

OMAHA PUBLIC SCHOOLS  
2022-23 PRE-PARTICIPATION PACKET

Revised: May 14, 2022 (Krogstrand)



Contents:

- NSAA Consent Form
- Omaha Public Schools & NSAA Pre-Participation Health History Form (to be kept by student's physician)
- Omaha Public Schools & NSAA Physical Examination Form (to be kept by student's physician)
- Omaha Public Schools & NSAA Physician's Recommendation, Parent/Student Release of Doctor's Recommendation & Shared Medical Information Form
- Omaha Public Schools Concussion Information Sheet & Acknowledgment Form
- Omaha Public Schools Medical Health Insurance Information Form

SCHOOL PERSONNEL:

- Please ensure that all forms with the OMAHA PUBLIC SCHOOLS LOGO are signed, completed and returned before allowing an athlete to participate.
- Only those with the OPS Logo in the top-right corner should be kept by the school. Return all other paperwork to the student or dispose of any additional information turned in.

To be completed for  
students participating in any  
NSAA activities.

## Student and Parent Consent Form



School Year: 20\_\_\_\_-20\_\_\_\_  
Member School: \_\_\_\_\_  
Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

The undersigned(s) are the Student and the parent(s), guardian(s), or person(s) in charge of the above-named Student and are collectively referred to as "Parent".

The Parent and Student hereby:

(1) Understand and agree that participation in NSAA sponsored activities is voluntary on the part of the Student and is a privilege;

(2) Understand and agree that (a) by this Consent Form the NSAA has provided to the Parent and Student of the existence of potential dangers associated with athletic participation; (b) participation in any athletic activity may involve injury **or illness** of some type; (c) the severity of such injury can range from minor cuts, bruises, sprains, and muscle strains to more serious injuries to the body's bones, joints, ligaments, tendons, or muscles, to catastrophic injuries to the head, neck and spinal cord, and on rare occasions, injuries so severe as to result in total disability, paralysis and death; **(d) the severity of an illness, including contagious diseases such as the COVID 19 virus, and bacterial infections may be so severe as to result in disability and death;** and, (e) even the best coaching, the use of the best protective equipment and strict observance of rules, injuries are still a possibility;

(3) Consent and agree to participation of the Student in NSAA activities subject to all NSAA by-laws and rules interpretations for participation in NSAA sponsored activities, and the activities rules of the NSAA member school for which the Student is participating; and,

(4) Consent and agree to (a) the disclosure by the Member School at which the Student is enrolled to the NSAA, and subsequent disclosure by the NSAA, of information regarding the Student, including the student's name, address, telephone listing, electronic mail address, photograph, date of and place of birth, major fields of study, dates of attendance, grade level, enrollment status (e.g., full-time or part-time), participation in officially recognized activities and sports, weight and height of as a member of athletic teams, degrees, honors and awards received, statistics regarding performance, records or documentation related to eligibility for NSAA sponsored activities, medical records, and any other information related to the Student's participation in NSAA sponsored activities; and, (b) the Student being photographed, video recorded, audio taped, or recorded by any other means while participating in NSAA activities and contests, consent to and waive any privacy rights with regard to the display of such recordings, and waive any claims of ownership or other rights with regard to such photographs or recordings or to the broadcast, sale or display of such photographs or recordings.

(5) Consent and agree to authorize licensed sports injury personnel to evaluate and treat any **injury or illness** that occurs during the student's participation in NSAA activities. This includes all reasonable and necessary preventive care, treatment and rehabilitation for these injuries. This would also include transportation of the student to a medical facility if necessary. Such licensed sports injury personnel are independent providers and are not employed by the NSAA.

(6) Acknowledge that Parents are obligated to pay for professional medical and/or related services; the NSAA shall not be liable for payment of such services. We give permission to any and all of the Student's health care providers and the NSAA and its employees, staff, agents, and consultants to release and discuss all records and information about the Student including otherwise confidential medical information and records. We understand that this release has been requested and may be used for the purpose of determining eligibility pertaining to activities participation, fitness, injury, injury status, or emergency.

I acknowledge that I have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities.

Name of Student [Print Name] \_\_\_\_\_ Student Signature \_\_\_\_\_ Date \_\_\_\_\_

(I am)(We are) the Student's [circle appropriate choice] (Parent) (Guardian). (I)(We) acknowledge that (I)(We) have read paragraphs (1) through (6) above, understand and agree to the terms thereof, including the warning of potential risk of injury inherent in participation in athletic activities. Having read the warning in paragraph (2) above and understanding the potential risk of injury to my Student, (I)(we) hereby give (my)(our) permission for \_\_\_\_\_ [insert student name] to practice and compete for the above named high school in activities approved by the NSAA, **except those crossed out below:**

|                 |                       |            |               |        |           |        |               |
|-----------------|-----------------------|------------|---------------|--------|-----------|--------|---------------|
| Baseball        | Basketball            | Bowling    | Cross Country | Debate | Football  | Golf   | Journalism    |
| Music           | Play Production       | Soccer     | Softball      | Speech | Swim/Dive | Tennis | Track & Field |
| Unified Bowling | Unified Track & Field | Volleyball | Wrestling     |        |           |        |               |

| Parent(s)/Guardian Printed Name(s)* | Parent/Guardian Signature | Date of Signature |
|-------------------------------------|---------------------------|-------------------|
|                                     |                           |                   |
|                                     |                           |                   |

**\*Both Mother and Father must sign, unless parents are divorced, the custodial parent must sign, or if the student is not living with parents, the student's legal guardian.**

Revised June 2021

# OMAHA PUBLIC SCHOOLS HEALTH HISTORY FORM

To be completed (with parent/guardian if student is under 18) prior to the physical exam. **Form shall not be shared with the school or any school personnel, but only given to the physician prior to the physical exam.**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Grade: \_\_\_\_\_

Sports: \_\_\_\_\_

|                                                                                  |  |
|----------------------------------------------------------------------------------|--|
| List all past and current medical conditions:                                    |  |
| Have you ever had surgery?<br>If Yes, list all procedures:                       |  |
| List all prescriptions, over-the-counter meds or supplements you currently take: |  |
| Do you have any allergies?<br>If Yes, Please list them here:                     |  |

Over the last two weeks, how often have you been bothered by the following problems? (Circle Response)

|                                                                                                               | Not At All | Several Days | Over Half the Days | Nearly Every Day |
|---------------------------------------------------------------------------------------------------------------|------------|--------------|--------------------|------------------|
| Feeling nervous, anxious or on edge                                                                           | 0          | 1            | 2                  | 3                |
| Not being able to stop or control worrying                                                                    | 0          | 1            | 2                  | 3                |
| Little interest in pleasure or doing things                                                                   | 0          | 1            | 2                  | 3                |
| Feeling down, depressed or hopeless                                                                           | 0          | 1            | 2                  | 3                |
| <i>A sum of 3 or greater is considered positive on either subscale (Q1+2, or Q3+4) for screening purposes</i> |            |              |                    |                  |

**ANSWER EACH OF THE FOLLOWING QUESTIONS SPECIFIC TO "IN THE PAST YEAR"  
& EXPLAIN ANY YES ANSWERS ON THE BACK OF THIS SHEET:**

| GENERAL QUESTIONS                                                                                                                                                                                                                                                                                                    | Yes        | No        | MEDICAL QUESTIONS                                                                                                                               | Yes        | No        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 1. Do you have any concerns you'd like to discuss with your provider?                                                                                                                                                                                                                                                |            |           | 16. Do you cough, wheeze, or have difficulty breathing during or after exercise?                                                                |            |           |
| 2. Has a provider ever denied or restricted your participation in sports for any reason?                                                                                                                                                                                                                             |            |           | 17. Are you missing a kidney, an eye, a testicle, your spleen or any other organ?                                                               |            |           |
| 3. Do you have any ongoing medical issues or recent illnesses?                                                                                                                                                                                                                                                       |            |           | 18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?                                                          |            |           |
| <b>HEART HEALTH QUESTIONS ABOUT YOU</b>                                                                                                                                                                                                                                                                              | <b>Yes</b> | <b>No</b> | 19. Do you have recurring skin rashes or rashes that come and go, including herpes or MRSA?                                                     |            |           |
| 4. Have you ever passed out or nearly passed out during or after exercise?                                                                                                                                                                                                                                           |            |           | 20. Have you had a concussion or head injury that caused confusion, a prolonged headache or memory problems?                                    |            |           |
| 5. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?                                                                                                                                                                                                                          |            |           | 21. Have you ever had numbness, tingling or weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling? |            |           |
| 6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?                                                                                                                                                                                                                |            |           | 22. Have you ever become ill while exercising in the heat?                                                                                      |            |           |
| 7. Has a doctor ever told you that you have any heart problems?                                                                                                                                                                                                                                                      |            |           | 23. Do you or does someone in your family have sickle cell trait or disease?                                                                    |            |           |
| 8. Has a doctor ever requested a test for your heart? (Example: electrocardiography or echocardiography)                                                                                                                                                                                                             |            |           | 24. Have you ever had, or do you have any problems with your eyes or vision?                                                                    |            |           |
| 9. Do you get light-headed or feel shorter of breath than your friends during exercise?                                                                                                                                                                                                                              |            |           | 25. Do you worry about your weight?                                                                                                             |            |           |
| 10. Have you ever had a seizure?                                                                                                                                                                                                                                                                                     |            |           | 26. Are you trying to, or has anyone recommended that you gain or lose weight?                                                                  |            |           |
| <b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY</b>                                                                                                                                                                                                                                                                      | <b>Yes</b> | <b>No</b> | 27. Are you on a special diet, or do you avoid certain types of foods or food groups?                                                           |            |           |
| 11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before 35 years of age (including drowning or unexplained car crash)                                                                                                                                   |            |           | 28. Have you ever had an eating disorder?                                                                                                       |            |           |
| 12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS) short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CVPT)? |            |           | 29. Have you ever had COVID-19?                                                                                                                 |            |           |
| 13. Has anyone in your family had a pacemaker or implanted defibrillator before age 35?                                                                                                                                                                                                                              |            |           | <b>FEMALES ONLY</b>                                                                                                                             | <b>Yes</b> | <b>No</b> |
| <b>BONE AND JOINT QUESTIONS</b>                                                                                                                                                                                                                                                                                      | <b>Yes</b> | <b>No</b> | 30. Have you ever had a menstrual period?                                                                                                       |            |           |
| 14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint or tendon that caused you to miss a practice or a game?                                                                                                                                                                      |            |           | 31. How old were you when you had your first period?                                                                                            |            |           |
| 15. Do you have a bone, muscle, ligament or joint injury that bothers you?                                                                                                                                                                                                                                           |            |           | 32. When was your most recent period?                                                                                                           |            |           |
|                                                                                                                                                                                                                                                                                                                      |            |           | 33. How many periods have you had in the past 12 months?                                                                                        |            |           |

**CERTIFICATION OF HEALTH: I hereby state that, to the best of my knowledge, my answers on this form are complete and correct:**

Signature of Athlete: \_\_\_\_\_

Signature of parent/guardian (if under 18): \_\_\_\_\_

Date: \_\_\_\_\_

*Form adapted with permission © American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine, 2019*

# OMAHA PUBLIC SCHOOLS PREPARTICIPATION PHYSICAL EXAM FORM

Athlete Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Grade: \_\_\_\_\_

## 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, e-cigarettes, vaping, chewing tobacco, snuff or dip?
- Over the past 30 days, have you used 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-enhancing supplement?
- Have you ever taken any supplements to help you gain or lose weight or improve your performance?
- Do you wear a seatbelt or helmet?

### 2. Consider reviewing questions on cardiovascular symptoms (#4-13 on health history form)

| EXAMINATION |                          |             |
|-------------|--------------------------|-------------|
| Height:     | Weight:                  | BP:         |
| Pulse:      | Vision: R 20/      L 20/ | Corrected?: |

| MEDICAL                                                                        | Normal | Abnormal Findings |
|--------------------------------------------------------------------------------|--------|-------------------|
| Appearance                                                                     |        |                   |
| Head/Mouth                                                                     |        |                   |
| Eyes, ears, nose and throat - Pupils equal & Hearing                           |        |                   |
| Lymph Nodes                                                                    |        |                   |
| Heart* -Heart sounds, murmurs, pulse, rhythm, auscultation, COVID-19 diagnosis |        |                   |
| Lungs                                                                          |        |                   |
| Abdomen - Liver/Spleen, masses                                                 |        |                   |
| Skin - HSV, Lesions, Staphy, MRSA, etc                                         |        |                   |
| Neurological                                                                   |        |                   |
| MUSCULOSKELETAL                                                                | Normal | Abnormal Findings |
| Neck                                                                           |        |                   |
| Back                                                                           |        |                   |
| Shoulder & Arm                                                                 |        |                   |
| Elbow & Forearm                                                                |        |                   |
| Wrist, Hand and Fingers                                                        |        |                   |
| Hip & Thigh                                                                    |        |                   |
| Knee                                                                           |        |                   |
| Leg & Ankle                                                                    |        |                   |
| Foot & Toes                                                                    |        |                   |
| Functional                                                                     |        |                   |
| • Double-leg squat test, single-leg squat test, box drop or step drop test     |        |                   |

\* Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or exam findings, or a combination

Name of Examiner: \_\_\_\_\_

Signature of Examiner: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

## TO BE COMPLETED BY ATHLETE OR PARENT/GUARDIAN (If athlete is younger than 18 years of age):

*I hereby give permission for the release of the results of the actual physical examination and selected "Shared Medical Information" on the next page to the school for the purposes of participation in athletics and activities.*

**Student Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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# OMAHA PUBLIC SCHOOLS

## PHYSICIAN RECOMMENDATION FORM & SHARED MEDICAL INFORMATION



Athlete Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction, with recommendations for the further evaluation or treatment of

\_\_\_\_\_

☐ Medically eligible only for certain sports (list below):

\_\_\_\_\_

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are 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 medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of health care professional: \_\_\_\_\_, \_\_\_\_\_

### SHARED EMERGENCY INFORMATION – For School Purposes/Information

Allergies:

\_\_\_\_\_  
\_\_\_\_\_

Medications:

\_\_\_\_\_  
\_\_\_\_\_

Other information:

\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts:

\_\_\_\_\_  
\_\_\_\_\_

# OMAHA PUBLIC SCHOOLS – CONCUSSION FACT SHEET FOR STUDENTS



## ***What is a concussion?***

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you haven't been knocked out
- Can be serious even if you've just been "dinged" or "had your bell rung"

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

## ***What are the symptoms of a concussion?***

You can't see a concussion, but you might notice one or more of the symptoms listed below or that you "don't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

## ***What should I do if I think I have a concussion?***

- **Tell your coaches and your parents.** Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- **Get a medical check-up.** A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- **Give yourself time to get better.** If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

## ***How can I prevent a concussion?***

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. In order for equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow your coach's rules for safety and the rules of the sport
- Practice good sportsmanship at all times

**IT IS BETTER TO MISS ONE GAME THAN A WHOLE SEASON – SEE SOMETHING – SAY SOMETHING!!!**

---

Student's Name (Please Print)

---

Date

---

Grade

---

Signature of Student

---

Date

---

Parent's Signature

---

Date

# OMAHA PUBLIC SCHOOLS – CONCUSSION FACT SHEET FOR PARENTS



## ***What is a concussion?***

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

## ***What are the signs and symptoms?***

You can't see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

| Signs Observed By Parents or Guardians                                                                                                                                                                                                                                                                                                                                                                                                                                            | Symptoms Reported by Athlete                                                                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Appears dazed or stunned</li><li>• Is confused about assignment or position</li><li>• Forgets an instruction</li><li>• Is unsure of game, score, or opponent</li><li>• Moves clumsily</li><li>• Answers questions slowly</li><li>• Loses consciousness (even briefly)</li><li>• Shows mood, behavior, or personality changes</li><li>• Can't recall events prior to hit or fall</li><li>• Can't recall events after hit or fall</li></ul> | <ul style="list-style-type: none"><li>• Headache or "pressure" in head</li><li>• Nausea or vomiting</li><li>• Balance problems or dizziness</li><li>• Double or blurry vision</li><li>• Sensitivity to light or noise</li><li>• Feeling sluggish, hazy, foggy, or groggy</li><li>• Concentration or memory problems</li><li>• Confusion</li><li>• Just not "feeling right" or is "feeling down"</li></ul> |

## ***How can you help your teen prevent a concussion?***

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches' rules for safety and the rules of the sport
- Encourage them to practice good sportsmanship at all times.

## ***What should you do if you think your child has a concussion?***

1. **Keep your child out of play.** If your child has a concussion, her/his brain needs time to heal. Don't let your child return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your child is symptom-free and it's OK to return to play. A repeat concussion that occurs before the brain recovers from the first – usually within a short period of time (hours, days, or weeks) – can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your child to return to sports.
3. **Teach your child that it's not smart to play with a concussion.** Rest is key after a concussion. Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Don't let your child convince you that s/he's "just fine".
4. **Tell all of your child's coaches and the student's school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your child has ever had a concussion. Your child may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your child's coaches, school nurse, and teachers. If needed, they can help adjust your child's school activities during her/his recovery.

\_\_\_\_\_  
Parent's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Grade

**OMAHA PUBLIC SCHOOLS**  
**Health Insurance Information**



**To participate in Athletics for the Omaha Public Schools, all athletes must demonstrate that they have health insurance coverage.**

Our school district, in conjunction with K & K Insurance company, provide for student insurance coverage for those that may choose to enroll to complete this requirement. The total premium of this insurance must be paid by the student or parent/guardian. The purpose of this coverage is to assist in the cost of treatment of accidental injury that may occur in the realm of athletic participation. Payments from K & K Insurance are to be considered of a “secondary” nature and made in concert with any payments from another insurance company for the same injury.

Proof of insurance, either through the K & K Insurance company, or through personal/private health insurance coverage must be provided as below before a student is allowed to participate in Omaha Public Schools Athletics programming. K & K insurance information and enrollment options can be found at [www.studentinsurance-kk.com](http://www.studentinsurance-kk.com).

**Athlete Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Check the statement that applies:**

\_\_\_\_\_ **The above-named student shall participate in the Athletic Benefit Injury Plan offered by K & K Insurance.**

|                                         |  |
|-----------------------------------------|--|
| <b>K&amp;K Insurance Policy Number:</b> |  |
|-----------------------------------------|--|

\_\_\_\_\_ **The above-named student has health insurance coverage through another entity as detailed below:**

|                           |  |
|---------------------------|--|
| <b>Insurance Company:</b> |  |
| <b>Policy Number:</b>     |  |

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