LAWRENCE PUBLIC SCHOOLS
ATHLETIC INSURANCE COMPLIANCE – School Year _____

USD 497

(PLEASE PRINT)

Student's Name _____
(Last) (First) (Middle Initial)

Grade _____ School _____ Date of Birth ____/____/____ Date of Last Tetanus ____/____/____

Home Address _____ Telephone _____
Zip code

Father's/Guardian's Name _____ Phone _____

Mother's Name _____ Phone _____

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

Name _____ Phone _____ Relationship _____

Family Physician _____ Business Phone _____

As required by the Kansas State School Athletic Association, all students participating in athletics and cheerleading must be protected by accident insurance for catastrophic injuries exceeding **$25,000**. This coverage is provided by the athletic participation fee paid by each participant. In addition, school policy requires that all participants in school sponsored sports-related activities provide proof of medical insurance coverage for treatment up to **$25,000**. Compliance with this regulation can be accomplished by one or both of the following options:

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

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

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

OPTION 1 I certify that _____ is protected by medical insurance for treatment **up to at least $25,000**:
(Student name)

Company Name _____ Policy/Group Plan Number _____

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

MEDICAL AUTHORIZATION

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

Date _____ Signature of Parent/Guardian _____
(SIGN IN FRONT OF A NOTARY PUBLIC)

State of Kansas County of _____

Subscribed and sworn before me this _____ day of _____ in the year of _____.

_____
(Signature of Notary Public)

My commission expires: _____ (Seal)