Lipscomb Academy Elementary School Student Health Form

Dear Parent:
In order for your child to be evaluated by the school nurse/employee, should she/he become ill or experience some other type of health concern, your permission is required. By signing below, you have given the school permission to assist your child medically.

Student's name: _____ **DOB:** _____ **Teacher:** _____

Parent/guardian Signature: _____ **Date:** _____

I give the school nurse/employee permission to administer:

Acetaminophen (Tylenol)	Yes ____ No ____
Antacid	Yes ____ No ____
Cough drops	Yes ____ No ____
Triple Antibiotic Ointment (Neosporin)	Yes ____ No ____
Benadryl Cream	Yes ____ No ____
Caladryl lotion	Yes ____ No ____
Hydrocortisone cream	Yes ____ No ____
Benadryl (for allergic reactions only)	Yes ____ No ____
Orajel	Yes ____ No ____
Saline eye drops	Yes ____ No ____
Peroxide	Yes ____ No ____

Physician's name: _____ **Phone:** _____

PLEASE LIST ALL MEDICATIONS THE CHILD TAKES (home and school)

Name of Drug	**Dosage**	**Times taken**	**Purpose**

Medication Allergies _____
Other Allergies _____
Existing Medical Conditions _____
(Example: diabetes, seizure disorder, depression)

PERSONS TO CALL IF THE STUDENT IS SICK OR INJURED:

	(Name)	(Home)	(Work)	(Cell phone)
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Guardian	_____	_____	_____	_____

EMERGENCY NUMBERS IF PARENTS CANNOT BE REACHED:

Name _____ _____ Phone _____ Relationship _____

Name _____ _____ Phone _____ Relationship _____

LIPSCOMB ACADEMY (PK-12)
STUDENT ACCIDENT INSURANCE
2016-2017 SCHOOL YEAR

BENEFITS FOR *REGULAR PLAN*

DOCTOR – HOSPITAL – DENTAL EXPENSES

•**DOCTOR VISITS IN OFFICE OR HOSPITAL –** Pays up to $15.00 for the initial physician's visit; up to $10.00 for each necessary follow-up hospital or office visit.

•**SURGERY –** Pays 60% of the "usual and customary" (as defined below) physician's expenses up to an aggregate maximum of $1,000.00 per injury.

•**INPATIENT HOSPITAL SERVICE –** Pays up to an aggregate maximum of $150.00 per day.

•**HOSPITAL OUTPATIENT SERVICES –** When not confined in a hospital, services rendered by and within a hospital shall be covered to a maximum of $60.00 per injury, which includes all visits to the hospital for the same injury.

•**X-RAY SERVICE** – Pays up to $10.00 per x-ray not to exceed 4 x-rays per injury, including reading. (When rendered by doctor or hospital as outpatient)

•**AMBULANCE** – To and from the hospital, benefits shall not exceed $25.00 per injury.

•**DENTAL TREATMENT -** $100.00 per tooth for repair or replacement of each injured sound natural tooth. **See optional extended dental benefits outlined in this brochure.**

•**PHYSIOTHERAPY, DIATHERMY, OR SIMILAR TREATMENT –** Diathermy, ultrasonic, whirlpool or heat treatments, adjustment, manipulation, massage or any form of physical therapy and/or office visit connected therewith, expenses shall not exceed $10.00 per visit not to exceed 5 visits.

•**MOTOR VEHICLE –** Benefits shall not exceed $500.00 per accident – two or three wheeled motor vehicle injuries not covered. See Exclusions 7 and 11.

•**CASTS & BRACES –** Pays up to $25.00 per injury when prescribed and necessitated in conjunction with a covered accident.

•**EYEGLASSES REPLACEMENT –** Pays up to $25.00 per injury when prescribed and necessitated in conjunction with a covered accident.

When injury covered by this policy results in treatment by a Licensed Physician within 30 days from the date of injury, the company will pay the usual and customary expenses for the services and supplies as listed above actually incurred within one year from the date of injury to a maximum of $25,000 per injury. "Injury" means loss resulting from accidental bodily injury caused directly by an accident, independent of other causes and sustained while the policy is in force. The "usual and customary" charges shall be the allowable charges as set forth in the Revised California Relative Value Studies using a $100.00 per unit conversion factor for surgery. Benefits for assistant surgeon's fees and anesthetist's fees shall be limited to 25% of the allowable surgery benefit.

TO FILE A CLAIM: Notify school officials immediately. Obtain a claim form from the school. Submit the claim along with bills within 90 days of the date of accident.

Offered and Administered by
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