AUTHORIZATION FOR TRANSPORTATION & TREATMENT

We hereby authorize school personnel to transport ______________________________
(Student's Name)

to a physician's office and/or emergency facility for treatment in the event that medical care is

needed while the athlete is involved in: **(circle one)**

Boys/Girls Basketball	Football	Wrestling	Boys/Girls Track
Boys/Girls Golf	Baseball	Softball	Boys/Girls Swimming
Boys/Girls Cross Country	Volleyball	Boys/Girls Tennis	Boys/Girls Soccer
Cheer	Bocce		

We authorize the physician/hospital staff to treat our son/daughter as they deem necessary.

Insurance Carrier________________________ Identification/Group Number_________________

Home Phone # (   )______________________Work Phone # (   )______________________

Mother/Guardian's Cell Phone # (   )__________________________

Father/Guardian's Cell Phone # (   )___________________________

______________________________________ ______________________________
(Parent/Guardian Signature) **(Date)**

Please list any allergies, past surgeries and/or other medical information you feel the coaches need to know:

BRADFORD AREA HIGH SCHOOL

81 Interstate Parkway
Bradford, PA 16701

Mike Erickson, Athletic Director/Facility Coordinator
(814)362-3845, extension 5029

Dear Parent/Guardian:

The Bradford Area School District provides insurance coverage for students participating in interscholastic athletics, including cheerleaders and band members. Our current carrier is Bollinger, Inc.

This coverage is primary for the first $100.00 of expenses incurred. After the $100.00 of specified medical expenses have been paid for an injury, this policy will only pay the expenses for covered charges which are not covered under any other valid and collectible group insurance, to the fullest extent of the policy benefits. Policy benefits can be discussed with the carrier at 800-526-1379.

When there is other insurance, claims should be made to this insurance carrier as well as our insurance. To the extent expenses in excess of $100.00 that are not covered by the other insurance carrier, a copy of the benefit determination should be submitted to our carrier.

The Bradford Area School District does not guarantee what expenses will be covered.

I understand that my child is covered by school insurance if injured while playing Interscholastic athletics.

______________________________ ______________________________
Parent/Guardian Signature Date

I have fully read and understand the Interscholastic Athletic Policy established by the Bradford Area School District.

______________________________ ______________________________
Athlete's Signature Date

______________________________ ______________________________
Parent/Guardian Signature Date

__________________ (was / was not) a student of the Bradford Area School District for the entire
Student circle one
previous school year.

SECTION 7: RE-CERTIFICATION BY PARENT/GUARDIAN

This form must be completed not earlier than six weeks prior to the first Practice day of the sport(s) in the sports season(s) identified herein by the parent/guardian of any student who is seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in all subsequent sport seasons in the same school year. The Principal, or the Principal's designee, of the herein named student's school must review the SUPPLEMENTAL HEALTH HISTORY.

If any SUPPLEMENTAL HEALTH HISTORY questions are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

SUPPLEMENTAL HEALTH HISTORY

Student's Name ____ Male/Female (circle one)

Date of Student's Birth: ______/______/_________ Age of Student on Last Birthday: ______ Grade for Current School Year: ___ ___

Winter Sport(s): ________________________________ Spring Sport(s): ________________________________

CHANGES TO PERSONAL INFORMATION (In the spaces below, identify any changes to the Personal Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Current Home Address ____

Current Home Telephone # (   )__________________ Parent/Guardian Current Cellular Phone # (   )________________

CHANGES TO EMERGENCY INFORMATION (In the spaces below, identify any changes to the Emergency Information set forth in the original Section 1: PERSONAL AND EMERGENCY INFORMATION):

Parent's/Guardian's Name______________________________________ Relationship __________________

Parent/Guardian E-mail Address:____

Address ______________________________ Emergency Contact Telephone # (   )____________________

Secondary Emergency Contact Person's Name ____________________________ Relationship _________________

Address ______________________________ Emergency Contact Telephone # (   )____________________

Medical Insurance Carrier __________________________________ Policy Number _____________________

Address ____ Telephone # (   )____________________

Family Physician's Name____, MD or DO (circle one)

Address ____Telephone # (   )____________________

If any SUPPLEMENTAL HEALTH HISTORY questions below are either checked yes or circled, the herein named student shall submit a completed Section 8, Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine, to the Principal, or Principal's designee, of the student's school.

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

#	Question	Yes	No
1.	Since completion of the CIPPE, have you sustained a serious illness and/or serious injury that required medical treatment from a licensed physician of medicine or osteopathic medicine?	❑	❑
	An additional note to item #1. if serious illness or serious injury was marked "Yes", please provide additional information below		
2.	Since completion of the CIPPE, have you had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	❑	❑
3.	Since completion of the CIPPE, have you experienced dizzy spells, blackouts, and/or unconsciousness?	❑	❑
4.	Since completion of the CIPPE, have you experienced any episodes of unexplained shortness of breath, wheezing, and/or chest pain?	❑	❑
5.	Since completion of the CIPPE, are you taking any NEW prescription medicines or pills?	❑	❑
6.	Do you have any concerns that you would like to discuss with a physician?	❑	❑

#'s	Explain yes answers; include injury, type of treatment & the name of the medical professional seen by student

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature ____Date____/____/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature ____Date____/____/_____