Lumberton Independent School District
Lumberton, Texas

EMERGENCY INFORMATION AND PROCEDURE

Pupil's Name _____ Age _____
(Last) (First) (M.I)

Pupil's Birthdate_____ /_____ /_____ SS#_____-_____-_____ Religion _____

Pupil's Address_____ Zip_____

Pupil's Home Phone #_____ Cell#_____ Pupil's School_____

In case of an emergency, illness, or accident to the above pupil, the school is authorized to proceed as indicated below:

Contact Father_____ Home Phone _____ Work Phone _____ Cell Phone _____

Contact Mother_____ Home Phone _____ Work Phone _____ Cell Phone _____

Other Contact_____ Home Phone _____ Work Phone _____ Cell Phone _____
(NAME AND RELATIONSHIP)

Doctor to be notified_____ Office Phone _____

Local Hospital_____

PARENTAL INSURANCE #1 INFORMATION

If you do **NOT** have insurance for your child please check here ☐

If you have a second insurance for your child please include that information on a separate sheet of paper.

Name of Insurance Co. & Address:	(circle one) HMO PPO OTHER	Insurance Co. Phone #:
Name of Policy Holder:		Relationship to Policy Holder:
Policy#		Group#
Policy Holder's Place of Employment & Address:		

By signing below I am giving my consent to allow the medical personnel for Lumberton High School to have access to any medical information from any other medical institution or physician that they may need to provide care.
It is understood that all costs related to any medical services will be billed to the insurance company designated above. The balance remaining upon payment from our personal insurance will then be submitted to the athletic insurance carrier. It is also understood that I am responsible for a **$500** deductible before the schools insurance takes effect and I must cooperate with the provider of services in processing any necessary insurance forms or providing requested information.

Additionally, It is understood that if there is a balance remaining after payment or denial by the insurance companies payments, it is the responsibility of the parent or legal guardian whose signature appears below. This blanket approval shall remain in effect for the school year or until it has been revoked in writing by the undersigned.

X _____ _____
Signature of Parent(s) or Legal Guardian(s) Date

PARENT PERSCRIBED MEDICATIONS

Required before over-the-counter or short-term prescribed medications can be given at school.

I relieve Lumberton ISD of any responsibility for the benefits or consequences of this medication when it is parent-prescribed. I also acknowledge that the school bears no responsibility for assuring that the medication is taken. This note will remain a permanent part of the student's school health record. The school reserves the right to limit the duration of parent-prescribed medications and/or require physician statement for continued use of any medication beyond a two-week time period. All medications will be kept in a locked storage area restricting availability to other students. If these medication policies are abused or ignored, there will be immediate loss of privileges.

Name of Medication _____
Amount of medication to be given _____ Time to be given _____
Reason for its administration _____

X _____ _____
Signature of Parent(s) or Legal Guardian(s) Date