

# CABELL COUNTY PUBLIC SCHOOLS

P.O. BOX 446

2850 FIFTH AVENUE

HUNTINGTON, WEST VIRGINIA 25702

Student's Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Blood Type (if known) \_\_\_\_\_

Parent or Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Contact Other Than Parent \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Family Physician's Office Number \_\_\_\_\_

Known Allergies \_\_\_\_\_

Hospitalization Insurance: Name of Company \_\_\_\_\_

Policy No. \_\_\_\_\_ Medical? \_\_\_\_\_ Surgical? \_\_\_\_\_ Accident? \_\_\_\_\_

Permission is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, X-ray examinations and immunizations for the named student. In the event of serious illness, the need for minor surgery, or significant accidental injury, I understand that an attempt will be made by the **attending** physician to contact me in the most expeditious way possible. If said physician is not able to communicate with me or the other person listed above, the treatment necessary for the best interest of the above named student may be given.

In the event that an emergency arises during a practice session, an effort will be made to contact the parents or guardians as soon as possible. Permission is also granted to the athletic trainer, coaches, Emergency Medical Technician (EMT) or Paramedic to provide the needed emergency treatment to the athlete prior to his or her admission to the medical facilities.

Signature of parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Athletes are also covered under an "All Athletic Plan". This coverage is an "excess" contract that picks up where other insurance stops. If the covered person is covered by any other individual, franchise, blanket or group insurance which provides benefits for medical care or treatment, the Plan will pay only the covered expenses which are not paid under the other insurance. Claims should be submitted under this contract only if there is no other insurance or if the other insurance does not provide coverage for the expense.

County of CABELL, State of WEST VIRGINIA

Sworn to and subscribed before me this \_\_\_\_\_

Day of \_\_\_\_\_, 20\_\_\_\_\_

Witness my hand and official seal.

\_\_\_\_\_, Notary Public

My commission Expires \_\_\_\_\_

Form: S-0001

Revised: 7/97