawrence Public Schools USD #497, immediate observation or treatment is required, I authorize and direct said staff members to arrange transportation for my child (properly accompanied) to the nearest medical facility for assessment and/or treatment. This document further authorizes and empowers any faculty/staff member of USD #497 to sign or grant any and all medical, dental, surgical, optometry or similar such authorizations to any licensed medical doctor, surgeon, dentist, optometrist, nurse or similar person trained in the healing arts as may be reasonable and necessary for the treatment of my child, during any time that my child may be under the supervision of USD #497 staff, for any school-related activity or athletic event.

Date _____________________ Signature of Parent/Guardian ____

(MUST BE SIGNED IN FRONT OF A NOTARY PUBLIC – FORM NOT ACCEPTED WITHOUT NOTARY STAMP & SIGNATURE)

State of Kansas County of ____

Subscribed and sworn before me this ________________ day of ___________________________ in the year of ____________.

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(Signature of Notary Public)

My commission expires: ____