Cleveland Metropolitan School District

INTERSCHOLASTIC ATHLETICS INSURANCE COVERAGE

SPORT: ________________________________ SCHOOL: ___________________________

I hereby permit _________________________, a student in the Cleveland Metropolitan

Athlete's Name

School District to participate in ___________________________ K-8 or Senior High

School

School's Interscholastic Athletics Program.

- ❑ **_____________________ has no health insurance**
  Athlete's Name
- ❑ **_____________________ is covered by the following family medical and dental insurance**
  Athlete's Name

	NAME OF COMPANY	POLICY NUMBER
MEDICAL	___________________________	_________________________
DENTAL	___________________________	_________________________

All students participating in the Interscholastic Athletics program are covered by a supplemental insurance policy through the Cleveland Metropolitan School District. This athletic coverage is provided by Arthur Gallagher Insurance Company and covers the following sports in out K-8 and Senior High Athletics Programs:

FOOTBALL, VOLLEYBALL, SOCCER, CROSS-COOUNTRY, GOLF, BASKETBALL, SWIMMING, WRESTLING, BOWLING, SOFTBALL, BASEBALL, TRACK, TENNIS, WEIGHTLIFTING, CHEERLEADING, AND FENCING.

COVERAGE

Parents MUST submit their own family insurance claim first. The Board of Education Athletics' coverage will then pay all other charges, which are in excess of the amount collectible from all other family insurance (maximum $2500). A student is covered while practicing for, competing in, or traveling to and from, athletic contest as a representative of a Cleveland Metropolitan K-8 and Senior High School. All events must be under the regulation and jurisdiction of the school and under the direct supervision of a full-time school employee. I release ________________ School, and/or the State Board of Education, and the Interscholastic Athletic Office, of any and all medical, dental, and hospital expenses beyond the Interscholastic Athletic Insurance Coverage. Any and all expenses are the responsibility of the parent/guardian of the student athlete.

DATE _____________________

SIGNED _________________________ RELATIONSHIP ________________________

ADDRESS ____

CITY ZIP

TELEPHONE NUMBER ____________________________

MUST BE SIGNED AND RETURNED TO SCHOOL BEFORE THE FIRST DAY OF PRACTICE

Cleveland Metropolitan School District

EMERGENCY INFORMATION

School ______________________ **School Year** _______-_______ **Grade** __________

Student's Name ____ **Birth Date** ___________
Last First Middle

Address ____
Street City State Zip

Lives with Father / Stepfather / Custodian (Circle One)

______________________ **Employed at** ______________________ **Phone** (____) ____________
Name

Lives with Mother / Stepmother / Custodian (Circle One)

______________________ **Employed at** ______________________ **Phone** (____) ____________
Name

EMERGENCY NUMBER: IN THE EVENT PARENT CANNOT BE REACHED FOR EMERGENCY

Name __________________________
Address ________________________
Relationship_____________________

Does your child have any medical condition or allergies which may require emergency treatment or to which a physician should be alerted (Circle) NO YES (Explain) _____

____

____

<u>PART I – TO GRANT CONSENT</u>

In the event that I cannot be contacted, I hereby give my consent for:

1) the administration of any treatment deemed necessary by Dr. ____________________ (preferred Physician) ___________________ (Physician phone #) or Dr. ____________________ (preferred Dentist) ___________________ (Dentist phone #) or medical specialist Dr. ____________________ (preferred specialist) ___________________ (medical specialist phone #) of if they are unavailable, by another licensed practitioner: and

2) the transfer of my child to ____________________ (preferred hospital) ___________________ (Hospital phone #), or any hospital reasonably accessible. **(This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring on the necessity for such surgery, are obtained prior to the performance of such surgery).**

Signature of Parent/Guardian ____________________________ **Date** _______________________

Address ____

<u>PART II – REFUSAL TO CONSENT</u>

I do not give my consent for emergency medical treatment of my child. I wish the school to take no action or to: ____

Signature of Parent/Guardian ____________________________ **Date** _______________________

Address ____

PLEASE NOTIFY US OF ANY CHANGES IN THE ABOVE INFORMATION