

# LANCASTER ISD 2010-2011

Please circle correct campus and grade for the 2010-2011 school year.

CAMPUS: LHS LMS

GRADE: 6 7 8 9 10 11 12

## EMERGENCY & INSURANCE INFORMATION

**The following information must be completed and signed even if your child is not covered by personal insurance.**

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Student Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Student ID: \_\_\_\_\_ Birth date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Gender: M / F Grade: \_\_\_\_\_

Emergency Contacts: (Please list a parent/guardian as the first contact.)

1 Relationship: \_\_\_\_\_ Name: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

2 Relationship: \_\_\_\_\_ Name: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Medical Conditions:

Asthma Diabetes\* Allergies: \_\_\_\_\_  
Other: \_\_\_\_\_

**\*If your child is a diabetic it is your responsibility to bring in your child's Diabetic Management Plan from your child's physician.**

Is the student covered under a family insurance policy? Y / N

Insurance Company: \_\_\_\_\_ Circle one: HMO PPO Other

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address2: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Group No: \_\_\_\_\_ Policy/Member No: \_\_\_\_\_

The Lancaster Independent School District (LISD) provides an insurance policy for all of its athletes. The LISD insurance policy is **secondary** to any personal insurance policy under which the athlete is insured. If the athlete is not already covered under a personal insurance policy, the LISD insurance pays according to its insurance policy. In order to qualify for benefits, the injury must be related to participation in LISD athletics; the injured athlete must be seen, preferably by a LISD athletic trainer and/or LISD team physician, within 30 days of the incident; and the claim must be filed within 90 days of the incident. The supervising coach or athletic trainer must receive prior notice that an athlete is going to the doctor because of an athletic injury. This is not done to prevent an athlete from going to the doctor, but so that we can keep up with injuries accurately and fill out the claim forms properly. Any athlete who has an injury due to UIL sports competition or workouts should report it to the athletic trainer or coach immediately. The school will not be held responsible for any visits to the doctor which the supervising coach or athletic trainer does not receive prior notice. The student accident policy pays only up to the limits of the policy, and in some cases may not pay the entire medical bill, especially to providers outside of the approved provider network (you may contact a LISD athletic trainer to determine if a provider is in the insurance network). LISD is not responsible for any balance on any medical bills after the accident plan has paid. **I agree to these terms, and to file my own insurance claim with my personal insurance carrier if I have any. I agree to pay amounts not paid by the LISD insurance carrier.**

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**OVER-THE-COUNTER MEDICATION**

Lancaster High School carries the following over-the-counter medication to treat the indicated conditions. All are administered according to packaged instructions unless otherwise directed by a licensed physician. Check the boxes next to the medications you **DO NOT** wish the LISD staff to provide to your child. If you should have any questions regarding the medications, contact your physician or a LANCASTER ISD athletic trainer at LHS- (972) 218-1800 X 6102.

- |   |  |
|---|--|
| <input type="checkbox"/> Muscle Pain: Analgesics Heat/Cold Ointment | <input type="checkbox"/> Antacid/Antigas: Alamag Plus                          |
| <input type="checkbox"/> Wound Care: Sterile Saline Solution        | <input type="checkbox"/> Nausea: Phosphorylated glucose/levulose (ex. Emetrol) |
| <input type="checkbox"/> Heat Relief: Electrolyte Tablets           | <input type="checkbox"/> Rash: Hydrocortisone Cream                            |
| <input type="checkbox"/> Cough: Cough/Throat lozenge                | <input type="checkbox"/> Blister Care: Skin Lubricant/Petrolatum Based         |
- Yes, the Lancaster ISD Athletic Trainers can provide ALL of the medications listed above to my child.**  
 **NONE – Do NOT provide any medication to my child.**

My Child is Allergic to the following medications: \_\_\_\_\_

**FOR FOOTBALL PLAYERS ONLY:**

**WARNING:** No helmet can prevent all head or neck injuries a player might receive while participating in football. Do not use the helmet to butt, ram, or spear an opposing player. This is a violation of the football rules and such use can result in severe head or neck injuries, paralysis, or death to you and possible injury to your opponent.

In case of injury or illness, I give the athletic trainer(s) of Lancaster ISD my permission to administer the “over-the-counter” medications as indicated above.

I do hereby request, consent, and authorize the exchange of information regarding the above student between the student’s healthcare provider(s) – including physician(s), physical therapist(s), chiropractor(s), or other licensed healthcare professional(s) involved with the athlete’s care – and representative(s) of Lancaster ISD – including coach(s), athletic trainer(s), and administrator(s). I understand that the information exchanged should only be information that may effect or potentially affect the health, well-being, and athletic participation of said student and/or other participants including team member(s), coach(s), athletic trainer(s), official(s), competitor(s), and others involved in the student’s athletic activity and care.

If, in the judgment of any representatives of the school, the above student needs immediate care and treatment as a result of an injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, athletic trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomsoever on account of such care and treatment of said student.

**Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_