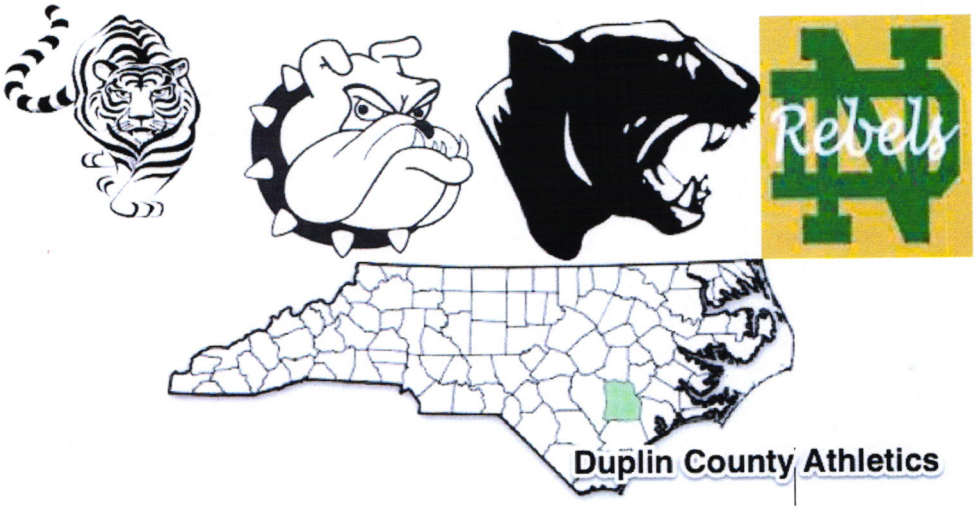
Duplin County School's

Student-Athlete and

Parent Forms

Mr. Ken Avent, Distric Athletic Director
Celia Uranga, Administrative Assistant for Duplin County Athletics



Originally Adopted by Duplin County Board of Education
August 3, 1999

2022-2023 School Year

Updated July 2022

Duplin County Schools
Department of Athletics

School _____

Sports _____

Acknowledgment of Athletic Handbook

I acknowledge receipt of a Duplin County Schools Student-Parent Handbook / Coaches and Athletic Director's Athletic Handbook and have read the rules concerning eligibility and conduct for student-athletes. I understand the rules and guidelines of the North Carolina Department of Public Instruction, the Duplin County Board of Education, NCHSAA, and the school in which I attend. I have viewed the required power point regulations on eligibility, sports medicine, and sportsmanship.

Signature of Parent _____ Date _____

Signature of Student _____ Date _____

Athletic Directors **MUST** submit a signed copy to the principal and for all coaches in his/her school who will be involved in coaching athletics. Athletic Directors MUST maintain a copy of this document which is to be signed by all student-athletes and their parent or guardian.

Student Athlete Pledge

As a student, I know I am a role model. I understand the spirit of fair play while playing hard. I will refrain from engaging in all types of disrespectful behavior, including inappropriate language, taunting, trash talking, and unnecessary physical contact. I know the behavior expectations of Duplin County Schools, my school, my conference, and the State Department of Public Instruction and hereby accept the responsibility and privilege of representing this school and community as a student athlete.

Student Athlete _____ Date _____

Student Athlete's Parent Pledge

As a parent, I acknowledge that I am a role model. I will remember that school athletics is an extension of the classroom, offering learning experiences for the students. I must show respect for all players, coaches, spectators, and support groups. I will participate in cheers that support, encourage, and uplift the teams involved. I understand the spirit of fair play and the good sportsmanship expected by Duplin County Schools, our school, our conference, and the State Department of Public Instruction. I hereby accept my responsibility to be a model of good sportsmanship that comes with being the parent of a student athlete.

Parent(s) _____ Date _____

Promesa de los padres del Estudiante Atleta

Como padre o madre, entiendoque soy unmodeloparamishijos. No olvidaréque los deportesescolares son una extension del salon de clase y queofrecen a los estudiantesoportunidades de aprendizaje. Tengoqueserrespetuosohacia los jugadores, entrenadores, espectadores y grupos de apoyo.Animaré al equipo o atletasqueparticipen en unamaneraque los apoye, alienate, y les levanter el ánimo. Entiendo el espíritudeportivo y de juegolimpioque se espera de nuestroequipo, de nuestraconferencia y del NCDPI.Por la presente, acepto mi responsabilidad de serunmodelo del buenespíritudeportivoqueva con el hecho de ser padre o madre de un estudianteatleta.

Padre o madre_____ Hoy _____

Promesa de los padres del estudiante Atleta

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Padre o Madre_____ Hoy _____

ATHLETIC HONOR CODE

Duplin County Schools
Interscholastic Athletics

Student's Name _____
Parent of Guardian's Name_____
School _____
Sport(s)_____

I understand the eligibility requirements for interscholastic athletics in Duplin County Schools, and that these apply to the student named above. I have directed all questions I had to the school's athletic director and they have been answered.

By my signature(s) below, I verify that:

- I am the parent, legal custodian or legal guardian of the student named above.
- This student meets the age requirements to participate on an athletic team.
- This student meets the academic requirements to participate on an athletic team.
- The home address I gave to the registrar and to the athletic director at this student's school is where this student and I actually live at the present time.
- We live in the attendance area for this school, or received a transfer to this school.
- I am not aware of any other students or parents who have given false information to DCS so they may play on an athletic team.
- I will immediately report all suspected athletic eligibility violations to the principal and athletic director at this school.

Further, I am aware that if I:
...give false address or other eligibility information, or
...Do not report the use of false addresses or other eligibility information by others, or
...Do not update my address with the school and athletic director in the event that it changes during the school year,
This student-athlete and his or her athletic team may be penalized by the North Carolina High School Athletic Association and by Duplin County Schools.

Signature of Parent or Legal Guardian: _____

Signature of Student-Athlete: _____

Duplin County High School Student-Athlete
Drug Testing Consent Form

School Year: _____

□EDHS □JKHS □NDHS □WRH

A student athlete and his/her parent/guardian must sign this consent form before the student athlete is allowed to participate in any game or practice.

I, _____ ***(Name of Student)***, have read and do hereby declare that I will be a participant in the Board of Education approved policy on Drug Screening of Athletes. I authorize the school to administer drug testing and to release the results of the test to my parent(s)/guardian(s), athletic director, head coach, principal, personnel director, and the superintendent or his/her designee.

I, _____ ***(Name of Parent/Guardian),*** as the parent/guardian have read and consent to and authorize the Duplin County School System to conduct a drug test on my son/daughter; and to the release of information concerning the results of such test to me, athletic director, head coach, principal, support service director, and the superintendent or his/her designee.

Any athlete refusing to be tested forfeits their right to participate in athletics for 365 days.

1st Offense - Suspended from team practice and play for two weeks, however the athlete must attend practice. The athlete is required to attend counseling sessions via mental health. All cost will be covered by athlete or athlete's family. The student will be required to submit for drug testing on demand within six weeks of positive test. Student must provide verification of mental health counseling at cost to student and family.

2nd Offense - All athletic eligibility will be terminated for 365 days.

_____ ___/___/_____
Student's Signature/Date/Social Security Number

_____
Sport(s)

_____ Parent/Guardian's Signature/

_____ _____/_____
Date Home Phone/Work Phone

_____
Address

Permission for Medical Treatment

Athlete's Name _____

Dear Parent or Guardian:

The pre-participation examination is a limited medical checkup to screen your child to see if he/she can safely participate in sports. The exam does screen for the common problems that have been shown to be a danger to athletes. It is not a comprehensive medical exam and often does not detect rare medical conditions. If you have concerns about your child having a serious medical illness, please schedule a visit with your personal physician. Additionally, your child's regular health care, routine physical examinations, and laboratory testing should continue to come from his/her personal physician.

I recognize that there are inherent risks in all athletic events (head and spinal cord injuries, fractures, etc.), and hereby give my permission to _____ High School for my son/daughter to participate in interscholastic athletic activities.

Permission is hereby granted to _____ School and its authorized representatives to proceed with any needed medical or minor surgical treatment, x-ray examination, and immunization for the above-named individual. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above-named individual may be given.

I hereby release _____ School and members of its athletic staff including, but not limited to, its coaches, sports first responder, administrators, and all others connected with school athletic activities, and any attending physicians or surgeons, from any and all damages for injuries sustained by my son/daughter while participating in any sports activity connected with _____School and do hereby agree to hold harmless any and all of the above from any and all damages which they may suffer as a result of injuries sustained by my son/daughter while participating as above stated.

Is student named above allergic to any medication? Yes _____ No _____

If yes, list medications: _____

Signature _____ Phone # _____ Home _____ Business

Emergency contact if parent not available _____ Phone #_____

Concussion Management Guidelines: Home Instruction Sheet

Your student-athlete _____ is suspected of sustaining a concussion on _____ during _____. The following are guidelines suggested in the care of your athlete:

What is a concussion?

A concussion is defined as a head injury that results in a temporary loss of normal brain function, causing a variety of physical, cognitive and emotional symptoms.

What are your student-athlete's symptoms?

Headache Drowsiness Confusion Loss of Consciousness Memory Loss Nausea

Vomiting Photosensitivity Visual Disturbances Convulsions Muscle Weakness

Dizziness Unequal Pupils Unusual Eye Movements Balance Problems

Personality Disturbance Ringing in Ears

Other: _____

How do you manage your student-athlete's symptoms?

- ***If your student-athlete's symptoms worsen or new symptoms develop, he/she needs to be taken to the ER immediately!***
- **Your student-athlete needs to be monitored for the remainder of the day/evening. This does not mean that he/she needs to be woken up every hour during the night. It is fine to let them sleep!**
  - **The only time an athlete should be woken every hour at night is if they lost consciousness or if they had prolonged periods of amnesia. If this was the case- they should have been seen in the ER.**
- **Your athlete may take Tylenol or Acetaminophen for a headache. Follow directions on the bottle.**
- **Once symptoms have fully resolved, you will need to take your student-athlete to a qualified physician, neuropsychologist, physician assistant or nurse practitioner to be cleared for return to play. This person should be well versed in the diagnosis and treatment of concussions.**
  - **The NCHSAA Concussion Return to Play form will be given to you or your student-athlete by the Certified Athletic Trainer**
  - ***Form must be signed by the physician and returned to the Certified Athletic Trainer. If the form is not signed or returned, your student-athlete will be held out of play. This is a NCHSAA rule.***
- ***DO NOT:* Eat spicy foods, drive a car, use Aspirin, Alleve, Advil or any other NSAID products.**

Questions? **If you or your student-athlete has any questions feel free to contact the Athletic Trainer or Athletic Director**

Extracurricular Travel Release Form

Date: _____

I understand as parent/guardian of _____ that by signing this permission form, I am hereby giving up the following:

1. All accident insurance coverage provided by the school beyond the limited coverage of the regular school insurance. I understand Duplin County Schools does not carry catastrophic coverage.
2. In case of an accident, my regular school insurance coverage may be denied if the route taken home by the driver is determined to be different from the most direct route between the location of the activity and home.
3. That the person allowing the student to ride home with them assumes full liability for that student's safety should an accident occur.

With the aforementioned understandings, I hereby legally and morally release all school officials and the Duplin County Board of Education from any and all liability resulting from accident or injury occurring during the time of this release.

Therefore, _____ has my permission to travel with

_____ to or from this activity.

Parent/Guardian Signature _____

Other Local School, Parent/Guardian Signature _____

Source: Duplin County Board of Education, Kenansville, NC
Date: January, 1986

Student-Athlete COVID Questionnaire

Student-Athlete's Name: _____

Date of Birth: _____ Age: _____

COVID RELATED QUESTIONS ABOUT THE STUDENT-ATHLETE	YES	NO	NA
1. Since January 1, 2020 have you been told that you have had a positive test for COVID-19, **OR** have you been told by a medical professional, your school, or local health department that you have had to quarantine (stay home) due to concern that you had COVID-19 symptoms?			
2. If the answer to 1 was "Yes", has the *Return to Play Form: COVID-19 Infection Medical Clearance Releasing The Student-Athlete to Resume Full Participation in Athletics* been completed?			
3. Have you been fully vaccinated against COVID?			

Note: The NCHSAA maintains an unquestionable commitment to the health and safety of student-athletes and athletic staff alike. These questions were not included in the History section of the 2021-2022 Preparticipation Physical Evaluation (PPE) as that is a copyrighted document. The Association strongly recommends answering these questions to assist health care professionals, licensed athletic trainers, first responders and coaches in screening students for potential long-term impacts related to COVID-19 such cardiovascular implications. The answers may also help administrators and health care professionals determine whether a student-athlete who may have been exposed to a confirmed positive case of COVID-19 needs to quarantine even though they do not exhibit symptoms.

While the Association strongly recommends answering these questions, choosing not to do so will not impact the eligibility of a student-athlete to participate in athletics.

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex: M/F _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (**check box next to appropriate number**)*

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical issues or recent illness?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?	☐	☐
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐	☐
7. Has a doctor ever told you that you have any heart problems?	☐	☐
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	☐	☐
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐

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BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?	☐	☐
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	☐	☐
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	☐	☐
22. Have you ever become ill while exercising in the heat?	☐	☐
23. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
24. Have you ever had or do you have any problems with your eyes or vision?	☐	☐

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?	☐	☐
26. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
27. Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
28. Have you ever had an eating disorder?	☐	☐
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?	☐	☐
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)	☐	
Eyes, ears, nose, and throat • Pupils equal • Hearing	☐	
Lymph nodes	☐	
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)	☐	
Lungs	☐	
Abdomen	☐	
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis	☐	
Neurological	☐	
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck	☐	
Back	☐	
Shoulder and arm	☐	
Elbow and forearm	☐	
Wrist, hand, and fingers	☐	
Hip and thigh	☐	
Knee	☐	
Leg and ankle	☐	
Foot and toes	☐	
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test	☐	

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

NCHSAA Approved for Use Beginning March 2021

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Information Sheet

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (http://www.cdc.gov/concussion/)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

Revised: February 2021 - Approved for use in current or upcoming school year.

Gfeller-Waller NCHSAA Student-Athlete & Parent/Legal Custodian Concussion Statement Form

Instructions: The student athlete and his/her parent or legal custodian, must initial beside each statement acknowledging that they have read and understand the corresponding statement. The student-athlete should initial in the left column and the parent or legal custodian should initial in the right column. Some statements are applicable only to the student-athlete and should only be initialed by the student-athlete. This form must be completed for each student-athlete, even if there are multiple student-athletes in the household.

Student-Athlete Name: (please print)_____

Parent/Legal Custodian Name(s): (please print)_____

Student-Athlete Initials		Parent/Legal Custodian(s) Initials
	A concussion is a brain injury, which should be reported to my parent(s) or legal custodian(s), my or my child's coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some signs and symptoms might be present immediately; however, other symptoms can appear hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	Not Applicable
	If I think a teammate has a concussion, I should tell my coach(es), parent(s)/ legal custodian(s) or medical professional about the concussion.	Not Applicable
	I, or my child, will not return to play in a game or practice if a hit to my, or my child's, head or body causes any concussion-related symptoms.	
	I, or my child, will need written permission from a medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away, right away. I realize that resolution from a concussion is a process that may require more than one medical visit.	
	I realize that ER/Urgent Care physicians will not provide clearance to return to play or practice, if seen immediately or shortly after the injury.	
	After a concussion, the brain needs time to heal. I understand that I or my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms listed on the Student-Athlete/ Parent Legal Custodian Concussion Information Sheet.	
	I have asked an adult and/or medical professional to explain any information contained in the Student-Athlete & Parent Concussion Statement Form or Information Sheet that I do not understand.	

By signing below, we agree that we have read and understand the information contained in the Student-Athlete & Parent/Legal Custodian Concussion Statement Form, and have initialed appropriately beside each statement.

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/Legal Custodian Date

Revised: February 2021 - Approved for use in current or upcoming school year.

2022-2023 NCHSAA ELIGIBILITY, CONSENT TO PARTICIPATE, AND RELEASE FORM

THIS DOCUMENT MUST BE SIGNED BY THE STUDENT-ATHLETE OF AN NCHSAA MEMBER SCHOOL AND BY THE STUDENT-ATHLETE'S PARENT OR LEGAL CUSTODIAN BEFORE PARTICIPATION. STUDENT-ATHLETES MAY NOT PARTICIPATE WITHOUT THE SIGNATURE OF THE STUDENT-ATHLETE AND PARENT(S)/LEGAL CUSTODIAN.

I (the student-athlete and parent(s)/legal custodian) acknowledge that I have read and understand the eligibility rules applicable to participation in sports through the North Carolina High School Athletic Association (NCHSAA). I understand that a copy of the NCHSAA Handbook is on file with the member school's principal and/or Athletic Director, and that I may review it, in its entirety if I so choose. I know my school is a member of the NCHSAA and must adhere to all regulations that govern interscholastic athletic programs, including, but not limited to, Federal and State laws, local regulations, and the rules and regulations of the NCHSAA. I agree to follow the rules of my school and the NCHSAA and to abide by their decisions. I acknowledge and understand that participation in interscholastic athletics is a privilege, not a right. I understand that classroom performance, dropping a class, or taking coursework through other educational options could affect eligibility and compliance with NCHSAA academic standards.

STUDENT CODE OF RESPONSIBILITY

As a student-athlete, I **understand and accept** the following responsibilities:

I will **respect the rights and beliefs** of others and will treat others with courtesy and consideration. I will be **fully responsible** for my own actions and the consequences of my actions.

I will **respect the property** of others.

I will **respect and obey the rules** of my school and the laws of my community, state, and country.

I will **show respect to those who are responsible for enforcing the rules** of my school and the laws of my community, state, and country.

I **understand that a student whose character or conduct violates** the school's Athletic Code or School Code of Responsibility could be deemed ineligible for a period of time as determined by the principal or school system Administration.

PARENTS, LEGAL CUSTODIANS, OR STUDENT-ATHLETES WHO DO NOT WISH TO ACCEPT THE RISK DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS FORM.

I (the student-athlete and parent(s)/legal custodian) recognize that participation in interscholastic athletics involves some inherent risks for potentially severe injuries including, but not limited to, serious neck, head and spinal injuries, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, serious injury or impairment to other aspects of the body, or effects to the general health and well-being of the child, and in rare cases, death. Although serious injuries are not common in supervised school athletic programs, it is impossible to eliminate all risk. The student-athlete and parent(s)/legal custodian have a responsibility to help reduce that risk. I understand that student-athletes must obey all safety rules, report all physical and hygiene problems to their coaches, follow a proper conditioning program, and inspect their own equipment daily.

I (the student-athlete and parent(s)/legal custodian) authorize medical treatment should the need arise for such treatment while the student-athlete is under the supervision of the member school. I **consent to medical treatment** for the student-athlete following an injury or illness suffered during practice and/or a contest. I understand that in the case of **injury or illness requiring treatment by medical personnel and transportation to a health care facility**, a reasonable attempt will be made to contact the parent/legal custodian if the student-athlete is a minor, but that, if necessary, the student-athlete will be treated and transported via ambulance to the nearest hospital. I further authorize the use or disclosure of the student-athlete's personally identifiable health information should treatment for illness or injury become necessary.

I (the student-athlete and parent(s)/legal custodian) **understand all concussions are potentially serious** and may result in complications including prolonged brain damage and death if not recognized and managed properly. Further, I understand that if the student-athlete is removed from a practice or competition due to a suspected concussion, he or she will be unable to return to participation unless and until clearance is given in compliance with applicable laws. I also acknowledge that I **have received, read, and signed** the **Gfeller- Waller Concussion Information Sheet, as well as viewed the CrashCourse concussion education video.**

I (the student-athlete and parent(s)/legal custodian) **consent to the NCHSAA's use of the student-athlete's name**, image, likeness, and athletic-related information in reports of contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics, and grant the NCHSAA the right to photograph and/or videotape the participant and further to use the student-athlete's face, likeness, voice, and appearance in connection with exhibitions, publicity, advertising, promotional, and commercial materials without reservation or limitation. The NCHSAA, however, is under no obligation to exercise said rights herein. I further consent to the disclosure, by the member school to the NCHSAA upon the NCHSAA's request, of all records relevant to the student-athlete's eligibility including, but not limited to, their records relating to enrollment, attendance, academic standing, age, discipline, finances, residence, and physical fitness. The student-athlete and parent/legal custodian, individually and on behalf of the student-athlete, hereby irrevocably, and unconditionally release, acquit, and discharge, without limitation, the NCHSAA its officers, agents, attorneys, representatives, and employees (collectively, the "Releasees") from any and all losses, claims, demands, actions and causes of action, obligations, damages, and costs or expenses of any nature (including attorney's fees) that the student and/or legal custodian incur or sustain to person, property, or both, which arise out of, result from, occur during, or are otherwise connected with the student-athlete's participation in interscholastic athletics if due to the ordinary negligence of the Releasees.

By signing this document, we acknowledge that we have read the above information and that we consent to participation by the herein named student-athlete. We understand that the authorizations and rights granted herein are voluntary and that we may revoke any or all of them at any time by submitting said revocation in writing to the student-athlete's member school. We understand that if we submit a revocation, the student-athlete will no longer be eligible for participation in interscholastic athletics; provided, however, that revoking authorization to use the student-athlete's name, image, likeness, and athletic-related information will not affect eligibility.

Student's Signature | Date of Birth | Grade in School | Date

Signature of Parent or Legal Custodian | Date

FORMULARIO DE ELEGIBILIDAD, CONSENTIMIENTO PARA PARTICIPAR Y AUTORIZACIÓN DE TRATAMIENTO DE LA NCHSAA DEL 2022-2023

ESTE DOCUMENTO DEBE SER FIRMADO POR EL ESTUDIANTE-ATLETA DE LA ESCUELA MIEMBRO DE LA NCHSAA Y POR EL PADRE/ MADRE/ TUTOR LEGAL DEL ESTUDIANTE ANTES DE QUE EL ESTUDIANTE PARTICIPE. LOS ESTUDIANTES NO PUEDEN PARTICIPAR SIN LA FIRMA DEL ESTUDIANTE Y DEL PADRE/ MADRE/ TUTOR LEGAL.

Reconozco (el estudiante-atleta y el padre/madre/ tutor) que he leído y entendido las Reglas de Elegibilidad de la Asociación Atlética de las Escuelas de Secundaria Superior de Carolina del Norte (NCHSAA, por sus siglas en inglés). Entiendo que una copia del Manual de la NCHSAA está archivada con el director *y/o* el director deportivo de la escuela miembro, y que puedo revisarla, si así lo deseo. Sé que mi escuela es un miembro de la NCHSAA y debe adherirse a todas las regulaciones que rigen los programas deportivos interescolares, incluyendo, pero no limitado a, las leyes federales y estatales, las regulaciones locales y las impuestas por la NCHSAA. Entiendo que las reglas locales pueden ser más estrictas que las de la NCHSAA y estoy de acuerdo en seguir las reglas de mi escuela y de la NCHSAA, y acatar sus decisiones. Reconozco y entiendo que la participación en el atletismo interescolar es un privilegio, noun derecho. Entiendo que el desempeño en el salón de clases, retirar una clase o tomar cursos a través de otras opciones educativas podría afectar la elegibilidad y el cumplimiento de los estándares académicos de la NCHSAA.

CÓDIGO DE RESPONSABILIDAD DEL ESTUDIANTE

Como un estudiante-atleta, **entiendo y acepto** las responsabilidades siguientes:

Respetaré los derechos y creencias de los demás y trataré a los demás con cortesía y consideración. Seré **totalmente responsable** de mis acciones y de las consecuencias de mis acciones.

Respetaré la propiedad de los demás.

Respetaré y obedeceré las normas de mi escuela y las leyes de mi comunidad, estado y país.

Mostraré respeto a los responsables de hacer cumplir las normas de mi escuela y las leyes de mi comunidad, estado y país.

Entiendo que un estudiante cuya personalidad o conducta viole el código de atletismo o el código de responsabilidad de la escuela podría ser considerado no calificar para participar en los deportes por un período de tiempo determinado por el director o la administración del sistema escolar

LOS PADRES, TUTORES LEGALES O ESTUDIANTES QUE NO DESEAN ACEPTAR EL RIESGO DESCRITO EN ESTA ADVERTENCIA NO DEBEN FIRMAR ESTE FORMULARIO.

Reconozco (el estudiante-atleta y el padre/madre/ tutor) que la participación en los deportes interescolares implica algunos riesgos inherentes de lesiones potencialmente graves incluyendo, pero no limitado a, lesiones graves en el cuello, la cabeza y la columna vertebral, lesiones graves virtualmente a todos los huesos, articulaciones, ligamentos, músculos, tendones, y otros aspectos del sistema músculo-esquelético, lesiones graves o deterioro de otros aspectos del cuerpo, o efectos sobre la salud general y el bienestar del niño, y en casos raros, la muerte. Aunque las lesiones graves no son comunes en los programas deportivos escolares supervisados, es imposible eliminar todo riesgo. Debido a estos riesgos inherentes, el estudiante y su padre / madre/ tutor legal tienen la responsabilidad de ayudar a reducir ese riesgo. Los participantes deben obedecer todas las reglas de seguridad, informar todos los problemas físicos y de higiene a sus entrenadores, seguir un programa de acondicionamiento adecuado e inspeccionar su propio equipo diariamente.

Autorizo (el estudiante-atleta y el padre/madre/ tutor) el tratamiento médico, en caso de que surja la necesidad de tal tratamiento, mientras que el/la estudiante-atleta esté bajo la supervisión de la escuela miembro. Doy **consentimiento para tratamiento médico** para el estudiante-atleta después de una lesión o enfermedad sufrida durante la práctica *y/o* un juego/competencia. Entiendo que en el caso de una **herida o enfermedad que requiera tratamiento médico y transporte a un centro de salud**, que se hará un intento razonable por contactar al padre / madre/ tutor legal, en caso que el estudiante-atleta sea menor de edad, pero que si es

necesario, el estudiante-atleta recibirá tratamiento y será llevado en ambulancia al hospital más cercano. Además autorizo el uso o divulgación de la información de salud personal de mi estudiante-atleta, si el tratamiento por enfermedad o lesión es necesario.

Entiendo (el estudiante-atleta y el padre/ madre/ tutor) que **todas las concusiones (golpes en la cabeza) son potencialmente serias** y pueden resultar en complicaciones incluyendo daño cerebral prolongado y muerte, si no se identifica y maneja correctamente. Además, entiendo que si el/la estudiante-atleta es sacado de una práctica o competencia, debido a la sospecha de una concusión cerebral, él/ella no podrá volver a participar en las actividades deportivas ese día. Después de ese día, él/ella deberá presentar una autorización escrita de un médico (M.D. O 0.0.) o un entrenador atlético, que trabaje bajo la supervisión de un médico, antes de que pueda volver a participar. También reconozco que he **recibido, leído y firmado la hoja de información de concusión de Gfeller-Waller, así como visto el vídeo de educación de la concusión cerebral de Crash Course**.

Yo (el estudiante-atleta y el padre/ madre/ tutor) **doy consentimiento para que la NCHSAA use el nombre del estudiante**, imagen, gustos, y la información atlética en los informes de las competencias, la literatura promocional de la Asociación y otros materiales y comunicados relacionados con los deportes interescolar; y le doy a la NCHSAA el derecho de fotografiar y/o filmar al participante, y seguir utilizando la cara del participante, voz y apariencia en relación con exposiciones, publicidad, materiales promocionales y comerciales sin reserva ni limitación. Sin embargo, la NCHSAA no tiene ninguna obligación de ejercer dichos derechos en este documento. Asimismo, autorizo la divulgación, por parte de la escuela miembro, a la NCHSAA, a su solicitud, de todos los registros relacionados con la elegibilidad atlética del estudiante-atleta incluyendo, pero no limitado a, sus registros relacionados con la matrícula, asistencia, nivel académico, edad, disciplina, finanzas, residencia y aptitud física. El estudiante y padre / madre/ tutor legal individualmente y en nombre del estudiante, por la presente irrevocablemente, e incondicionalmente liberan de responsabilidad, sin limitación, a la NCHSAA, sus oficiales, agentes, abogados, representantes y empleados (colectivamente, los "Releasees") de todas las pérdidas, reclamos, demandas, acciones y causas de acción, obligaciones, daños y costos o gastos de cualquier naturaleza (incluyendo honorarios de abogado) que el estudiante y/o el tutor legal incurran o sostienen a una persona, a una propiedad o a ambos, Que surgen de, resulten de, ocurren durante o están conectados de otra manera con la participación del estudiante en las actividades de atletismo interescolar, debido a la negligencia ordinaria de los "Releasees".

Al firmar este documento, reconocemos que hemos leído la información anterior y que estamos de acuerdo con que este estudiante participe. Entendemos que las autorizaciones y derechos otorgados en este documento son voluntarios y que podemos revocarlos en cualquier momento presentando dicha revocación por escrito a la escuela miembro del participante. Al hacerlo, sin embargo, entendemos que el participante ya no calificará para participar en los deportes interescolar,

Firma del estudiante	Fecha de nacimiento	Nivel de grado en la escuela	Fecha

Firma del padre/ madre/ tutor legal	Fecha

VOLUNTEER AGREEMENT

DUPLIN COUNTY SCHOOLS

_____SCHOOL YEAR

***NOTE: An employee of the Board of Education may NOT volunteer to perform a job that is the same or similar job for which he/she is employed.**

I, _____, of my own free will, volunteer my time and service to participate as _____ for _____ School. My time and service in this volunteer capacity are given without promise, expectation or receipt of any form of compensation, benefits or other remuneration for this service.

I understand and agree that my volunteer participation is not being performed in the course and scope of my regular employment at _____ School, and that my participation in this activity is not in any way required by _____ School or the Public Schools of Duplin County. I acknowledge and agree that my volunteer services do not involve the same or similar type of services I perform as an employee of _____ School. I further acknowledge and agree that my volunteer services are not closely related to my duties and responsibilities as an employee.

I understand that my participation as a volunteer may be terminated at any time, without cause, and that I may withdraw from participation at any time for any reason and that my withdrawal will not affect my continued employment with the Board of Education.

This agreement will continue in force until terminated.

_____ _____

Volunteer Signature Date

Administration Use Only

2022-2023 Student Accident Insurance Coverage

YOUNG GROUP
INSURING YOUR WORLD

QBE

Optional school time accident coverage

Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises; Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder. **Includes coverage for all Interscholastic Sports, excluding those participating in Senior High interscholastic tackle football.**

Annual Premium

Standard Plan - $9.00 **Intermediate Plan - $19.00** **Premier Plan - $51.00**

Optional 24 hour accident coverage

Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. **Includes coverage for all Interscholastic Sports, excluding those participating in Senior High interscholastic tackle football.**

Annual Premium

Standard Plan - $59.00 **Intermediate Plan - $109.00** **Premier Plan - $289.00**

Optional 24-Hour Accident – Summer Only coverage, Students Only

Summer begins on the first day after the school year ends.
Summer ends the first day of the next school year.

Standard Plan - $14.00 **Intermediate Plan - $26.00** **Premier Plan - $61.00**

Optional high school tackle football coverage (Can be purchased separately or with other coverage)

Covers Accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is covered when going directly and uninterruptedly to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Optional Football Coverage begins on the date of premium receipt (on or after the policy effective date) and ends on the last day of practice or competition. This optional high school tackle football coverage is also available to ninth graders who play tackle football with grades 10-12. Ninth Graders who play with 9th graders ONLY, are not charged extra for football coverage.

Annual Premium

Standard Plan - $96.00 **Intermediate Plan - $157.00** **Premier Plan - $357.00**

Spring/Summer Weight and Conditioning Training Only Rates

Standard Plan - $ 47.00 **Intermediate Plan - $ 73.00** **Premier Plan - $138.00**

(for new players who participate in spring training and who are not already covered under Optional Football Coverage)

Optional 24 hour dental coverage (Can be purchased separately or with other coverage)

Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 24 months after the date of Injury. The maximum eligible expenses payable per covered Injury is $50,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of $1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth.

Annual Premium: $8.00

Coverage period

Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on 1) the date you complete your enrollment on-line and your premium is paid, or 2) the date your enrollment form and premium payment are received by the agent, but not before the first day of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending academic classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends at midnight on the day before school reopens for the following school year. Coverage is available under these plans throughout the school year at the premiums quoted. There are no pro rata premiums available.

Coverage Basis: Primary

Benefits are payable for covered medical expenses from the first dollar of expense incurred. Benefits are paid in addition to and without regard to payments from other insurance.

Accident Medical Expense benefits

When a covered accident results in 1) treatment by a legally qualified Physician or surgeon (other than a member of the immediate family or person retained by the school) or 2) Hospital confinement, and treatment begins within 60 days from the date of the accident, the Company will pay the benefit as shown in the Schedule of Benefits. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the Accident are covered.

Benefits for any one Accident will not exceed the Maximum Benefits stated in the Schedule of Benefits for the Plan purchased. Expenses incurred after one year from the date of the accident are not covered, even though the service is a continuing one, or one that is necessarily delayed beyond one year from the date of the accident.

Accident Death & Dismemberment benefits

When a covered Injury results in any of the Losses stated in the Schedule of Benefits for Accidental Death or Dismemberment, then the Company will pay the benefit stated in the schedule for that Loss. The Loss must occur within 365 days after the date of the Accident. The maximum benefit as stated in the Schedule of Benefits under Maximum Benefits, is payable for the following Losses:

1) Life; 2) Both Hands or Both Feet or Sight of Both Eyes; 3) One Hand and One Foot; 4) One Hand and Entire Sight of One Eye; 5) One Foot and Entire Sight of One Eye. Half of the maximum benefit will be paid for the Loss of one Hand, one Foot, the Sight of one eye or the loss of Thumb and Index Finger of the Same Hand. Loss of Hand or Foot means the complete Severance through or above the wrist or ankle joint. Loss of Sight means the total, permanent Loss of Sight in One Eye. Loss of Sight must be irrecoverable by natural, surgical or artificial means. Loss of Thumb and Index Finger of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). Severance means the complete separation and dismemberment of the part from the body.

If the Insured suffers more than one of the above covered losses as a result of the same Accident, the total amount the Company will pay is the maximum benefit. Benefits are paid in addition to any other benefits provided by the Policy.

Definitions

A **Covered Accident** means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in an injury or loss. The Accident must occur while the Policy is in force and while the Insured is covered under the Policy. **Usual and Customary** means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided. Such services and supplies must be recommended and approved by a Physician.

Exclusions

Benefits will not be paid for injuries caused by: 1) suicide, intentionally self-inflicted injury, or any attempt thereat while sane or insane; 2) treatment of hernia of any kind; 3) travel in or on any on-road or off-road vehicle that does not require motor vehicle licensing; 4) commission or attempt to commit a felony or an assault, or commission of or active participation in a riot or insurrection; 5) declared or undeclared war or act of war; 6) services or treatment provided by persons who do not normally charge for services, unless there is a legal obligation to pay; 7) flight in, boarding or alighting from an aircraft except as a fare-paying passenger on a regularly scheduled commercial or charter airline; 8) bungee-cord jumping, parachuting, skydiving, parasailing or hang-gliding; 9) an accident if the insured is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license, unless the insured holds a valid learner's permit and the insured is receiving instruction from a driver's education instructor; 10) services or treatment rendered by any person who is employed or retained by the policyholder or living in the insured's household: a parent, sibling, spouse or child either of the insured or the insured's spouse or the insured; 11) cosmetic surgery, except for reconstruction surgery needed as the result of a covered injury; 12) injuries compensable under workers' compensation law or any similar law; 13) sickness, disease, bodily or mental illness, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound, or accidental ingestion of contaminated food; 14) the insured being legally intoxicated as determined according to the laws of the jurisdiction in which the covered accident occurred or voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage; 15) any hospital stay or days of a hospital stay that are not appropriate treatment for the condition and locality; 16) treatment of injury resulting from a condition that the insured knew existed on the date of a covered accident, unless the company has received a written medical release from his physician; 17) injury sustained as a result of practice or play in interscholastic football and/or sports, unless the requisite premium for such coverage has been selected and paid.

Retain this description for your records

IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. This information is a brief description of the important features of this insurance plan. It is not a contract. Terms and conditions of coverage are set forth on policy form series BAM-03-1000.00, or applicable state versions, underwritten by QBE Insurance Corporation. This Blanket Accident Medical Insurance Policy is subject to the laws of the jurisdiction in which it is issued. Additional exclusions and limitation may apply. You may review a copy of the policy upon request.

How to file a claim

In the event of an Accident, students should notify school immediately. To file a claim, obtain a claim form from the school, attach bill(s) to the completed claim form and mail to the address indicated on the form.

Call the Claim Administrator below with any claims questions.

Claims for benefits must be filed within 90 days from the date of the accident, or as soon as reasonably possible.

Program Manager:

The Young Group, Inc.
P.O. Box 91386
Raleigh, NC 27675

Toll Free: **888.574.6288**

Claim Administrator:

Health Special Risk, Inc.
8400 Belleview Drive, Suite 150
Plano, TX 75024

Toll Free: **866.409.5734**

Schedule of Benefits

Coverage for Injuries due to Accidents only

Maximum Benefits:	Standard Plan	Intermediate Plan	Premier Plan
School-Time Option	$25,000	$25,000	$25,000
24-Hour Option	$25,000	$25,000	$25,000
Football Option	$25,000	$25,000	$25,000
Accidental Death Benefit / Double Dismemberment	$10,000 / $15,000	$10,000 / $15,000	$10,000 / $15,000
Single Dismemberment	$5,000	$5,000	$5,000
Loss Period for Medical Benefits	Treatment must begin within 60 days from the date of Injury		
Benefit Period for Medical and AD&D Benefits	1 Year	1 Year	1 Year
Accident Medical Coverage Basis	Primary	Primary	Primary
Covered Expenses:			
Hospital/Facility Services – Inpatient			
Hospital Room and Board (Semi-Private Room Rate)	$150 Max per day	$200 Max per day	80% U&C*
Inpatient Hospital Miscellaneous	$500 Max per day	$1,000 Max per day	80% U&C*
Registered Nurses' Services	75% U&C*	80% U&C*	80% U&C*
Physician's Visits (One visit/day max; only applies to non-surgical visits)	$30 first visit / $25 each subsequent visit	$50 first visit / $30 each subsequent visit	80% U&C*
Hospital/Facility Services – Outpatient			
Outpatient Hospital Miscellaneous (Except physician services and x-rays paid as below)	$750 Maximum	$1,000 Maximum	80% U&C* / $5,000 Maximum
Hospital Emergency Treatment	$150 Maximum	$250 Maximum	80% U&C*
Physician's Services			
Surgical Fees	$750 Maximum	$1,000 Maximum	80% U&C* / $5,000 Maximum
Assistant Surgeon &/or Anesthesiologist	20% of Surgical Benefits	25% of Surgical Benefits	80% U&C*
Consultant	$200 Maximum	$400 Maximum	80% U&C*
Physician's Visits (One visit/day max; only applies to non-surgical visits; excludes physical therapy)	$30 first visit / $25 each subsequent visit	$50 first visit / $30 subsequent visit	80% U&C* / $50 per day maximum
Physician's Outpatient Treatment in connection with Physical Therapy (One visit/day max)	$30 first visit / $20 each subsequent visit / 5 Visits Max.	$40 first visit / $30 each subsequent visit / 5 Visits Max.	80% U&C* / $50 per day max / 15 Visits Max.
Other Services			
Prescriptions - outpatient	$50 Maximum	$100Maximum	80% U&C*
X-rays, including interpretation - outpatient	$200 Maximum	$400 Maximum	80% U&C*
Diagnostic Imaging (MRI, CAT Scan, etc) including interpretation – outpatient	$200 Maximum	$400 Maximum	80% U&C* / $1,200 Maximum
Laboratory	$50 Maximum	$150 Maximum	80% U&C* / $600 Maximum
Ambulance	$200 Max.	$500 Max.	80% U&C*
Durable Medical Equipment (including Orthopedic Braces & Appliances)	$75 Maximum	$100 Maximum	80% U&C*
Replacement of eyeglasses, hearing aids, contact lenses if medical treatment is also received for the covered injury	100% U&C*	100% U&C*	100% U&C*
Dental Treatment to sound, natural teeth due to covered injury	$100/tooth	$300/tooth	80% U&C*

* U&C means Usual & Customary expense

Coverage Selected: **(Keep for your records)**

Standard Plan	☐ School-Time $9.00	☐ 24-Hour Accident $59.00	☐ 24-Hour Summer Only $14.00	☐ Football $96.00
Intermediate Plan	☐ School-Time $19.00	☐ 24-Hour Accident $109.00	☐ 24-Hour Summer Only $26.00	☐ Football $157.00
Premier Plan	☐ School-Time $51.00	☐ 24-Hour Accident $289.00	☐ 24-Hour Summer Only $61.00	☐ Football $357.00
	☐ 24-Hour Extended Dental $8.00			

Spring/Summer Weight and Conditioning Training Only Rates

☐ Standard Plan - $47.00 ☐ Intermediate Plan - $73.00 ☐ Premier Plan - $138.00

Enrollment

To enroll for coverage with a credit card, please go to www.k12studentinsurance.com

You can also enroll by **using the form below. Just cut along the dotted line, complete the form and mail it, along with your check or money order, to the following address:**

The Young Group, Inc.
P.O. Box 91386
Raleigh, NC 27675

QUESTIONS?
Call Toll-free: 888.574. 6288

If you are enrolling more than one Student, please complete a separate form for each Student.
Do not send cash.

2022-2023 ENROLLMENT FORM (please print or type)

Student's Last Name | Student's First Name | Student's Middle Initial | Grade

Address | City | State | Zip

Telephone Number | Birthdate

Email Address

School System or School District | Name of School

Check your selection below.

Standard Plan	☐ School-Time $9.00	☐ 24-Hour Accident $59.00	☐ 24-Hour Summer Only $14.00	☐ Football $96.00
Intermediate Plan	☐ School-Time $19.00	☐ 24-Hour Accident $109.00	☐ 24-Hour Summer Only $26.00	☐ Football $157.00
Premier Plan	☐ School-Time $51.00	☐ 24-Hour Accident $289.00	☐ 24-Hour Summer Only $61.00	☐ Football $357.00
	☐ 24-Hour Extended Dental - $8.00			

Spring/Summer Weight and Conditioning Training Only Rates

☐ Standard Plan - $47.00 ☐ Intermediate Plan - $73.00 ☐ Premier Plan - $137.00

Please make check or money order payable to: QBE Insurance Corporation.

Total Enclosed:

Signature of Parent or Guardian | Date

Student I.D. Card

Please fill-in the information below and cut along the dotted lines.

2022-2023 Student I.D. Card

Name of School: | School District:

Student Name:

CLAIM QUESTIONS: CALL 866.409.5734

Cobertura del seguro estudiantil contra accidentes 2022-2023

YOUNG GROUP
INSURING YOUR WORLD

QBE

Cobertura escolar opcional contra accidentes

El seguro proporciona protección contra lesiones ocurridas durante las horas y los días escolares y durante la asistencia y la participación en actividades patrocinadas y supervisadas por la escuela tanto dentro como fuera de las instalaciones escolares. Actividades recreativas de verano patrocinadas por la escuela; excursiones escolares de un día (sin pasar la noche) y actividades religiosas patrocinadas por la escuela. El seguro proporciona cobertura durante el viaje hacia la actividad, durante y después de la misma como miembro de un grupo en un medio de transporte proporcionado o coordinado por el titular de la póliza. **Incluye cobertura para todos los deportes interescolares, excepto para aquellos que practiquen fútbol americano interescolar de la escuela secundaria.**

Prima anual

Plan estándar - $9.00 **Plan intermedio - $19.00** **Plan premier - $51.00**

Cobertura opcional contra accidentes las 24 horas

El seguro proporciona cobertura en todo momento, las 24 horas del día. Proporciona cobertura durante los fines de semana y los periodos de vacaciones incluido todo el verano. Los estudiantes están protegidos mientras están en sus hogares o fuera de los mismos, en cualquier lugar y en cualquier momento. **Incluye cobertura para todos los deportes interescolares, excepto para aquellos que practiquen fútbol americano interescolar de la escuela secundaria.**

Prima anual

Plan estándar - $59.00 **Plan intermedio - $109.00** **Plan premier - $289.00**

Cobertura opcional contra accidentes las 24 horas – Cobertura solamente durante el verano, únicamente para estudiantes

El verano comienza el primer día después de que finalice el año escolar.
El verano finaliza el primer día del siguiente año escolar.

Plan estándar - $14.00 **Plan intermedio - $26.00** **Plan premier - $61.00**

Cobertura opcional para fútbol americano de la escuela secundaria (puede adquirirse por separado o con otra cobertura)

Proporciona cobertura contra accidentes durante la participación en prácticas y competiciones interescolares de fútbol americano de un colegio de educación secundaria. El seguro ofrece cobertura cuando el estudiante se dirige de forma directa e ininterrumpida hacia dicha práctica o competición, o regresa de la misma, como parte un grupo en un medio de transporte proporcionado o coordinado por el titular de la póliza. La cobertura opcional para fútbol americano comienza el día en que se recibe el pago de la prima (el día en que la póliza entra en vigencia o posteriormente) y finaliza el último día de práctica o competición. Esta cobertura opcional para fútbol americano de la escuela secundaria también está disponible para los alumnos de 9.° grado que juegan fútbol americano con alumnos de 10.° y 12.° grado. A los estudiantes de noveno grado que jueguen contra estudiantes de noveno grado ÚNICAMENTE, no se les cobrará ninguna cantidad adicional por la cobertura para el fútbol.

Prima anual

Plan estándar - $96.00 **Plan intermedio - $157.00** **Plan premier - $357.00**

Tarifas para el Programa de Entrenamiento y Preparación Física de Primavera/Verano únicamente

Plan estándar - $ 47.00 **Plan intermedio - $ 73.00** **Plan premier - $138.00**

(para los nuevos jugadores que participen en el entrenamiento de primavera y que aún no están cubiertos con la Cobertura Opcional para Fútbol)

Cobertura dental opcional las 24 horas (puede contratarse por separado o con otra cobertura)

La cobertura tiene vigencia las 24 horas del día. Se debe tratar la lesión dentro de los 60 días después de ocurrido el accidente. Los beneficios se abonan dentro de los 24 meses posteriores a la fecha de la lesión. El límite máximo de gastos aprobados a pagar por lesión cubierta asciende a $50,000. Además, en los casos en que el odontólogo certifique que se debe posponer el tratamiento hasta después del Periodo de Beneficios, se pagarán los beneficios diferidos hasta una cantidad máxima de $1,000. El estudiante deberá recibir tratamiento de un odontólogo legalmente certificado, que no sea su familiar directo. La cobertura se limita al tratamiento de los dientes sanos y naturales.

Prima anual: $8.00

Periodo de cobertura

La cobertura opcional escolar contra accidentes, la cobertura opcional contra accidentes las 24 horas y la cobertura dental opcional las 24 horas entran en vigencia en 1) la fecha en la que complete su suscripción en línea y pague su prima, o 2) la fecha en la que el agente reciba su formulario de inscripción y el pago de la prima, pero no antes del primer día del año escolar. La cobertura opcional escolar contra accidentes finaliza al cierre del calendario escolar normal de nueve meses, excepto si el estudiante asiste a clases académicas exclusivamente patrocinadas y únicamente supervisadas por la escuela durante el verano. La cobertura opcional contra accidentes las 24 horas y la cobertura dental opcional terminan a medianoche el día antes de que la escuela reinicie sus actividades el siguiente año escolar. La cobertura se encuentra disponible conforme a los planes descritos durante todo el año escolar según las primas cotizadas.

(Las primas prorrateadas no se encuentran disponibles).

Cobertura primaria: Primaria

Se pagarán los beneficios por los gastos médicos cubiertos desde el primer dólar del gasto en el que se incurra. Los beneficios se pagan de manera adicional a cualquier otro pago que pueda recibirse de otro seguro.

Beneficios por gastos médicos por accidente

Cuando un accidente cubierto por la póliza resulte en 1) un tratamiento impartido por un médico o cirujano legalmente cualificado (que no sea familiar directo del estudiante ni una persona contratada por la escuela) o 2) la hospitalización del asegurado para recibir un tratamiento dentro de los 60 días posteriores a la fecha de la lesión, la Compañía pagará los beneficios según lo indicado en la Tabla de Beneficios. Solamente se cubrirán los gastos médicos elegibles en los que incurrió el Asegurado dentro de las 52 semanas a partir de la fecha del accidente.

Los beneficios para cualquier accidente no excederán en total la cantidad máxima establecida en la Tabla de Beneficios del Plan contratado. No se cubrirán los gastos en los que se incurra después de un año a partir de la fecha de la lesión, aunque el servicio sea continuo o sea necesario demorarlo pasado un año desde la fecha de la lesión.

Beneficios por muerte accidental y desmembramiento

Cuando una lesión cubierta por la póliza resulta en cualquiera de las pérdidas establecidas en la Tabla de Beneficios por muerte accidental o desmembramiento, la Compañía pagará los beneficios establecidos en la tabla para dicha pérdida. La pérdida debe haberse sufrido dentro de los 365 días posteriores a la fecha del accidente.
El beneficio máximo a pagar se establece en la Tabla de Beneficios en el punto Beneficios Máximos, y cubre las siguientes pérdidas:

1) Vida; 2) ambas manos o ambos pies, o la vista en ambos ojos; 3) una mano y un pie; 4) una mano y la vista completa en un ojo; 5) un pie y la vista completa en un ojo. Se pagará la mitad del beneficio máximo por la pérdida de una mano, un pie o la vista en un ojo o la pérdida del dedo pulgar y dedo índice de la misma mano. Pérdida de la mano o pie significa la amputación total a la altura o por encima de la muñeca o la articulación del tobillo. Pérdida de la vista significa la pérdida completa y permanente de la vista en un ojo. La pérdida de la vista debe ser irrecuperable por medios naturales, quirúrgicos o artificiales. Pérdida del pulgar e índice de la misma mano significa la amputación total a la altura o por encima de las articulaciones metacarpofalángicas de la misma mano (las articulaciones entre los dedos y la mano). Amputación significa la separación total y el desmembramiento de una parte del cuerpo.

Si el Asegurado sufre más de una de las pérdidas cubiertas mencionadas anteriormente como resultado del mismo accidente, la cantidad total que pagará la Compañía será la cantidad del beneficio máximo. Los beneficios se pagarán de manera adicional a cualquier otro beneficio proporcionado por la Póliza.

Definiciones

Accidente cubierto significa un evento repentino, inesperado y externo que resulta, directamente e independientemente de todas las demás causas, en una lesión o pérdida. El accidente debe ocurrir durante el periodo de vigencia de la Póliza y mientras el Asegurado está cubierto por la misma. **Gastos razonables** significa el promedio que cobran la mayoría de los proveedores por el tratamiento, los servicios e insumos dentro del área geográfica donde se proporciona el tratamiento, el servicio y los insumos. Dichos servicios e insumos deben ser recomendados y aprobados por un médico.

Exclusiones

No se pagarán beneficios por lesiones causadas por: 1) suicidio, lesión autoinfligida intencionalmente, o cualquier intento similar, esté la persona en su sano juicio o no; 2) tratamiento de hernia de cualquier tipo; 3) viajar en un vehículo estándar o un vehículo motorizado recreativo que no requiere licencia de vehículo motorizado; 4) cometer o intentar cometer un delito grave o agresión, o por iniciar o participar activamente de un disturbio o insurrección; 5) guerra declarada o no declarada o acto de guerra; 6) servicios o tratamiento proporcionado por personas que no cobran usualmente por servicios, a menos que exista la obligación legal de pagar; 7) realizar un vuelo, embarcar en o descender de una aeronave excepto que el Asegurado sea un pasajero que haya pagado su boleto en una aerolínea comercial o un vuelo chárter regular; 8) practicar bungee-jumping (puenting), paracaidismo, paracaidismo con caída libre, parapente, parasailing, ala delta; 9) un accidente si el asegurado es el operador de un vehículo motorizado y no posee una licencia válida de conductor del vehículo motorizado, a menos que posea un permiso de aprendiz válido y reciba instrucciones del instructor de manejo; 10) servicios o tratamiento proporcionado por cualquier persona empleada o contratada por el titular de la póliza o que resida en la residencia del asegurado: un padre, un hermano, un cónyuge o niño del asegurado o del cónyuge del asegurado o el asegurado; 11) cirugía estética, excepto la cirugía reconstructiva necesaria como resultado de una lesión cubierta por la póliza; 12) lesiones cubiertas conforme la ley de indemnización laboral o cualquier ley similar; 13) enfermedad, dolencia, enfermedad corporal o mental, infección bacteriana o viral o tratamiento médico o quirúrgico que de allí resulte, excepto cualquier infección bacteriana que resulte de un corte o herida externa accidental, o una ingestión accidental de alimentos contaminados; 14) por estar legalmente intoxicado según lo establecido en las leyes del estado en el cual ocurra la lesión o por la ingestión voluntaria de estupefacientes, drogas, veneno, gas o escapes, a menos que sean recetados o se tomen por instrucción de un médico y de acuerdo con la dosificación prescrita; 15) cualquier estancia en hospital o días de estancia en hospital que no correspondan al tratamiento apropiado por la afección y su ubicación; 16) tratamiento de la lesión que resulte de una afección que el asegurado conocía el día en que se produce una lesión cubierta por la póliza, a menos que la compañía haya recibido el alta médica por escrito de su médico; 17) lesión sufrida como resultado de una práctica o un juego interescolar de fútbol americano o durante actividades deportivas, a menos que se haya pagado la prima requerida de dicha cobertura.

Conserve esta descripción para sus registros

AVISO IMPORTANTE – ESTA PÓLIZA NO OFRECE COBERTURA POR ENFERMEDAD. La información aquí descrita es una reseña de los aspectos importantes de esta póliza de seguro. No es un contrato. Los términos y condiciones de la cobertura se especifican en el formulario de póliza serie BAM-03-1000.00, o sus versiones correspondientes según el estado, suscrito por QBE Insurance Corporation. Esta póliza ampliada de seguro médico por accidentes se encuentra sujeta a las leyes de la jurisdicción donde fue emitida. Pueden aplicarse exclusiones y limitaciones adicionales. Puede solicitar una copia de la póliza.

Cómo presentar una reclamación

En caso de accidente, los estudiantes deberán notificarlo a la escuela de inmediato. A fin de presentar una reclamación, deberá solicitar un formulario de reclamaciones a la escuela, adjuntar al formulario completo el o los recibos de pagos efectuados y en viarlo por correo a la dirección indicada en el formulario.

Llamar al Administrador de Reclamaciones que se indica abajo para cualquier consulta sobre reclamaciones.

Las reclamaciones de beneficios deben presentarse dentro de los 90 días posteriores a la fecha del accidente o tan pronto como sea posible.

Gerente del programa:

The Young Group, Inc.
P.O. Box 91386
Raleigh, NC 27675

Línea gratuita: **888.574.6288**

Administrador de reclamaciones:

Health Special Risk, Inc.
8400 Belleview Drive, Suite 150
Plano, TX 75024

Línea gratuita: **866.409.5734**

Tabla de beneficios

Cobertura de lesiones por accidentes solamente

Beneficio máximo:	**Plan estándar**	**Plan intermedio**	**Plan premier**
Opción Escolar	$25,000	$25,000	$25,000
Opción 24 horas	$25,000	$25,000	$25,000
Opción Fútbol Americano	$25,000	$25,000	$25,000
Beneficio por muerte accidental / desmembramiento doble	$10,000 / $15,000	$10,000 / $15,000	$10,000 / $15,000
Desmembramiento único	$5,000	$5,000	$5,000
Periodo de pérdida para recibir los beneficios médicos	El tratamiento debe comenzar dentro de los 60 días posteriores a la fecha de la lesión		
Periodo para beneficios médicos, por muerte accidental y desmembramiento	1 año	1 año	1 año
Cobertura médica primaria por accidentes	Primaria	Primaria	Primaria
Gastos cubiertos:			
Servicios de hospital/centro médico - Hospitalización			
Habitación y alimentos en el hospital (tarifa de habitación semi privada)	$150 máx. por día	$200 máx. por día	80% GR*
Servicios varios para pacientes hospitalizados	$500 máx. por día	$1,000 máx. por día	80% GR*
Servicios de enfermera matriculada	75% GR*	80% GR*	80% GR*
Consultas médicas (Una consulta/día máx.; solo aplicable a visitas no quirúrgicas)	$30 primera consulta / $25 cada consulta subsiguiente	$50 primera consulta / $30 cada consulta subsiguiente	80% GR*
Servicios de hospital/centro médico - Ambulatorio			
Servicios varios para pacientes ambulatorios (excepto los servicios del médico y las radiografías, que se especifican a continuación)	$750 máximo	$1,000 máximo	80% GR* / $5,000 máximo
Tratamiento en sala de emergencias del hospital	$150 máximo	$250 máximo	80% GR*
Servicios del médico			
Gastos quirúrgicos	$750 máximo	$1,000 máximo	80% GR* / $5,000 máximo
Cirujano auxiliar y/o anestesiólogo	20% de beneficios quirúrgicos	25% de beneficios quirúrgicos	80% GR*
Asesor médico	$200 máximo	$400 máximo	80% GR*
Consultas médicas (Una consulta/día máx.; solo aplicable a visitas no quirúrgicas; no incluye terapia física)	$30 primera consulta / $25 cada consulta subsiguiente	$50 primera consulta / $30 cada consulta subsiguiente	80% GR* / $50 por día máximo
Tratamiento médico ambulatorio relacionado con Terapia física (Una consulta/día máx.)	$30 primera consulta / $20 cada consulta subsiguiente / 5 consultas máx.	$40 primera consulta / $30 cada consulta subsiguiente / 5 consultas máx.	80% GR* / $50 por día máximo / 15 consultas máximo

Tabla de beneficios (continúa)

Otros servicios

Recetas - ambulatorio	$50 máximo	$100 máximo	80% GR*
Radiografías, con informe - ambulatorio	$200 máximo	$400 máximo	80% GR*
Diagnóstico por imágenes (resonancias magnéticas, tomografías computarizadas, etc.) con informe - ambulatorio	$200 máximo	$400 máximo	80% GR* / $1,200 máximo
Laboratorio	$50 máximo	$150 máximo	80% GR* / $600 máximo
Ambulancia	$200 máx.	$500 máx.	80% GR*
Equipo médico de larga duración (incluidos soportes y aparatos ortopédicos)	$75 máximo	$100 máximo	80% GR*
Reemplazo de gafas, audífonos, lentes de contacto, si además se recibe tratamiento médico para la lesión cubierta	100% GR*	100% GR*	100% GR*
Tratamiento dental para los dientes sanos y naturales a causa de una lesión cubierta	$100/diente	$300/diente	80% GR*

* GR significa Gastos razonables

Cobertura elegida: **(Consérvese para sus registros)**

Plan estándar	☐ Escolar $9.00	☐ Accidente las 24 horas $59.00	☐ Accidente las 24 horas solo en verano $14.00	☐ Fútbol americano $96.00
Plan intermedio	☐ Escolar $19.00	☐ Accidente las 24 horas $109.00	☐ Accidente las 24 horas solo en verano $26.00	☐ Fútbol americano $157.00
Plan premier	☐ Escolar $51.00	☐ Accidente las 24 horas $289.00	☐ Accidente las 24 horas solo en verano $61.00	☐ Fútbol americano $357.00

☐ Cobertura dental ampliada las 24 horas $8.00

Tarifas para el Programa de Entrenamiento y Preparación Física de Primavera/Verano únicamente

☐ Plan estándar - $47.00 ☐ Plan intermedio - $73.00 ☐ Plan premier - $138.00

Suscripción

Para solicitar la cobertura con tarjeta de crédito, diríjase a www.k12studentinsurance.com.

También puede suscribirse **utilizando el formulario que se muestra a continuación. Recorte el formulario por la línea punteada, complételo y envíelo por correo junto con su cheque u orden de pago, a la siguiente dirección:**

The Young Group, Inc.
P.O. Box 91386
Raleigh, NC 27675

¿PREGUNTAS?
Línea gratuita: 888.574.6288

Si desea inscribir a más de un estudiante, complete un formulario distinto para ese estudiante. **No envíe dinero en efectivo.**

FORMULARIO DE INSCRIPCIÓN 2022 – 2023 (completar a máquina o en letra mayúscula)

Apellido del estudiante: | Nombre del estudiante: | Inicial del segundo nombre del estudiante: | Grado

Dirección | Ciudad | Estado | Código postal

Número telefónico | Fecha de nacimiento

Email

Sistema escolar o distrito escolar | Nombre de la escuela

Marque la opción elegida.

Plan estándar	☐ Escolar $9.00	☐ Accidente las 24 horas $59.00	☐ Accidente las 24 horas solo en verano $14.00	☐ Fútbol americano $96.00
Plan intermedio	☐ Escolar $19.00	☐ Accidente las 24 horas $109.00	☐ Accidente las 24 horas solo en verano $26.00	☐ Fútbol americano $157.00
Plan premier	☐ Escolar $51.00	☐ Accidente las 24 horas $289.00	☐ Accidente las 24 horas solo en verano $61.00	☐ Fútbol americano $357.00

☐ Cobertura dental ampliada las 24 horas $8.00

Tarifas para el Programa de Entrenamiento y Preparación Física de Primavera/Verano únicamente

☐ Plan estándar - $47.00 ☐ Plan intermedio - $73.00 ☐ Plan premier - $137.00

Efectuar los cheques o pagos en efectivo a la orden de: QBE Insurance Corporation.

Total adjunto:

Firma del padre/madre o tutor | Fecha

Tarjeta de identificación de estudiante

Por favor, complete la información que se requiere a continuación y recorte por las líneas punteadas.

✂----------

Tarjeta de identificación estudiante 2022 – 2023

Nombre de la escuela: | Distrito escolar:

Nombre del estudiante:

PREGUNTAS SOBRE RECLAMACIONES: LLAME AL 866.409.5734

✂----------

QBE

STUDENT CLAIM FORM

1. Please fully complete this form
2. Attach itemized bills
3. Mail, E-mail or Fax to *HSR*

HSR
Health Special Risk, Inc.

P.O. Box 117558
Carrollton, Texas 75011-7558
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free (866) 409-5734
E-mail : K12claims@hsri.com

School District: Duplin County

School Name:

Policy Number: **District Paid** ☐ SHH100036 **Voluntary** ☐ SHH100037 **CAT** ☐ SHH910054

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (injured/ill person)	2. Social Security Number	3. Gender ☐ M ☐ F	4. Date of Birth	5. E-Mail

6. Address of Injured Person	7. Phone Number (include area code)

8. Parent/Legal Guardian Name, Address, City, State & Zip	9. Phone Number (include area code)

10. Date of Accident/Illness	11. Time of Accident ☐ a.m. ☐ p.m.	12. Place where Accident Occurred	13. Date of First Treatment

Dental Claims	14. Indicate which Teeth were Involved in the Accident	15. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

16. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐Yes ☐No

17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details

18. Which Best Describes the Activity:

☐ Play or practice of interscholastic sports
☐ Not school related
☐ Off campus lunch hour
☐ On campus lunch hour
☐ In school bus
☐ School sponsored field trip
☐ Traveling to/from school
☐ On school property during school hours
☐ School sponsored activity during school hours
☐ Other _____

19. Name of Person Supervising the Activity	Witness to Accident? ☐Yes ☐No	20. Type of Activity or Sport

Signature of Parent/Legal Guardian:		Signature of School Official:	
X	Date:	X	Date:

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

If applicable, claimant's primary employer name, address, and phone number _____

If applicable, mother's primary employer name, address, and phone number _____

If applicable, father's primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

Signature of Parent/Legal Guardian:		Signature of Witness:	
X	Date:	X	Date:

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim.

(If not signed submit proof of payment)

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____

FRAUD STATEMENTS

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska and Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Maryland, West Virginia & Rhode Island: Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, Indiana: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: WARNING :Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Georgia: Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
   a) In any written statement;
   b) In the filing of a claim; or
   c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;
2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;
3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects the person to criminal and civil penalties.

Minnesota; A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico and Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be subject to prosecution for insurance fraud.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Listed below are important instructions and comments about filing a claim.

Note: Benefit Period is 52 weeks from date of accident

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding "**OTHER INSURANCE STATEMENT**", marking either yes or no, and signing the line for authorization, so that ***HSR*** and the doctors/hospital may communicate concerning your claim.
2. **Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.**
3. Only one claim form for each accident needs to be submitted.
4. Once completed, make a photocopy for your records, and mail to the address shown below.
5. DO NOT assume that anyone else will mail this claim form to ***HSR*** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to ***HSR*** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment and amount) incurred (including the CPT/procedure code).
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim.

EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. ***HSR*** will consider benefits after your other, primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. ***HSR*** will not be able to consider your claim without this information.

Federal mandate in Section 111, MMSEA requires ***HSR*** to obtain specific information prior to processing any medical claims. You may view this mandate at www.cms.hhs.gov/mandatoryinsrep/ Below is a list of the required information.

- Social security number, if the claimant is a minor we require social security number of the minor, not the parent.
- Date of birth
- Gender

If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 8:00 a.m. thru 6:00 p.m. central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818.

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