WRHS Sports Participation Information

The list below shows each athlete what is required to participate in sports at WRHS. **In order to practice and compete, each of the following items must be completed on DragonFly Max BEFORE the start date of the sport.**

Requirements for Warner Robins High School for Athletes for 2022-2023

Electronic Signature Agreement Good for 2022 academic year	Required	Warner Robins High School
HHC Patient Privacy Acknowledgement and Consent Good for 2022 academic year	Required	Warner Robins High School
HCSD Emergency Contact and Medical Authorization Good for 2022 academic year	Required	Warner Robins High School
HCSD Parental Consent for Participation Good for 2022 academic year	Required	Warner Robins High School
HHC Authorization For Medical Examination and Treatment	Required	Warner Robins High School

Requirements from GHSA for Athletes for 2022-2023

GHSA Student / Parent Sudden Cardiac Arrest Awareness Form Good for 2022 academic year	Required	GHSA
GHSA Student / Parent Concussion Awareness Form Good for 2022 academic year	Required	GHSA
GHSA Heat and Humidity Policy For ALL Sports Good for 2022 academic year	Required	GHSA
GHSA Health History Form Good for 2022 academic year	Required	GHSA
GHSA Physical Examination Form Good for one year, or for the entire next school year after April 1st	Required	GHSA
GHSA Medical Eligibility Form Good for one year, or for the entire next school year after April 1st	Required	GHSA

Completing DragonFly Information.

To fill out these forms, log in to athlete's account on DragonFly Max (either the phone app or pc site - https://max.dragonflyathletics.com/maxweb/max-cover/login) and tap to fill out the school's paperwork. If athlete already has a login DO NOT CREATE A NEW ONE. If they have forgotten their password, do a password reset.

If athlete does not have a DragonFly Max account, they will need to create one by logging in to www.dragonflymax.com and sign up for free, or by downloading the app (App Store or Google Play) and signing up for free. Be sure to use the School Name: **Warner Robins High School**, and /or the School Code: **HX78EY**. Once they have created their profile, the athlete will need to complete all the forms above.

The school will have to approve the GHSA Physical Exam Form and GHSA Medical Eligibility Form once those have been uploaded to DragonFly Max. Make sure the correct forms are uploaded WITH a doctor's signature.

DragonFly
- Simplified Sports Medicine -

DragonFly MAX is an electronic health record designed to save you time & ensure the athlete is healthy and ready to participate in athletic competition. We focus on the details so you can focus on what matters...safe and healthy athletes.

Follow the easy steps below to get started using DragonFly MAX.

"I'M A PARENT"

1. Visit www.dragonflymax.com, click "Do My Forms" and follow prompts to the sign-up page.
2. On the sign-up page, click "Sign Up for Free".
3. Follow the prompts to create your **Parent Account** with **your** email address or phone number.
4. Enter your child's School Code when prompted and confirm this is the correct school.
5. Click "Add A Child" in the DragonFly MAX web site, then follow the prompts to create your **child's profile** and complete his/her participation forms, including uploading any necessary documents.
6. After completing your child's forms, you can review his/her profile OR add another child's profile.

Now that you're done, download DragonFly MAX from the App Store or Google Play and sign in.

"I'M AN ATHLETE, COACH, OR SCHOOL ADMINISTRATOR."

1. Download the DragonFly MAX app from either the App Store or Google Play.

Download on the App Store GET IT ON Google Play

2. Click "Get Started" and follow the prompts to create your account.
3. Choose your role in the school (i.e. - Athlete, Coach, Administrator, etc).
   - If you are a Coach or Administrator, select whether your school IS or IS NOT already using MAX. *(Hint: If you have a School Code, then your school IS using MAX)*
4. Enter your School Code (shown below) when prompted, then tap "Request" to join the school.

School Name: Warner Robins High School
School Code: HX78EY

Now you're all set! You can find out more about additional features at DRAGONFLYMAX.COM

■ PREPARTICIPATION PHYSICAL EVALUATION

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): _____

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? **(check box next to appropriate number)***

	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 ≥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*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
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)?		
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 *Staphylococcus aureus* (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?		
FEMALES ONLY	**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. *SEE NEXT PAGE*

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: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

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		
Height: ft in Weight: lbs		
BP: / (/) Pulse: bpm Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
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 • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] 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:

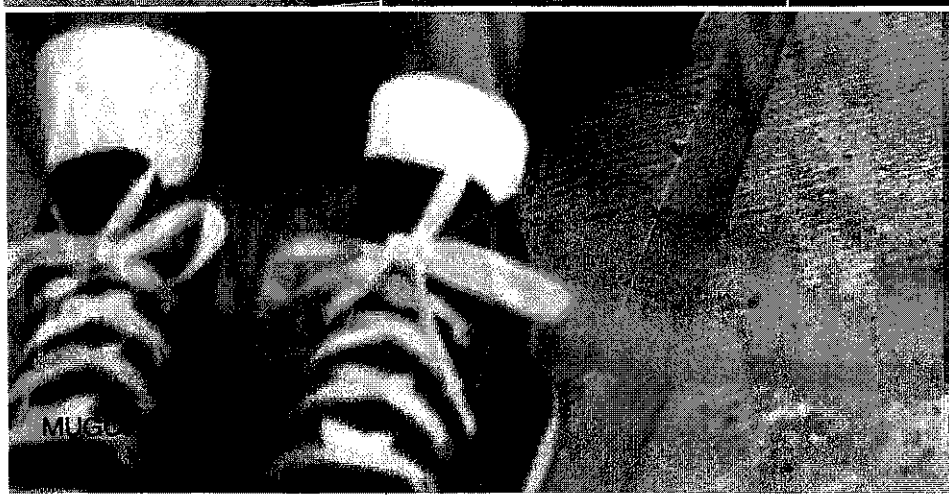
_____

_____

Voluntary Student Accident Insurance

2021-2022
NATIONAL



NATIONAL

2021-2022

K-12 Voluntary Student Accident Insurance Coverage

(Not Available in AR, FL, ID, KS, KY, MD, MT, NC, NH, NY, SD, TX, & WA)

Coverage underwritten by: Mutual of Omaha Insurance Company; 3300 Mutual of Omaha Plaza; Omaha, NE 68175

ELIGIBILITY:

All registered students grades PreK-12 of a participating school/district.

COVERAGE OPTIONS

AT SCHOOL COVERAGE: Insurance coverage is provided during the hours and days when school is in session, while attending or participating in school sponsored and supervised activities on or off school premises (i.e. day field trips) and while participating in interscholastic athletics (except injuries incurred while participating in High School Football events/activities). Coverage is provided while traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from the Insured's home premises and school premises when school is in session. If the Policyholder provides mandatory coverage for students under an At School, Interscholastic Athletic/Activity or Football program, benefits will be payable under those programs before being considered under an At School Voluntary program.

24-HOUR COVERAGE: Provides coverage for injuries incurred 24-Hours a day, 365 days a year, at home, at school and while participating in interscholastic athletics (except injuries incurred while participating in High School Football events/activities). If the Policyholder provides mandatory coverage for students under an Interscholastic Athletic/Activity, Football or At School program, benefits will be payable under those programs before being considered under a 24-Hour Voluntary program.

FOOTBALL ONLY: Insurance coverage is provided for High School Football athletes during athletic tryouts, preseason play, practice, state interscholastic governing body approved conditioning, regular and post season play and for travel to, during or after covered athletic activities as a member of a group in transportation furnished and arranged by the school. If the Policyholder provides mandatory coverage for Football athletes under an Interscholastic Athletic/Activity or Football program, benefits will be payable under those programs before being considered under a Voluntary Football Only program.

EXTENDED DENTAL COVERAGE: This is supplemental coverage for expenses resulting from covered accidental dental injuries. The dental benefits provided are: (a) 100% of Allowable Expense for examinations, X-Rays, endodontics and oral surgery to a maximum of $10,000; or (b) dental expenses toward the cost of bridges, dentures or replacement of previous dental repairs to a maximum of $250. No coverage is provided for orthodontics (braces) for any reason or damage or loss thereof. Extended Dental Coverage must be purchased in conjunction with a 24-Hour, At School or Football program; it cannot be purchased as stand alone coverage.

COVERAGE PERIOD – Coverage under the At School, 24-Hour and Football programs begins on the date of premium receipt but not before the start of the school year activities. At School Coverage ends at the close of the regular nine-month school term. 24-Hour Coverage ends when school reopens for the following fall term. Coverage is available under both plans throughout the school year at the premiums quoted **(no pro rata premiums available).**

BENEFITS

ACCIDENT MEDICAL EXPENSE: When a covered injury to an Insured results in treatment by a physician or surgeon beginning within 60 days of the date of the accident; we will pay benefits as shown in the **Schedule of Benefits**, in excess of the Medical Deductible, if any. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the accident are covered. Benefits for any one accident shall not exceed in the aggregate the maximum Medical Benefit of $25,000. We will pay the Medical Expenses an Insured incurs for covered services that exceed amounts payable by any Other Insurance Plan, subject to the Deductible, Benefit Percentage, and Benefit Period.

ACCIDENTAL DEATH AND SPECIFIC LOSS: Benefits are paid for losses incurred within 180 days from the date of Injury. The following benefits (the largest applicable amount) are paid in addition to the medical benefit:

Loss of Life	$10,000.00
Loss of both hands, both feet, sight in both eyes, speech and hearing	$10,000.00
Loss of one hand, one foot, sight in one eye, speech or hearing	$5,000.00
Loss of Thumb and Index Finger of the Same Hand	$500.00

"Loss" means, with regard to hands and feet, actual severance above the wrist or ankle joint, with regard to sight, speech or hearing the total and irrevocable loss thereof. Loss means, with regard to thumb and index finger of the same hand, severance of two or more entire phalanges of both the thumb and index finger.

DEFINITIONS

Allowable Expense means a Medical Expense otherwise payable under the policy that is not in excess of the 80th percentile identified on Context4HealthCare (the "Database"). When there is, in Our determination, minimal data available from the Database for a Medical Expense, We will determine the amount to pay by calculating the unit cost for the applicable service category using the Database and multiplying that by the relative value of the Medical Expense based upon a commercially available relative value scale selected by Us. In the event of an unusually complex medical procedure, a Medical Expense for a new procedure or a Medical Expense that otherwise does not have a relative value that is in Our determination applicable, We will assign a relative value. The Medical Expenses We pay may not reflect the actual charges of a provider and does not take into account the provider's training, experience or category of licensure. A provider may charge the Insured the difference between what the provider charges and the amount We pay under the policy. The Database will be updated by us as information becomes available from the supplier, up to twice each year. We may modify the Database in Our discretion to reflect Our experience. We have the right, in Our discretion, to substitute or replace the Database with another database or databases of comparable purpose, with or without notice.

Injury means bodily harm which: (1) requires treatment by a Physician; (2) results in loss due to an Accident, independent of Sickness and all other causes; and (3) occurs within the Scope of Coverage.

Hospital means an institution which: (1) is operated pursuant to law; (2) is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis; (3) is under the supervision of a staff of Physicians; (4) provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.); and (5) has medical, diagnostic and treatment facilities, with major surgical facilities on its premises or available to it on a prearranged basis. Hospital does not include: (1) a clinic or facility for: (a) convalescent, custodial, educational or nursing care; (b) the aged, drug addicts or alcoholics; (c) rehabilitation; or (2) a military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless: (a) the services are rendered on an emergency basis; and (b) the individual has a legal liability to pay for the services given in the absence of insurance.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for a loss due to or expenses incurred for:

(1) intentionally self-inflicted injury, suicide while sane or insane; (2) voluntary self-administration of any drug or chemical substance not prescribed by or not taken according to the directions of the Insured's Physician; (3) Injury caused by, attributable to, or resulting from the Insured's Intoxication; (4) Injury caused by, attributable to, or resulting from the Insured's use of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage; (5) operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage; (6) operating a motor vehicle while having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred; (7) commitment of or an attempt to commit a felony, or engagement in an illegal activity; (8) participation in a riot or insurrection; (9) any Injury that results from fighting, brawling, assault or battery; (10) an act of declared or undeclared war; (11) active duty service in any Armed Forces; (12) operating, learning to operate, or serving as a pilot or crew member of any aircraft unless specified in the INSURED RISKS section of this policy; (13) mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment); (14) parachuting, except for self-preservation; (15) snow skiing, scuba diving, bob-sledding, bungee jumping, ballooning, flight in an ultralight aircraft, sky diving, hang-gliding, glider flying, sailplaning, or parasailing; (16) participation in professional or amateur racing; (17) injuries associated with activities or travel outside the United States; (18) sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning; (19) dental treatment or dental X-rays, except as otherwise provided, and only when Injury occurs to sound natural teeth; (20) orthodontic braces or appliances; (21) any loss for which benefits are paid under state or federal worker's compensation, employers' liability, or occupational disease law; (22) charges which the Insured would not have to pay if the Insured did not have insurance; (23) a charge which is in excess of the Allowable Expense; (24) cosmetic surgery, except reconstructive surgery due to a covered Injury; (25) participation in semi-professional and professional sports, play or practice, or any related travel; (26) participation in practice or play of any sports activity, including travel to and from games and practice, unless specified in this policy; (27) assistant surgeon services, unless specified in this policy; (28) elective treatment or surgery that is not prescribed by a Physician and is not Medically Necessary, health treatment, or examination where no Injury is involved; (29) Pre-existing Conditions; (30) any Heart or Circulatory Malfunction; (31) loss caused by or resulting from nuclear radiation or the release of nuclear energy; (32) services or treatment incurred to the extent that they are paid or payable under any Other Insurance Plan; (33) services or treatment incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. This exclusion does not apply in any state where it is prohibited; (34) travel in or upon: (a) a snowmobile; (b) any two or three wheeled motor vehicle; (c) any off-road motorized vehicle not requiring licensing as a motor vehicle in the jurisdiction where operated; (35) any Accident in which the Insured is operating a motor vehicle without a current and valid motor vehicle operator's license (except in a driver's education program); (36) treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy.

NATIONAL
VOLUNTARY STUDENT ACCIDENT INSURANCE
SCHEDULE OF BENEFITS

[illegible]	[illegible]	HIGH OPTION
Room & Board	**Semi-Private Room Rate/$150 per day maximum**	**80% of Allowable Expense/Semi-Private Room Rate**
Hospital Miscellaneous	**Up to $600 per day maximum**	**Up to $1,200 per day maximum**
Registered Nurse	**75% of Allowable Expense**	**100% of Allowable Expense**
Physician's Nonsurgical Visits	**Up to $40 first day; $25 per day thereafter**	**Up to $60 first day; $40 per day thereafter**
(Benefits are limited to one visit per day and do not apply when related to surgery)		
[illegible]		
Hospital Outpatient Surgery – Facility Charge	**Up to $1,000 maximum**	**Up to $1,200 per day maximum**
Physician's Nonsurgical Visits	**Up to $40 first day; $25 per day thereafter**	**Up to $60 first day; $40 per day thereafter**
(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)		
Physiotherapy	**Up to $30 first day; $20 per day thereafter/5 day maximum**	**Up to $60 first day; $40 per day thereafter/5 day maximum**
Emergency Room	**Up to $150 maximum**	**Up to $300 maximum**
(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)		
X-Ray Services (Includes charges for reading)	**$200 maximum**	**$600 maximum**
Diagnostic Imaging - Cat Scan/MRI (includes charges for reading)	**$300 maximum**	**$600 maximum**
Laboratory	**$50 maximum**	**$300 maximum**
Injections	**Up to $25/injury**	**Up to $25/injury**
Prescription Drugs	**$75 maximum**	**$200 maximum**
Orthopedic Braces and Appliances	**$75 maximum**	**$140 maximum**
[illegible]		
Surgeon's Fees	**$1,000 maximum. (No more than one procedure through the same incision will be paid)**	**$1,200 maximum. (No more than one procedure through the same incision will be paid)**
Anesthetist/Assistant Surgeon	**20% of surgeon's allowance**	**25% of surgeon's allowance**
Ambulance	**$300 maximum**	**$800 maximum**
Consultant	**$200 maximum**	**$400 maximum**
Treatment of Heat Exhaustion	**100% of Allowable Expense**	**100% of Allowable Expense**
Dental	**Up to $200 per tooth (Benefits are paid on sound natural teeth only)**	**Up to $500 per tooth (Benefits are paid on sound natural teeth only)**
Replacement of Eyeglasses, Contact Lenses and Hearing Aids	**$200 maximum (When broken as a result of a covered injury)**	**$300 maximum (When broken as a result of a covered injury)**

PLAN & RATE OPTIONS

(Make your selection on the enrollment form attached).

COVERAGE PLANS	LOW OPTION RATES	HIGH OPTION RATES
24-Hour	$ 86.65	$132.65
24-Hour Summer Only	$ 22.45	$ 35.30
At School	$ 21.40	$ 31.00
High School Football	$147.65	$230.05
Spring High School Football	$ 58.85	$ 92.00
Extended Dental	$ 9.65	$ 9.65

RETAIN THIS DESCRIPTION FOR YOUR RECORDS. Retain this student accident insurance flyer, and your canceled check, money order receipt or credit card receipt as your record of coverage. This flyer has been designed to illustrate the highlights of this insurance. All student accident insurance information is subject to the provisions of Policy Form SR2014 and state special versions. Exclusions and Limitations will apply. Should there be any discrepancy between the policy and this student accident information, policy provisions will prevail.

HSR
Health Special Risk, Inc.

2021-2022
VOLUNTARY
STUDENT ACCIDENT INSURANCE
ENROLLMENT FORM
(Not Available in AR, FL, ID, KS, KY, MD, MT, NC, NH, NY, SD, TX, & WA)

Student's Last Name:_____ Student's Date of Birth:_____

Student's First Name:_____ MI:_____ Telephone Number:_____

Student's Social Security Number:_____ Grade:_____ Student ID Number:_____

Address:_____
Street City State Zip

Name of School District:_____ Name of School Campus:_____
(Required to Process)

Signature of Parent or Guardian:_____ Date:_____ E-mail Address:_____

PLEASE CHECK YOUR SELECTION BELOW:

COVERAGE PLANS	LOW OPTION	HIGH OPTION
24-Hour	☐ $ 86.65*	☐ $132.65*
24-Hour Summer Only	☐ $ 22.45*	☐ $ 35.30*
At School	☐ $ 21.40*	☐ $ 31.00*
High School Football	☐ $147.65*	☐ $230.05*
Spring High School Football	☐ $ 58.85*	☐ $ 92.00*
Extended Dental	☐ $ 9.65*	☐ $ 9.65*
COMPANY USE ONLY: Check # _____ Amount Rec'd _____	**Enclose check for total amount payable to: Health Special Risk** TOTAL All Selections HERE: $_____	

***There is a $1.00 administration fee due with each paper enrollment form submission.**

Once completed, mail this form to:

Health Special Risk, Inc.
P.O. Box 957824
St. Louis, MO 63195-7824

For more information or assistance regarding all Student Insurance, contact our Customer Service Department at **1-866-409-5733**

IF YOU WISH TO PAY WITH MASTERCARD OR VISA: Go to www.K12StudentInsurance.com**

***A 5% administrative charge will be added for Credit Card Orders*

Accident Coverage underwritten by: Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175