Bartow County School System **2017 - 2018 School Year**

ATHLETIC PARTICIPATION, INSURANCE, AND CONSENT FORM

Parents and students signature needed in four places

PLEASE PRINT

Name_____ Male ____ Female ____
(Last) (First) (Middle)

Address: _____
(Street) (City) (Zip)

The student is domiciled at the above address located in the _____ High School District.
(School must be notified if student moves from the above address)

Have you attended this Bartow County school for at least one full school year? Yes_____ No _____

You live with (Name of Parent/Parents/Guardian) _____

Date of Birth _____ Telephone (Home) _____ (Work) _____ (Cell) _____

Date entered 9th grade _____ Your grade level for the 2016 -2017 school year _____

PARENTAL CONSENT FOR ATHLETIC PARTICIPATION

WARNING: BY ITS NATURE, PARTICIPATION IN INTER-SCHOLASTIC ATHLETICS AND INTRA-SCHOLASTIC SPORTS CLUBS INCLUDES A RISK OR INJURY WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG TERM CATASTROPHIC, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH. It is not possible to eliminate this risk

Participants have the responsibility to help reduce the chance of injury. PARTICIPANTS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR COACHES OR CLUB SUPERVISORSFOLLOW A PROPER CONDITIONING PROGRAM, ANDINSPECT THEIR EQUIPMENT DAILY.

By signing this permission form, you acknowledge that you have read and understand this warning. PARENTS OF STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THIS PERMISSION FORM.

In the event transportation related to the student's athletic/sports activities is not provided by the Bartow County School System or the student does not take advantage of the district - provided transportation, transportation will be the student's or the parents'/guardians' responsibility.

PERMISSION FORM.

I (We) hereby give consent for _____ to:

(1) Compete in athletics at _____ School of the Bartow County School System in Georgia High School Association approved sports *EXCEPT THOSE CROSSED* OUT below:

Baseball	Basketball	Golf	Volleyball	Tennis
Cross Country	Football	Softball	Wrestling	Weight Training
Rifle Team	Soccer	Swimming	Track & Field	Cheerleading

(2) To accompany any school team of which the student is a member on any of its local or out-of-town trips;
(3) and, I hereby verify that the information on both sides of this form is correct and understand that any false information may result in my son/daughter being declared ineligible.
(4) Parents should contact Head Coach for information regarding injuries to their son/daughter.

This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing.

_____ _____
S IGNATURE(S) OF PARENT(S) OR GUARDIAN(S) DATE

_____ _____
STUDENT SIGNATURE DATE

CONSENT

I hereby consent for_____ (student's name) to participate in school-sponsored trips, excluding overnight trips, associated with inter-scholastic athletic competitions. I understand that transportation may or may not be provided by the Bartow County School System. In the event transportation is not provided by the Bartow County School System, transportation will be the student's responsibility. If any emergency medical procedures or treatment are required by the student during the trip, I consent to the trip supervisor(s) taking, arranging for, and consenting to the procedures or treatment in his/her discretion.

ATHLETIC PARTICIPATION, INSURANCE, AND CONSENT FORM

I release and waive, and further agree to indemnify, hold harmless or reimburse the Bartow County School System, the Board of Education, its successors and assigns, its members, agents, employees and representatives thereof, as well as trip supervisors, from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during, or in connection with the student's participation in the activity, any trip associated with the activity, or the rendering of emergency medical procedures or treatment, it any.

S IGNATURE(S) OF PARENT(S) OR GUARDIAN(S)	DATE
STUDENT SIGNATURE	DATE

INSURANCE INFORMATION

Please INITIAL one of the following statements regarding insurance coverage for your son/daughter for the _____ school year, then sign
below:

_____ My son/daughter is adequately and currently covered by accident insurance that will cover injuries sustained while participating in interscholastic Athletics (including, but not limited to, Varsity, Junior Varsity and 9th grade Football), and intra-scholastic clubs and activities.

Company Providing Insurance: _____
Name of Insured: _____
Policy Number: _____

_____ I wish to purchase the Benefit Plan provided by the Bartow County School System. (A signed copy of this Benefit Plan should be stapled to this

S IGNATURE(S) OF PARENT(S) OR GUARDIAN(S)	DATE
STUDENT SIGNATURE	DATE

AUTHORIZATION

I understand that per The Georgia High School Association a **Pre-participation Physical Evaluation** must be performed by a physician to medically screen each student who participates in the athletic programs of the Bartow County School System I further understand that a basic medical screening (the required physical exam) is general in nature and limited in its scope and does not indicate or assure me that my child is completely free from impairments. If I wish for a more detailed physical exam to be performed upon my child/ward then it is my responsibility to arrange and pay for such an exam. If this more detailed exam is performed, it is my responsibility to notify the Bartow County School System, and its appropriate employees, of any potential medical problems uncovered by any physical exam given to my child/ward other than the general physical required by the school system for athletic participation. I agree to fully waive any and all claims of whatever nature, fully and finally, now and forever, for my child/ward, for myself, my estate, my heirs, my administrators, my executors, my assignees, my agents, my successors, and for all members of my family, and to indemnify, release, defend, exonerate, discharge and hold harmless the Bartow County School System, their schools, their trustees, officers, Board members, Board of Education, employees, agents, coaches, athletic trainers, physicians, and any other practitioner of the healing arts (an "Indemnified Party") from any and all liability, personal or property damages, claims, causes of action or demands brought against the Bartow County School System or indemnified party arising out of any injuries to my child/ward or to his or her property or losses of any kind which may result from or in connection with his or her participation in any activity related to the athletic programs provided by the Bartow County School System

My signature below attest that I have read, understand and concur with the information on this form, and that I give consent for my child to participate in the athletic programs as stated above.

S IGNATURE(S) OF PARENT(S) OR GUARDIAN(S)	DATE
STUDENT SIGNATURE	DATE

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

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

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION

THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability	
2. Date of disability	
3. Classification (if available)	
4. Cause of disability (birth, disease, accident/trauma, other)	
5. List the sports you are interested in playing	

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "yes" answers here

Please indicate if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
X-ray evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "yes" answers here

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

Signature of athlete _____ Signature of parent/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, 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 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 (questions 5–14).

EXAMINATION		
Height _____ Weight _____	☐ Male ☐ Female	
BP ____/____ (____/____) Pulse _____	Vision R 20/_____ L 20/_____	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic[c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a]Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b]Consider GU exam if in private setting. Having third party present is recommended.
[c]Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

_____

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician (print/type) _____ Date _____

Address _____ Phone _____

Signature of physician _____, MD or DO

EMERGENCY INFORMATION

Allergies _____

_____

_____

_____

_____

_____

Other information _____

_____

_____

_____

_____

_____

_____

_____

_____

STUDENT/PARENT CONCUSSION AWARENESS FORM

SCHOOL: _____

Student Name: _____

Parent(s)/Guardian(s) Name: _____

DANGERS OF CONCUSSION

Concussions at all levels of sports have received a great deal of attention and a state law has been passed to address this issue. Adolescent athletes are particularly vulnerable to the effects of concussion. Once considered little more than a minor "ding" to the head, it is now understood that a concussion has the potential to result in death, or changes in brain function (either short-term or long-term). A concussion is a brain injury that results in a temporary disruption of normal brain function. A concussion occurs when the brain is violently rocked back and forth or twisted inside the skull as a result of a blow to the head or body. Continued participation in any sport following a concussion can lead to worsening concussion symptoms, as well as increased risk for further injury to the brain, and even death.

Player and parental education in this area is crucial – that is the reason for this document. Refer to it regularly. This form must be signed by a parent or guardian of each student who wishes to participate in GHSA athletics. One copy needs to be returned to the school, and one retained at home.

COMMON SIGNS AND SYMPTOMS OF CONCUSSION

Headache, dizziness, poor balance, moves clumsily, reduced energy level/tiredness

Nausea or vomiting

Blurred vision, sensitivity to light and sounds

Fogginess of memory, difficulty concentrating, slowed thought processes, confused about surroundings or game assignments

Unexplained changes in behavior and personality

Loss of consciousness (NOTE: This does not occur in all concussion episodes.)

BY-LAW 2.68: GHSA CONCUSSION POLICY: In accordance with Georgia law and national playing rules published by the National Federation of State High School Associations, any athlete who exhibits signs, symptoms, or behaviors consistent with a concussion shall be immediately removed from the practice or contest and shall not return to play until an appropriate health care professional has determined that no concussion has occurred. (NOTE: An appropriate health care professional may include, licensed physician (MD/DO) or another licensed individual under the supervision of a licensed physician, such as a nurse practitioner, physician assistant, or certified athletic trainer who has received training in concussion evaluation and management.

a) No athlete is allowed to return to a game or a practice on the same day that a concussion (a) has been diagnosed, OR (b) cannot be ruled out.

b) Any athlete diagnosed with a concussion shall be cleared medically by an appropriate health care professional prior to resuming participation in any future practice or contest. The formulation of a gradual return to play protocol shall be a part of the medical clearance.

c) It is mandatory that every coach in each GHSA sport participate in a free, online course on concussion management prepared by the NFHS and available at www.nfhslearn.com at least every two years – beginning with the 2013-2014 school year.

d) Each school will be responsible for monitoring the participation of its coaches in the concussion management course, and shall keep a record of those who participate.

I HAVE READ THIS FORM AND I UNDERSTAND THE FACTS PRESENTED IN IT.

SIGNED: _____ _____

(Student) **(Parent or Guardian)**

DATE:

2017-2018 Student Accident Coverage

Serviced by: K&K Insurance Group, Inc. Phone: 855-742-3135

Remember to visit our website for faster enrollment: www.studentinsurance-kk.com
Online Enrollment—Secured Accident Coverage can be purchased any time throughout the year.

ACCIDENT ONLY COVERAGE: The Policy provides benefits for loss due to a covered Injury up to the Maximum Benefit of $25,000 for each Injury. Provided that treatme a qualified, licensed Physician begins within 60 days from the date of Injury, benefits will be paid for Covered Medical Expenses incurred within 52 weeks from the date Injury up to the Maximum Benefit per service as shown below.

SCHEDULE OF BENEFITS: Maximum Benefits Paid As Specified Below. Medically Necessary and Reasonable Charges are based on the 75th percentile.

Compare and Choose	Low Option Accident Only	High Option Accident Only
Maximum Benefit:	$25,000 (For Each Injury)	$25,000 (For Each Injury)
Deductible:	$0	$0
Inpatient		
Room & Board:	Up to $150 per day/ Semi-private room rate	80% of Reasonable Charges/ Semi-private room rate
Hospital Miscellaneous:	$600 maximum per day	$1,200 maximum per day
Registered Nurse:	75% of Reasonable Charges	100% of Reasonable Charges
Physician's Visits: (Benefits are limited to one visit per day and do not apply when related to surgery)	$40 first day/$25 each subsequent day	$60 first day/$40 each subsequent day
Outpatient		
Day Surgery Miscellaneous:	$1,000 maximum	$1,200 maximum
Physician's Visits: Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)	$40 first day/ $25 each subsequent day	$60 first day/ $40 each subsequent day
Outpatient Physical Therapy: (Benefits are limited to one visit per day)	$30 first day/$20 each subsequent day/ 5 days maximum	$60 first day/$40 each subsequent day 5 days maximum
Emergency Room Services: (Treatment must be rendered within 72 hours from the time of the injury)	$150 maximum	$300 maximum
X-Rays:	$200 maximum	$600 maximum
Diagnostic Imaging Services:	$300 maximum	$600 maximum
Laboratory:	$50 maximum	$300 maximum
Prescription Drugs:	$75 maximum	$200 maximum
Injections:	No Benefits	No Benefits
Orthopedic Braces & Appliances:	$75 maximum	$140 maximum
Inpatient and/or Outpatient		
Surgery Fees: (Limited to primary procedure per injury)	$1,000 maximum	$1,200 maximum
Anesthetist:	20% of Surgery Allowance	25% of Surgery Allowance
Assistant Surgeon:	20% of Surgery Allowance	25% of Surgery Allowance
Ambulance:	$300 maximum	$800 maximum
Consultant:	$200 maximum	$400 maximum
Dental Treatment due to Injury to Teeth: (For Injury to sound, natural teeth only)	$10,000 maximum per policy term	$10,000 maximum per policy term
Replacement of Eye Glasses, Contact Lenses or Hearing Aids that are broken as a result of a Covered Injury:	100% of Reasonable Charges	100% of Reasonable Charges
Durable Medical Equipment:	No Benefits	No Benefits
Maternity:	No Benefits	No Benefits
Complication of Pregnancy:	No Benefits	No Benefits

Expenses for the following are not covered: Prosthetic Devices, Mental and Nervous Disorders, Home Health Care, Injections.

This policy contains an excess provision. Benefits will not be paid under the Basic Accident Medical Expense for Covered Expenses to the extent that they are collectible under another Health Care

Details of these benefits may be found in the Master Policy on file at the School District. NOTE: This is a brief summary of the benefits and not a contract. A Master Policy has been provided to your school district that contains all of the provisions, limitations and exclusions and qualifications of the insurance benefits. The Master policy is the contract and will govern and control t payment of benefits.

Choose Your Coverage Plan: One-Time Payment For Accident Coverage

PLEASE NOTE - FOR COVERAGE PLANS LISTED BELOW
Coverage Effective Date: A person's coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.
Coverage Termination Date: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year. All coverage ceases if the policyholder cancels the policy or when the person ceases to be eligible. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.

	Low Option	High Option
24-Hour Accident (Students & Employees) Around-the-clock/anywhere in the world. Before, during and after school. Weekends, vacation and all summer including summer school. School sponsored and extracurricular sports excluding High School Football.	$105.00	$154.00
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.	$36.00	$48.00
At-School Accident (Students & Employees) During the regular school term, on school premises while school is in session. Direct and uninterrupted travel to and from home and scheduled classes. School Sponsored and supervised activities and sports excluding High School Football. Travel to and from school sponsored and supervised activities and sports while in a school furnished or approved vehicle.	$29.00	$37.00
High School Football (Full Year) Play or practice of regularly scheduled football. Consult your Athletic Department for enrollment instructions.	$171.00	$284.00
High School Football (Spring Only Rates) For new players who participate in spring training and not already insured under Football Coverage. Sports seasons are defined by your state high school athletic association.	$74.00	$120.00
High School Football and At-School Accident (Covers all athletics)	$200.00	$321.00
High School Football and 24-Hour Accident (Covers all athletics)	$276.00	$438.00

Facts about the Policy

1. WHO IS ELIGIBLE: students of the policyholder who make the required premium contribution for the coverage selected are eligible. Student status continues after graduation and between school years unless the person enrolls at a different school district.
2. The Master Policy on file with the school district is a non-renewable policy.
3. This is a limited benefit policy.
4. COVERAGE EFFECTIVE DATE: A person's coverage takes effect at the later of the date his or her completed application and premium is received by the company or the effective date of the policy issued to his or her school or school district.
5. COVERAGE TERMINATION DATE: Coverage ends on the earlier of the date his or her coverage has been in force for twelve months or the first day of the next school year.
   All coverage ceases if the policyholder cancels the policy or when person ceases to be eligible. Termination of coverage for any reason will not affect a claim which occurs before coverage ends.
6. LATE ENROLLMENT: Coverage may be purchased at any time during the school year. There is no premium reduction for any individual who enrolls late in the year.
7. CANCELLATION: Coverage under the Policy will not be cancelled, and accordingly, premiums may not be refunded after acceptance by the Company. However, a pro-rata refund of premium shall be made in the event a Covered Person enters the Military Service.
8. STUDENT TRANSFER: The policy continues to be in force anywhere in the world if the Covered Person should relocate prior to the expiration of coverage.

Enroll online at:
www.StudentInsurance-kk.com

or by mail using attached enrollment form.

1. Complete and detach the enrollment form.
2. Make check or money order payable to Nationwide Life Insurance Company. Do not send cash. The Company is not responsible for cash payments.
3. Write your child's name on your check or money order.
4. Mail completed enrollment form with payment back to:
   K&K Insurance Group,
   P.O. Box 2338
   Fort Wayne, IN 46801-2338
5. Your cancelled check, credit card billing, or money order stub will be your receipt and confirmation of payment.
6. Keep this brochure for future reference. Individual policies will not be sent to you.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information ab our customers or former customers to anyone, except as permitted or required by law. We be we maintain appropriate physical, electronic a procedural safeguards to ensure the security o your nonpublic personal information.

Administered by:

K&K Insurance Group, P.O. Box 2338,
Fort Wayne, IN 46801-2338

Cut out card and retain for your records

STUDENT INSURANCE CARD

Student's Name_____

If premium has been paid, the student whose name appears above has been insured under a Policy issued to:

School District:_____

Accident Only Coverage: q 24-HOUR q 24-HOUR (Summer Only Coverage)
q AT-SCHOOL q FOOTBALL q FOOTBALL (Spring Only)

Paid by Check #_____ Amount Paid:_____ Date Paid:_____

Policy #_____

Underwritten by: Nationwide Life Insurance Company
Claims Questions: K&K Insurance Group, Inc.
1712 Magnavox Way • Fort Wayne, IN 46801 • 800-237-2917

Policy Exclusions and Limitations for Accident Only Coverages

The following exclusions apply to any and all Benefits and any applicable Riders, unless otherwise specifically referenced. We will not pay Benefits for:

1. An Injury or Loss that is:
   a. caused by war or any act of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of military nature (which does not include acts of terrorism);
   b. caused while the Insured is serving full-time active duty (more than 31 days) in any Armed Forces;
   c. caused by participating in a riot or violent disorder;
   d. the result of an Insured's taking part in committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act;
   e. the result of the Insured being under the influence of any drug, narcotic, intoxicant or chemical (unless prescribed by a Physician and taken according to the Physician's instructions) as defined by the law of the jurisdiction in which the Accidental Injury occurred. Conviction is not necessary for determination of being "under the influence."; or
   f. intentionally self-inflicted, including suicide or attempt thereof, while sane or insane.
2. An Injury or Loss that is the result of travel or flight (including getting in or out, on or off) in any aircraft except solely as a fare-paying passenger in a commercial aircraft, or as a passenger in a Policyholder chartered aircraft, provided such aircraft has a valid and current airworthiness certificate and is operated by a duly licensed or certified pilot, and while such aircraft is being used for the sole purpose of transportation and such travel is listed as a Covered Activity in the Schedule of Benefits.
3. Any Accident where the Insured is the operator and does not possess a current and valid motor vehicle operator's license (except in a Driver's Education Program).
4. An Accident that occurs while:
   a. participating in any hazardous activities, including the sports of snowmobile, ATV (all terrain or similar type wheeled vehicle), personal watercraft, sky diving, scuba diving, skin diving, hang gliding, cave exploration, bungee jumping, parachute jumping or mountain climbing;
   b. riding, driving, or testing a motorized vehicle used in a race or speed contest, sport, exhibition work or test driving. Motorized Vehicle for purposes of this provision means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATVs, snow mobiles, tractors, golf ca motorized scooters, lawn mowers, heavy equipmer used for excavating, boats, and personal watercraft Motorized Vehicle does not include a Medically Necessary motorized wheelchair, unless such activ specifically listed as a Covered Activity in the Sche of Benefits.
5. Medical or surgical treatment, diagnostic or preventati care of any Sickness, except for treatment of pyogenic infection that results from an Accidental Injury or a bacterial infection that results from the Accidental ingc of contaminated substances.
6. Any Heart or Circulatory Malfunction, whether or not known or diagnosed, except as may be otherwise cove under the Policy or unless the immediate cause of suc malfunction is external trauma.

Additional exclusions for the Accident Medical Expense Benefit and any applicable Riders: We will not pay Benefits for

1. Expenses Incurred for services or treatment rendered by a Physician, Nurse or any other Provider who is:
   a. employed or retained by the Policyholder, or its subsidiaries or affiliates;
   b. the Insured, or the Insured's Family Member.
2. Expenses Incurred for charges which the Insured would not have to pay if he/she did not have insurance or for which no charge is made.
3. Expenses Incurred for charges which are in excess of Reasonable Charges.
4. That part of medical expenses payable by any automobile insurance Policy without regard to fault.
5. Expenses Incurred for any treatment that is considered to be experimental by the American Medical Association (AMA) or the American Dental Association (ADA).
6. Expenses Incurred for the examination, prescription, purchase, or fitting of eyeglasses, contact lenses, or hearing aids, unless Injury has caused impairment of sight or hearing or unless repair or replacement of existing eye glasses, contact lenses or hearing aids is necessary as a result of a covered Injury.
7. Expenses Incurred for new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except as a result of Injury up to the Dental Maximum shown in the Schedule of Benefits, if applicable.
8. Expenses Incurred for personal comfort or convenience items including, but not limited to, Hospital telephone charges, television rentals, or guest meals.
9. Expenses Incurred for or in connection with Custodial Care, unless otherwise specified in the Schedule of Benefits.
10. Expenses Incurred for supervision of an anesthetist.
11. Expenses Incurred for Durable Medical Equipment ren excess of the purchase price.
12. Expenses Incurred for subsequent repairs and replace of prosthetic devices.
13. Expenses Incurred for any condition covered by any Workers' Compensation Act, Occupational Disease law similar law.

Accident Only Definitions:

Injury A bodily injury which is:

1. directly and independently caused by specific Accidental contact with another body or object;
2. a source of loss that is sustained while the Insured Person is covered under this Policy and while he or she is taking part in a Covered Activity.

For all Benefits, Injury includes Heart and Circulatory Malfunction, subject to the following conditions:

1. Malfunction must occur before age 65 while the Insured is taking part in a Covered Activity, and
2. The symptom(s) of such malfunction(s) is (are) first medically treated while the Policy is in force with respect to the Insured and within 48 hours of having taken part in a Covered Activity; and
3. Such Insured has not, within one year prior to the date of participation in the Covered Activity, been medically diagnosed with, or received any medication for, any myocardial infarction, angina pectoris, coronary thrombosis, hypertension, heart attack, or a cerebral vascular incident.

For the Accident Medical Expense Benefit, Injury also incl repetitive motion injuries resulting from participation in a Covered Activity. Repetitive motion injuries are injuries s as, but not limited to, strains, sprains, hernias, tennis elb tendonitis, bursitis, and muscle tears. The repetitive mot injury must be diagnosed by a Physician and occur withir days of participation in a Covered Activity.

All Injuries sustained in one Accident, including all relatec conditions and recurrent symptoms of these Injuries will l considered as one Injury.

Accidental Death & Specific Loss Benefits:

The Aggregate Limit is $500,000 and is the maximum amount payable for claims incurred for all Insureds under the Policy which are caused by any one Incident that occurs when the Policy is in force. If this limit is not sufficient to pay the total of all such Claims, then the Benefit payable to any one Insured will be determined in proportion to our total aggregate limit of liability. This Aggregate Limit of Liability applies only to Accidental Death and Specific Loss Benefits.

Life	$10,000
Both arms or both legs	$10,000
Both hands and both feet	$10,000
One arm and one leg	$10,000
One hand and one foot	$10,000
Either both hands or both feet	$10,000
Speech and hearing in both ears	$10,000
The sight of both eyes	$10,000
The sight of one eye and either one hand or one foot	$10,000
Either one arm or one leg	$7,500
Either one hand or one foot	$5,000
Speech or hearing in both ears	$5,000
Sight of one eye	$5,000
Hearing in one ear	$2,500
Both the thumb and index finger of one hand	$2,500

Enroll online for quicker service at www.StudentInsurance-kk.com

or complete and mail this form

Enrollment Form (School Year 2017-2018)

Student's Last Name:_____

Student's First Name:_____

Student's Middle Name:_____ Date of Birth:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Name of School District (required):_____

Name of School:_____

Grade Level: q Pre-K/Headstart q Kindergarten/Elementary q Middle School q High School/Above

Signature of Parent or Guardian:_____

Date:_____ Email Address:_____ Phone Number:_____

Student Insurance Plan Options — Check Your Selection:

Accident Only Coverage Plans	Low Option	High Option
24-HOUR	q $105.00	q $154.00
24-HOUR Summer Only	q $36.00	q $48.00
AT-SCHOOL	q $29.00	q $37.00
HIGH SCHOOL FOOTBALL COVERAGE Full Year	q $171.00	q $284.00
HIGH SCHOOL FOOTBALL COVERAGE Spring Only For New Players	q $74.00	q $120.00
HIGH SCHOOL FOOTBALL and AT-SCHOOL Covers all athletics	q $200.00	q $321.00
HIGH SCHOOL FOOTBALL and 24-HOUR Covers all athletics	q $276.00	q $438.00

Enclose check for total payment payable to: Nationwide Life Insurance Company. Checks, money orders, or credit cards accepted.
DO NOT SEND CASH
TOTAL ENCLOSED: $_____

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Mail this completed form with payment back to: K&K Insurance Group, P.O. Box 2338, Fort Wayne, IN 46801-2338

Complete this section only if you wish to pay with a Credit Card

Full name as it appears on card

First Name:_____ MI:_____ Last Name:_____

Billing Address (if different than above)

Street #_____ Address_____ Apt #_____

City:_____ State:_____ Zip:_____

Card Number: | | | | | | | | | | | | | | | | Expiration Date: Month: | | Year: | | | | |

Cardholder signature:_____

Company does not issue refunds nor accept responsibility for cash payments. (Rejection of check or credit card by bank for any reason, will invalidate insurance.)