LEE COUNTY SCHOOLS

IMPORTANT: THIS NOTIFICATION MUST BE SIGNED AND RETURNED BEFORE YOUR CHILD CAN PARTICIPATE IN THIS PROGRAM.

TO: **Parents of Students Participating in Athletics**

DATE: **20___ - 20___ School Year**

SUBJECT: **Athletic Student Insurance**

SCHOOL: **_____**

The Lee County School Board of Education requires that all students who participate in middle school and high school athletics be covered by accident insurance. As a result, the Lee County Board of Education has purchased a *secondary* insurance policy that provides limited coverage for students who participate in athletics.

Please be sure that you understand the following before deciding whether to permit your son or daughter to participate:

1. **This coverage is being provided by Mega Life and Health Insurance Company.**

2. **There are limitations in the Athletic Student Insurance coverage. It will not always pay for every accident. *If the parent has insurance, that policy automatically becomes primary. If no insurance is in effect, the Board's policy becomes primary.***

3. **Neither the Board of Education nor any of its employees will assume responsibility for claims resulting from injury to your child while he/she is participating in this program. This means that you will have to pay for any necessary medical treatment not covered by the Accident Insurance or any personal insurance coverage that you might have.**

For information purposes, please check one of the statements below and return promptly:

_____ **I have adequate personal insurance and release the Board of Education and its employees from any responsibility in this matter.**
Name of Insurance Company_____
Address of Insurance Company_____
Group Name/Number and Policy Number_____
Name of Policy Holder_____

_____ **I do not have other insurance, but I understand that I am responsible for payment of any charges not covered by the school policy.**

Permission is hereby granted to proceed with any needed medial or minor surgical treatment, x-ray examinations, and Immunizations for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury. I understand than an attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary in the best interest of the student may be given.

Each player must also receive a MEDICAL EXAMINATION by a physician licensed to practice medicine each calendar year (once every 365 days) in order to be eligible for practice or participation in interscholastic athletic contests. I hereby certify that my son/daughter has met this requirement and I agree for him/her to participate.

STUDENT'S FULL NAME_____

ADDRESS_____

SIGNED (Parent or Legal Guardian)_____DATE_____