

This form should be placed into the athlete's medical file and should **not** be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

**Disclaimer:** Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

## ■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

### HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Date of examination: \_\_\_\_\_ Sport(s): \_\_\_\_\_

Sex assigned at birth (F, M, or intersex): \_\_\_\_\_ How do you identify your gender? (F, M, or other): \_\_\_\_\_

Have you had COVID-19? (check one):  Y  N

Have you been immunized for COVID-19? (check one):  Y  N If yes, have you had:  One shot  Two shots

List past and current medical conditions. \_\_\_\_\_

Have you ever had surgery? If yes, list all past surgical procedures. \_\_\_\_\_

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).  
\_\_\_\_\_

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).  
\_\_\_\_\_

#### Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of 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 or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of  $\geq 3$  is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

#### GENERAL QUESTIONS

(Explain "Yes" answers at the end of this form.  
Circle questions if you don't know the answer.)

	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		

#### HEART HEALTH QUESTIONS ABOUT YOU

	Yes	No
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

#### HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)

9. Do you get light-headed or feel shorter of breath than your friends during exercise?	Yes	No
10. Have you ever had a seizure?		

#### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	Yes	No
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 (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS		Yes	No
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 game?			
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?			
MEDICAL QUESTIONS		Yes	No
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?			
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?			
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?			
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)?			
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?			
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?			
22. Have you ever become ill while exercising in the heat?			
23. Do you or does someone in your family have sickle cell trait or disease?			
24. Have you ever had or do you have any problems with your eyes or vision?			

MEDICAL QUESTIONS (CONTINUED)		Yes	No
25. Do you worry about your weight?			
26. Are you trying to or has anyone recommended that you gain or lose weight?			
27. Are you on a special diet or do you avoid certain types of foods or food groups?			
28. Have you ever had an eating disorder?			
<b>FEMALES ONLY</b>		Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

**Explain "Yes" answers here.**

**I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.**

Signature of athlete:

Signature of parent or guardian:

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

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**Disclaimer:** Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

## ■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance) PHYSICAL EXAMINATION FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### 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, chewing tobacco, snuff, or dip?
  - During the past 30 days, did you use 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 seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		NORMAL	ABNORMAL FINDINGS
Height:	Weight:		
BP: / ( / )	Pulse:	Vision: R 20/ 20/	Corrected: <input type="checkbox"/> Y <input type="checkbox"/> N
COVID-19 VACCINE			
Previously received COVID-19 vaccine: <input type="checkbox"/> Y <input type="checkbox"/> N			
Administered COVID-19 vaccine at this visit: <input type="checkbox"/> Y <input type="checkbox"/> N      If yes: <input type="checkbox"/> First dose <input type="checkbox"/> Second dose			
MEDICAL		NORMAL	ABNORMAL FINDINGS
Appearance			
<ul style="list-style-type: none"><li>• Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)</li></ul>			
Eyes, ears, nose, and throat			
<ul style="list-style-type: none"><li>• Pupils equal</li><li>• Hearing</li></ul>			
Lymph nodes			
Heart*			
<ul style="list-style-type: none"><li>• Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)</li></ul>			
Lungs			
Abdomen			
Skin			
<ul style="list-style-type: none"><li>• Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or <i>funga corporis</i></li></ul>			
Neurological			
MUSCULOSKELETAL		NORMAL	ABNORMAL FINDINGS
Neck			
Back			
Shoulder and arm			
Elbow and forearm			
Wrist, hand, and fingers			
Hip and thigh			
Knee			
Leg and ankle			
Foot and toes			
Functional			
<ul style="list-style-type: none"><li>• Double-leg squat test, single-leg squat test, and box drop or step drop test</li></ul>			

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

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

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

Signature of health care professional: \_\_\_\_\_, MD, DO, NP, or PA

## ■ PREPARTICIPATION PHYSICAL EVALUATION

### MEDICAL ELIGIBILITY FORM

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Medically eligible for all sports without restriction  
 Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of \_\_\_\_\_

Medically eligible for certain sports  
\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_, MD, DO, NP, or PA

### SHARED EMERGENCY INFORMATION

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency contacts: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

\*Entire Page Completed By Patient

## **Athlete Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
Sex: [ ] Male [ ] Female Grade \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Allergies \_\_\_\_\_  
Medications \_\_\_\_\_  
Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_  
Group Number \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

## **Emergency Contact Information**

Home Address \_\_\_\_\_ (City) \_\_\_\_\_ (Zip) \_\_\_\_\_  
Home Phone \_\_\_\_\_ Mother's Cell \_\_\_\_\_ Father's Cell \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
Father's Name \_\_\_\_\_ Work Phone \_\_\_\_\_  
Another Person to Contact \_\_\_\_\_  
Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

## Legal/Parent Consent

I/We hereby give consent for (athlete's name) \_\_\_\_\_ to represent (name of school) \_\_\_\_\_ in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. ***On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above during or resulting from participation in athletics.*** By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, ***I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.***

Signature of Athlete

Signature of Parent/Guardian

Date

## HUNTLAND SCHOOLS' ATHLETE PARENT CODE OF ETHICS

I hereby pledge to provide positive support, care, and encouragement for my child participating in Huntland Schools' athletic program by following this Parent Code of Ethics:

- I will recognize as a parent the tremendous influence I have on the education of my student-athlete, and I will not place the value of winning above the value of instilling the highest ideals of character for my child or other student-athletes; therefore, I will strive to set an example for the highest ethical and moral conduct.
- I will support the coaches and coaching staff in order to encourage a positive and enjoyable experience for all; therefore, I will refrain from coaching my child or other student-athletes during all sporting events.
- I will adhere and uphold all policies, procedures, and bylaws of Huntland Schools, The Franklin County Board of Education, and TSSAA.
- I will respect the authority of referees, umpires, officials, administrators, and coaches by not engaging in questions, confrontations, or discussions regarding a conflict at any sports event. Should I wish to discuss an issue, I will make appointment for a later date to meet with the coach, athletic director, or administration respectively.
- I will inform the coach of any physical disability or ailment that may affect the safety of my child and other student-athletes.
- I will be a role model and demonstrate good sportsmanship regardless of the situation for my child's team by treating other student-athletes, parents, referees, umpires, officials, spectators, administrators, and coaches with respect at all times.
- I understand that the sports environment for my child will be free from drugs and alcohol; therefore, I will refrain from their use at all sporting events.
- I am aware that should I fail to abide and uphold the aforementioned Parent Code of Ethics, I will be subject to disciplinary action that may include, but is not limited to, a verbal warning from a/an referee, umpire, official, administrator, or coach, a written warning, a disciplinary meeting with the administration, ejection from sporting event, required to pay monetary fee, game forfeit, suspension from athletic season events, and exclusion from the campus of Huntland School.

Name of Student Athlete: \_\_\_\_\_

Name of Parent Athlete: \_\_\_\_\_

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

# CONCUSSION

## INFORMATION AND SIGNATURE FORM FOR STUDENT-ATHLETES & PARENTS/LEGAL GUARDIANS (Adapted from CDC "Heads Up Concussion in Youth Sports")

Public Chapter 148, effective January 1, 2014, requires that school and community organizations sponsoring youth athletic activities establish guidelines to inform and educate coaches, youth athletes and other adults involved in youth athletics about the nature, risk and symptoms of concussion/head injury.

Read and keep this page.

Sign and return the signature page.

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting your bell rung" or what seems to be a mild bump or blow to the head can be serious.

### Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

### WHAT ARE THE SIGNS AND SYMPTOMS OF CONCUSSION?

Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury.

If an athlete reports **one or more** symptoms of concussion listed below after a bump, blow or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care provider\* says s/he is symptom-free and it's OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
Appears dazed or stunned	Headache or "pressure" in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness, even briefly	Feeling sluggish, hazy, foggy or groggy
Shows mood, behavior or personality changes	Concentration or memory problems
Can't recall events <i>prior</i> to hit or fall	Confusion
Can't recall events <i>after</i> hit or fall	Just not "feeling right" or "feeling down"

\*Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

## CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention after a bump, blow or jolt to the head or body if s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

## WHY SHOULD AN ATHLETE REPORT HIS OR HER SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brains. *They can even be fatal.*

### Remember:

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

## WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care provider\* says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. Exercising or activities that involve a lot of concentration such as studying, working on the computer or playing video games may cause concussion symptoms to reappear or get worse. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

\* Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training.

## Student-athlete & Parent/Legal Guardian Concussion Statement

Must be signed and returned to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: \_\_\_\_\_

Parent/Legal Guardian Name(s): \_\_\_\_\_

After reading the information sheet, I am aware of the following information:

Student-Athlete initials		Parent/Legal Guardian initials
	A concussion is a brain injury which should be reported to my parents, my coach(es) or a medical professional if one is available.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach and/or a medical professional about my injuries and illnesses.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a <i>health care provider</i> * to return to play or practice after a concussion.	
	Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.	
	After a bump, blow or jolt to the head or body an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting or a headache that gets worse.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away.	
	Sometimes repeat concussion can cause serious and long-lasting problems and even death.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

\* *Health care provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

Signature of Student-Athlete

Date

Signature of Parent/Legal guardian

Date

## **Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form**

### **What is sudden cardiac arrest?**

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

### **How common is sudden cardiac arrest in the United States?**

SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

### **Are there warning signs?**

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

### **What are the risks of practicing or playing after experiencing these symptoms?**

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

### **Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act**

The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
  - (i) Unexplained shortness of breath;
  - (ii) Chest pains;
  - (iii) Dizziness
  - (iv) Racing heart rate; or
  - (v) Extreme fatigue; and
- Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest
- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

*I have reviewed and understand the symptoms and warning signs of SCA.*

---

Signature of Student-Athlete

Print Student-Athlete's Name Date

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Signature of Parent/Guardian

Print Parent/Guardian's Name Date

## Insurance Coverage Statement

Please choose from the following two (2) options:

I. My student athlete, son or daughter, \_\_\_\_\_, is covered by  
(Name of student athlete)

my personal health insurance carrier, \_\_\_\_\_.  
(Name of insurance provider)

OR

II. My student athlete, son or daughter, \_\_\_\_\_, is NOT  
(Name of student athlete)  
covered by a personal health insurance carrier.

- I understand that the athletic insurance carried by the school system is a secondary coverage policy meaning it pays only after the parents' primary coverage pays.
- I understand that the responsibility to file the proper forms for payment is the parent's responsibility.

I have received a copy of the "Steps for Parents to Follow" form that tells me what to do in case an injury requires medical treatment from a doctor or emergency room.

*Parent/Legal Guardian Signature*

*Date*

## Steps for Parents to Follow in Case of an Injury to a Student Athlete

1. File claim with your personal insurance carrier immediately (Primary Insurance).
2. Parent will receive claim forms through the mail from the school system's insurance and these must be completed and returned to the insurance company with ninety (90) days of the injury (Secondary Insurance).
3. Parent may receive claim forms through the mail from Loomis and Lappann, Inc. which is the catastrophic insurance carrier through TSSAA in case treatment of injury should exceed \$10,000. Complete and return these claim forms to Loomis and Lappann, Inc. with ninety (90) days of the injury (Catastrophic Insurance).
4. Parents must send bills and EOB's (Explanation of Benefits) to VR Williams Insurance and/or call (931) 967-2268 or fax (931) 967-1128.

It is the parent's responsibility to file all claim forms in the ninety (90) day time frame for Each Injury that may occur with each insurance company to avoid issues of proper insurance notification and payment. Don't forget to make copies for your records of all claim forms submitted, bills received, and EOB forms received.

Following each step above will not guarantee every dollar of every injury will be covered by insurance, however, it will insure that no injury will be a financial disaster to any of our families.