



Hays High School Athletic Department  
2300 East 13<sup>th</sup> Street, Hays, KS 67601  
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## **2023-24 Hays High Athletic Physical Packet**

Parents and Guardians,

Enclosed are all the necessary forms needed to complete the process of registering your student-athlete for the 2023-24 school year. The forms included in this packet are:

1. The updated KSHSAA physical form.
2. The USD 489 student accident insurance information documents to review.
3. HHS Substance abuse policy form.
4. KSHSAA Concussion/Head Injury Release Form

Please use the most recent PPE(Physical form Rev. 4/2023 at bottom right) to complete the physical process.

All areas marked with an X must be signed/marked, by the parent/guardian and/or the student. The ENTIRE packet will need to be completed and turned into the HHS Athletic office prior to attending the first day of practice. Your student-athlete will not be able to participate until all forms have been marked, signed, and turned into the Athletic Office.

Thank you for your cooperation and GO INDIANS!

# PRE-PARTICIPATION PHYSICAL EVALUATION INSTRUCTIONS

## STUDENTS/PARENTS

1.  Complete the History Form (pages 1 & 2) portion PRIOR to your appointment with your healthcare provider.
2.  Sign the bottom of the History Form (page 2).
3.  Complete the Shared Emergency Information section on the Medical Eligibility Form (page 4).
4.  Sign the bottom of the Medical Eligibility Form (page 4) AFTER the pre-participation evaluation is complete and PRIOR to turning in the completed PPE to the school.
5.  Review the Student Eligibility Checklist (page 5) AND SIGN the bottom of the page PRIOR to turning in the completed PPE to the school.
6.  Review and sign the Concussion and Head Injury Release Form provided by the school.

## HEALTHCARE PROVIDERS

1.  Review the History Form (pages 1 & 2) with the student and his/her parent/guardian as part of the pre-participation physical evaluation.
2.  Complete the Physical Examination Form (page 3) AND SIGN the bottom of page 3.
3.  Complete the Medical Eligibility Form (page 4) AND SIGN page 4.

**NOTE: Two signatures are required by the healthcare provider!**

***The PPE form becomes part of the student's record at their school and should not be sent to the KSHSAA.***

## SCHOOL ADMINISTRATORS AND SCHOOL MEDICAL PERSONNEL

1.  Collect the completed PPE forms with the appropriate signatures on pages 2 – 5. **ONLY** personnel with a medical or educational need to review this information should have access to the PPE form. Forms should be kept secure and confidential at all times. The PPE should **NOT** be collected by coaches at practice.
2.  Based on your school's policy, determine which medical personnel or administrative staff are responsible to review and disseminate the student's medical information provided on the form. [Ensure Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) compliance]\*
3.  Provide copies of the Medical Eligibility Form to appropriate staff with supervisory responsibility of extracurricular activities (coaches, sponsors, etc.).
4.  Collect the required Concussion and Head Injury Release Form signed by the student and parent/guardian.

\* Schools should have policies in place identifying who has access to a student's complete private health information found on the PPE form. The Medical Eligibility Form can be used independently to share with staff who may not need complete access to the private health information found on the PPE.

The annual history and the physical examination shall not be taken earlier than May 1 preceding the school year for which it is applicable. The KSHSAA recommends completion of this evaluation by athletes/cheerleaders at least one month prior to the first practice to allow time for correction of deficiencies and implementation of conditioning recommendations.





# PRE-PARTICIPATION PHYSICAL EVALUATION

*PPE is required annually and shall not be taken earlier than May 1 preceding the school year for which it is applicable.*

**HISTORY FORM** (Pages 1 & 2 should be filled out by the student and **parent/guardian** prior to the physical examination)

Name	*Sex at Birth	Age	Date of birth
Grade	School	Sport(s)	
Home Address		Phone	-
Personal physician		Parent Email	

\*In cases of disorder of sexual development (DSD), designation of sex at birth may be delayed for a period of time until medical providers and family can make the appropriate determination.

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

\_\_\_\_\_

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

\_\_\_\_\_

**Medicines and Allergies:**  
 Please list all of the prescription and over-the-counter medicines, inhalers, and supplements (herbal and nutritional) that you are currently taking:  
 \_\_\_\_\_  No Medications

Do you have any allergies?  Yes  No If yes, please identify specific allergy below.

Medicines \_\_\_\_\_  Pollens \_\_\_\_\_  Food \_\_\_\_\_  Stinging Insects \_\_\_\_\_

What was the reaction? \_\_\_\_\_

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


<b>GENERAL QUESTIONS:</b>	<b>YES</b>	<b>NO</b>
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?		
4. Have you ever spent the night in the hospital?		
<b>HEART HEALTH QUESTIONS ABOUT YOU:</b>	<b>YES</b>	<b>NO</b>
5. Have you ever passed out or nearly passed out during or after exercise?		
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
7. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems?		
9. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		
10. Do you get light-headed or feel shorter of breath than your friends during exercise?		
11. Have you ever had a seizure?		
<b>HEART HEALTH QUESTIONS ABOUT YOUR FAMILY:</b>	<b>YES</b>	<b>NO</b>
12. 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)?		
13. 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)?		
14. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		
<b>BONE AND JOINT QUESTIONS:</b>	<b>YES</b>	<b>NO</b>
15. 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?		
16. Have you ever had any broken or fractured bones or dislocated joints?		
17. Have you ever had an injury that required x-rays, MRI, CT scan, injections or therapy?		
18. Have you ever had any injuries or conditions involving your spine (cervical, thoracic, lumbar)?		
19. Do you regularly use, or have you ever had an injury that required the use of a brace, crutches, cast, orthotics or other assistive device?		
20. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
21. Do you have any history of juvenile arthritis, other autoimmune disease or other congenital genetic conditions (e.g., Downs Syndrome or Dwarfism)?		


**KSHSAA PRE-PARTICIPATION PHYSICAL EVALUATION**

MEDICAL QUESTIONS:	YES	NO		
22. Do you cough, wheeze, or have difficulty breathing during or after exercise?				
23. Have you ever used an inhaler or taken asthma medicine?				
24. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organs?				
25. Do you have groin or testicle pain, a bump, a painful bulge or hernia in the groin area?				
26. Have you had infectious mononucleosis (mono)?				
27. Do you have any recurring skin rashes or skin infection that come and go, including herpes or methicillin-resistant Staphylococcus aureus (MRSA)?				
28. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems? If yes, how many? What is the longest time it took for full recovery? When were you last released?				
29. Do you have headaches with exercise?				
30. Have you ever had numbness, tingling, weakness in your arms (including stingers/burners) or legs, or been unable to move your arms or legs after being hit or falling?				
31. Have you ever become ill while exercising in the heat?				
32. Do you get frequent muscle cramps when exercising?				
33. Do you or does someone in your family have sickle cell trait or disease?				
34. Have you ever had or do you have any problems with your eyes or vision?				
35. Do you wear protective eyewear, such as goggles or a face shield?				
36. Do you worry about your weight?				
37. Are you trying to or has anyone recommended that you gain or lose weight?				
38. Are you on a special diet or do you avoid certain types of foods or food groups?				
39. Have you ever had an eating disorder?				
40. How do you currently identify your gender? <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____				
41. Over the last 2 weeks, how often have you been bothered by any of the following problems? (check box)	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
<i>(A sum of 3 or more is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes) Patient Health Questionnaire Version 4 (PHQ-4)</i>				
FEMALES ONLY:	YES	NO		
42. Have you ever had a menstrual period?				
43. If yes, are you experiencing any problems or changes with athletic participation (i.e., irregularity, pain, etc.)?				
44. How old were you when you had your first menstrual period?				
45. When was your most recent menstrual period?				
46. How many menstrual periods have you had in the past 12 months?				

Explain all Yes answers here from the previous two pages.

**By signing below, I certify that all information provided on pages 1-2 is accurate and true.** I understand that any false or misleading information provided as part of this exam could result in disqualification from activity participation for my child and my child's teams.

 Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

 Signature of student-athlete \_\_\_\_\_ Date \_\_\_\_\_

**KSHSAA PRE-PARTICIPATION PHYSICAL EVALUATION**

**PHYSICAL EXAMINATION FORM**

<b>Name</b> _____	<b>Date of birth</b> _____					
<b>Date of recent immunizations:</b>	<b>Td</b> _____	<b>Tdap</b> _____	<b>Hep B</b> _____	<b>Varicella</b> _____	<b>HPV</b> _____	<b>Meningococcal</b> _____

**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 adhere to safe sex practices?

**2. Consider reviewing questions on cardiovascular symptoms (questions 5-14 of History Form).**

**3. Per Kansas statute, any school athlete who has sustained a concussion shall not return to competition or practice until the athlete is evaluated by a healthcare provider and the healthcare provider (MD or DO only) provides such athlete a written clearance to return to play or practice.**

**4. Per Kansas Statute, students indicated as biological male at birth may not participate on girls teams.**

EXAMINATION			
Height	Weight	Male <input type="checkbox"/> Female <input type="checkbox"/>	BP (reference gender/height/age chart)**** / ( / ) Pulse
Vision R 20/	L 20/	Corrected: Yes <input type="checkbox"/> No <input type="checkbox"/>	
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/throat - Pupils equal, Gross Hearing			
Lymph nodes			
Heart * - Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)			
Pulses - Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Skin - Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), or tinea corporis			
Neurological***			
Genitourinary (optional-males only)**			
MUSCULOSKELETAL		NORMAL	ABNORMAL FINDINGS
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
Functional - e.g. double-leg squat test, single-leg squat test, and box drop or step drop test			

\*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those. \*\*Consider GU exam if in appropriate medical setting. Having third party present is recommended. \*\*\*Consider cognitive evaluation or baseline neuropsychiatric testing if a significant history of concussion. \*\*\*\*Flynn JT, Kaelber DC, Baker-Smith CM, et al. Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents. Pediatrics. 2017;140(3):e20171904.

I acknowledge I have reviewed the preceding patient history pages and have performed the above physical examination on the student named on this form.

Name of healthcare provider (print/type) \_\_\_\_\_ Date \_\_\_\_\_

**Signature of healthcare provider** \_\_\_\_\_, MD, DO, DC, PA-C, APRN  
*(please circle one)*

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

**Healthcare Providers: You must complete the Medical Eligibility Form on the following page**

Kansas State High School Activities Association, 601 SW Commerce Place | PO Box 495 | Topeka, KS 66601 | 785-273-5329

Adapted from PPE: Preparticipation Physical Evaluation, 5th Edition, © 2019 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. Permission is granted to reprint for non-commercial, educational purposes with acknowledgment.

# ■ KSHSAA PRE-PARTICIPATION PHYSICAL EVALUATION

## MEDICAL ELIGIBILITY FORM

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex at Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

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, except as indicated above. 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 healthcare provider (print or type): \_\_\_\_\_ Date: \_\_\_\_\_

**X** **Signature of healthcare provider:** \_\_\_\_\_, MD, DO, DC, or PA-C, APRN

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

## SHARED EMERGENCY INFORMATION

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

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

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

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

## Parent or Guardian Consent

To be eligible for participation in interscholastic athletics/spirit groups, a student must have on file with the superintendent or principal, a signed statement by a physician, chiropractor, physician's assistant who has been authorized to perform the examination by a Kansas licensed supervising physician or an advanced practice registered nurse who has been authorized to perform this examination by a Kansas licensed supervising physician, certifying the student has passed an adequate physical examination and is physically fit to participate (See KSHSAA Handbook, Rule 7). A complete history and physical examination must be performed annually before a student participates in KSHSAA interscholastic athletics/cheerleading.

I do not know of any existing physical or any additional health reasons that would preclude participation in activities. I certify that the answers to the questions in the HISTORY part of the Preparticipation Physical Examination (PPE), are true and accurate. I understand that any false or misleading information provided as part of this exam could result in disqualification from activity participation for my child and my child's teams. I approve participation in activities. I hereby authorize release to the KSHSAA, school nurse, certified athletic trainer (whether employee or independent contractor of the school), school administrators, coach and medical provider of information contained in this document. Upon written request, I may receive a copy of this document for my own personal health care records.

I acknowledge that there are risks of participating, including the possibility of catastrophic injury. I hereby give my consent for the above student to compete in KSHSAA approved activities, and to accompany school representatives on school trips and receive emergency medical treatment when necessary. It is understood that neither the KSHSAA nor the school assumes any responsibility in case of accident. The undersigned agrees to be responsible for the safe return of all equipment issued by the school to the student.

**X** **Signature of parent/guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/guardian phone:** \_\_\_\_\_

*The parties to this document agree that an electronic signature is intended to make this writing effective and binding and to have the same force and effect as the use of a manual signature.*

# ATTENTION PARENTS AND STUDENTS: KSHSAA ELIGIBILITY CHECKLIST

Student's Name \_\_\_\_\_ (PLEASE PRINT CLEARLY)

## NOTE: Transfer Rule 18 states in part, a student is eligible transfer-wise if:

**BEGINNING SEVENTH GRADER**—A seventh grader, at the beginning of his or her seventh grade year, is eligible under the Transfer Rule at any school he or she may choose to attend. In addition, age and academic eligibility requirements must also be met.

**BEGINNING NINTH GRADERS IN A THREE-YEAR JUNIOR HIGH SCHOOL**—So that ninth graders of a three-year junior high are treated equally to ninth graders of a four-year senior high school, a student who has successfully completed the eighth grade of a two-year junior high/middle school, may transfer to the ninth grade of a three-year junior high school at the beginning of the school year and be eligible immediately under the Transfer Rule. Such a ninth grader must then, as a tenth grader, attend the feeder senior high school of their school system. Should they attend a different school as a tenth grader, they would be ineligible for eighteen weeks.

**ENTERING HIGH SCHOOL FOR THE FIRST TIME**—A senior high school student is eligible under the Transfer Rule at any senior high school he or she may choose to attend when senior high is entered for the first time at the beginning of the school year. In addition, age and academic eligibility requirements must also be met.

## For Middle/Junior High and Senior High School Students to Retain Eligibility

**Schools may have stricter rules** than those pertaining to the questions above or listed below. Contact the principal or coach on any matter of eligibility. A student eligible to participate in interscholastic activities must be certified by the school principal as meeting all eligibility standards.

All KSHSAA rules and regulations are published in the official *KSHSAA Handbook* which is distributed annually to schools and is available at [www.kshsaa.org](http://www.kshsaa.org).

*Below Are Brief Summaries Of Selected Rules. Please See Your Principal For Complete Information.*



- Rule 7 Physical Evaluation - Parental Consent**—Students shall have passed the **attached evaluation** and have the written consent of their parents or legal guardian.
- Rule 14 Bona Fide Student**—Eligible students shall be a **bona fide undergraduate member** of his/her school in good standing.
- Rule 15 Enrollment/Attendance**—Students must be regularly **enrolled and in attendance** not later than Monday of the fourth week of the semester in which they participate.
- Rule 16 Semester Requirements**—A student shall not have more than two semesters of possible eligibility in grade seven and two semesters in grade eight. A student shall not have more than eight consecutive semesters of possible eligibility in grades nine through twelve, regardless of whether the ninth grade is included in junior high or in a senior high school.  
*NOTE: If a student does not participate or is ineligible due to transfer, scholarship, etc., the semester(s) during that period shall be counted toward the total number of semesters possible.*
- Rule 17 Age Requirements**—Students are eligible if they are not 19 years of **age** (16, 15 or 14 for junior high or middle school student) on or before August 1 of the school year in which they compete.
- Rule 19 Undue Influence**—The use of **undue influence** by any person to secure or retain a student shall cause ineligibility. If tuition is charged or reduced, it shall meet the requirements of the KSHSAA.
- Rules 20/21 Amateur and Awards Rules**—Students are eligible if they have not **competed under a false name** or for money or merchandise of intrinsic value, and have observed all other provisions of the Amateur and Awards Rules.
- Rule 22 Outside Competition**—Students may not engage in **outside competition** in the same sport during a season in which they are representing their school.  
*NOTE: Consult the coach, athletic director or principal before participating individually or on a team in any game, training session, contest, or tryout conducted by an outside organization.*
- Rule 25 Anti-Fraternity**—Students are eligible if they are not members of any **fraternity** or other organization prohibited by law or by the rules of the KSHSAA.
- Rule 26 Anti-Tryout and Private Instruction**—Students are eligible if they have not participated in **training sessions or tryouts** held by colleges or other outside agencies or organizations in the same sport while a member of a school athletic team.
- Rule 30 Seasons of Sport**—Students are not eligible for more than **four seasons** in one sport in a four-year high school, three seasons in a three-year high school or two seasons in a two-year high school.

## For Middle/Junior High and Senior High School Students to Determine Eligibility When Enrolling

If a **negative** response is given to any of the following questions, this enrollee should contact his/her administrator in charge of evaluating eligibility. This should be done before the student is allowed to attend his/her first class and prior to the first activity practice. If questions still exist, the school administrator should telephone the KSHSAA for a final determination of eligibility. (*Schools shall process a Certificate of Transfer Form T-E on all transfer students.*)

- | YES                         | NO                       |   |
|-----------------------------|--------------------------|---|
| 1. <input type="checkbox"/> | <input type="checkbox"/> | Are you a bona fide student in <b>good standing</b> in school? (If there is a question, your principal will make that determination.)   |
| 2. <input type="checkbox"/> | <input type="checkbox"/> | Did you <b>pass at least five new subjects (those not previously passed)</b> last semester? ( <i>The KSHSAA has a minimum regulation which requires you to pass at least five subjects of unit weight in your last semester of attendance.</i> )                              |
| 3. <input type="checkbox"/> | <input type="checkbox"/> | Are you planning to <b>enroll in at least five new subjects (those not previously passed)</b> of unit weight this coming semester? ( <i>The KSHSAA has a minimum regulation which requires you to enroll and be in attendance in at least five subjects of unit weight.</i> ) |
| 4. <input type="checkbox"/> | <input type="checkbox"/> | Did you <b>attend</b> this school or a feeder school in your district last semester? ( <i>If the answer is "no" to this question, please answer Sections a and b.</i> )   |
| <input type="checkbox"/>    | <input type="checkbox"/> | a. Do you reside with your parents?   |
| <input type="checkbox"/>    | <input type="checkbox"/> | b. If you reside with your parents, have they made a permanent and bona fide move into your school's attendance center?   |

The above named student and I have read the KSHSAA Eligibility Checklist and how to retain eligibility information listed in this form. The student/parent authorizes the school to release to the KSHSAA student records and other pertinent documents and information for the purpose of determining student eligibility. The student/parent also authorizes the school and the KSHSAA to publish the name and picture of student as a result of participating in or attending extra-curricular activities, school events and KSHSAA activities or events.

 Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of student \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_ Date \_\_\_\_\_

The parties to this document agree that an electronic signature is intended to make this writing effective and binding and to have the same force and effect as the use of a manual signature.



## FIRST AGENCY

5071 West H Avenue • Kalamazoo, MI 49009-8501 • Phone: (847) 378-5933

Dear Parents:

USD 489 Hays now provides supplemental accident medical insurance for all students and athletic participants for the 2022-2023 school year.

These programs will help take the worry out of all school sponsored activities and athletic events by providing supplemental accident medical insurance for all students and athletic participants. This plan will also cover all students and athletic participants for sponsored/supervised group travel to and from school and school-sponsored events.

This coverage is excess (secondary) to primary health plans. If an accident were to occur, all bills are to be submitted to your primary insurance. Any balances such as deductibles or copays will then be considered under the supplemental accident insurance.

Attached to this letter is a document with a description of what an accident is and how to file a claim. If you have questions, please contact The First Agency, a Gallagher Company, at (269) 381-6630.





# FIRST AGENCY

5071 West H Avenue • Kalamazoo, MI 49009-8501 • Phone: (269) 381-6630 • Fax (269) 492-0084

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USD 489 Hays now provides accident coverage for all students for the 2022-2023 school year.

Outlined below is important information regarding this coverage. It is intended as a brief description for reference only and is not the policy.

Only **ACCIDENTS** that occur in school-sponsored and supervised activities **INCLUDING** participants in interscholastic sports are covered.

## DEFINITION OF ACCIDENT:

An unexpected, sudden and definable event which is the direct cause of a bodily injury, independent of any illness, prior injury or congenital predisposition.

Conditions that result from participating in an activity do not necessarily constitute accidents. For example, illnesses, diseases, degeneration, conditions caused by continued stress to a particular area of the body, and existing conditions aggravated by an accident are not covered.

- A. This plan of insurance is **EXCESS ONLY**. It will not duplicate benefits paid or payable by any other insurance or plan including HMO's or PPO's.
- B. The policy will not cover expenses payable under the insured's HMO (Health Maintenance Organization), or PPO (Preferred Provider Organization). If the insured chooses not to use an authorized medical vendor (under HMO or PPO), the policy will only cover expenses incurred that it would have honored had the insured used the proper medical vendor.
- C. Medical treatment for a covered accident must begin within 60 days of that accident. Only expenses incurred within 104 weeks are considered. Benefits are determined on the basis of **REASONABLE AND CUSTOMARY** for the geographic location where services are performed.
- D. Specific exclusions of the policy include, but are not limited to, sickness, or disease, in any form; non-prescription drugs; fighting; and orthotics not prescribed exclusively for rehabilitation (e.g., playing brace, mouth guard).
- E. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

Accidents must be reported to the school within 20 days. Medical bills must be submitted to First Agency within 90 days after date of treatment. Questions regarding claim procedures may be directed to First Agency at 5071 West H Avenue, Kalamazoo, Michigan 49009 or 269/381-6630 or Fax 269/381-3055.

**KANSAS ASSOCIATION OF SCHOOL BOARDS INSURANCE PROGRAM**

Claim Serial Number (for office use only)

\_\_\_\_\_



Guarantee Trust Life Ins. Co.  
administered by  
**First Agency**  
5071 West H Avenue  
Kalamazoo, MI 49009-8501

# ACCIDENT CLAIM FORM

**PARENT/GUARDIAN TO COMPLETE**  
ALL INFORMATION MUST BE COMPLETE OR CLAIM CANNOT BE PROCESSED

Student's Full Name \_\_\_\_\_

Exact Date of Accident \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_

FATHER	MOTHER
Father's Full Name _____	Mother's Full Name _____
Home Address _____	Home Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____	Home Phone _____
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Self Employed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Self Employed? <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:</b>	<b>PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:</b>
Do you have insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Is this student covered? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Is this student covered? <input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Insurance Plan _____	Name of Insurance Plan _____
Phone Number _____	Phone Number _____
Group Number _____	Group Number _____
<b>If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.</b>	<b>If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.</b>

**AUTHORIZATION - To Permit Use and Disclosure of Health Information, please complete the Authorization form on the following page.**

## SCHOOL/ADMINISTRATOR/OFFICIAL/POLICYHOLDER TO COMPLETE

School Student Attends \_\_\_\_\_ in \_\_\_\_\_ School District \_\_\_\_\_

Student's Full Name (Last, First, MI): \_\_\_\_\_ Sex:  Male  Female Grade: \_\_\_\_\_

Student's Home Address: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_  AM  PM

Detailed Description of Accident: How did it occur? (or attach accident report completed by the school representative who witnessed the accident) \_\_\_\_\_

Where did it occur? \_\_\_\_\_

Part of body injured: \_\_\_\_\_  Right  Left

Activity: \_\_\_\_\_  Interscholastic  Intramural  Club  Other (describe) \_\_\_\_\_

Name of school authority supervising activity: \_\_\_\_\_

Was supervisor a witness to the accident?  Yes  No If No, date reported to school: \_\_\_\_\_

Signature of School Official: \_\_\_\_\_ Date: \_\_\_\_\_ Title of School Official: \_\_\_\_\_



First Agency  
5071 West H Avenue  
Kalamazoo, MI 49009

### HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

**This Authorization was prepared for purposes of obtaining information to process a claim for benefits.**

Policy/Certificate # \_\_\_\_\_

I, the undersigned, authorize any licensed physician, medical professional, hospital, clinic, or other medical-related facility, pharmacies, pharmacy benefit managers, governmental agency, insurance company, insurance support organization, consumer reporting agency, group policyholder, employer or benefit plan administrator to provide First Agency or an agent, attorney, or independent administrator, acting on its behalf, all medical and health information concerning advice, care or treatment provided to the patient named below. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization excludes psychotherapy notes. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. I understand that I or my authorized representative is entitled to receive a copy of the Authorization upon request.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to First Agency, in care of the Claim Department Manager, at the above address. I understand that a revocation will not be effective to the extent First Agency has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits.

I understand that First Agency may condition payment of a claim upon my signing this Authorization if the disclosure of information is necessary to determine the level or validity of the claim payment. Failure to sign this Authorization, or subsequent revocation of this Authorization, may impair the ability of First Agency to process your application or evaluate claims, and may be a basis for denying an application or claim for benefits; however, your ability to receive health care services will not be changed if you do not sign this Authorization.

Once information is disclosed to First Agency pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state privacy laws. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

This authorization shall remain in force and in effect until two (2) years from the date this authorization is signed at which time this authorization will expire.

If this Authorization is signed by my authorized representative, that individual's authority to act on my behalf is described below.

\_\_\_\_\_  
(Print Please) Name of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Please Print) Name of Authorized Representative, or Next of Kin

\_\_\_\_\_  
Relationship of Authorized Representative or Next of Kin to Patient

\_\_\_\_\_  
Signature of Authorized Representative or Next of Kin

\_\_\_\_\_  
Date

Dear Parent:

Our school provides accident coverage for all students. Outlined below is important information regarding this coverage. It is intended as a brief description for reference only and is not the policy.

Only **ACCIDENTS** that occur in school-sponsored and supervised activities **INCLUDING** participants in interscholastic sports are covered.

**DEFINITION OF ACCIDENT:**

An unexpected, sudden and definable event which is the direct cause of a bodily injury, independent of any illness, prior injury or congenital predisposition.

Conditions that result from participating in an activity do not necessarily constitute accidents. For example, illnesses, diseases, degeneration, conditions caused by continued stress to a particular area of the body, and existing conditions aggravated by an accident are not covered.

- A. This plan of insurance is **EXCESS ONLY**. It will not duplicate benefits paid or payable by any other insurance or plan including HMO's or PPO's.
- B. The policy will not cover expenses payable under the insured's HMO (Health Maintenance Organization), or PPO (Preferred Provider Organization). If the insured chooses not to use an authorized medical vendor (under HMO or PPO), the policy will only cover expenses incurred that it would have honored had the insured used the proper medical vendor.
- C. Medical treatment for a covered accident must begin within 60 days of that accident. Only expenses incurred within 104 weeks are considered. Benefits are determined on the basis of **REASONABLE AND CUSTOMARY** for the geographic location where services are performed.
- D. Specific exclusions of the policy include, but are not limited to, sickness, or disease, in any form; non-prescription drugs; fighting; and orthotics not prescribed exclusively for rehabilitation (e.g., playing brace, mouth guard).
- E. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.

Accidents must be reported to the school within 20 days. Medical bills must be submitted to First Agency within 90 days after date of treatment. Questions regarding claim procedures may be directed to First Agency at 5071 West H Avenue, Kalamazoo, Michigan 49009 or 269/381-6630 or Fax 269/381-3055.

**HOW TO FILE YOUR ACCIDENT CLAIM FORM:**

- 1. Complete **ALL** blanks. If information is not applicable, indicate the **reason** it is not (e.g., deceased, unknown).
- 2. Attach all **ITEMIZED** bills to date (**not** balance due statements) for **MEDICAL EXPENSES ONLY**. Subsequent medical bills can be submitted within 90 days after date of treatment.
- 3. Include all worksheets, denials, and/or statements of benefits from your primary insurer. (Each charge **must** be processed by all other insurances/plans before they can be processed by First Agency.)
- 4. If you are employed and no coverage is provided by your employer, **A LETTER OF VERIFICATION FROM YOUR EMPLOYER STATING THAT NO COVERAGE IS PROVIDED MUST BE SUBMITTED.**
- 5. Mail claim form within 90 days of the accident to:  
Guarantee Trust Life Ins. Co. administered by  
First Agency  
5071 West H Avenue  
Kalamazoo, MI 49009-8501



Hays High School Athletic Department  
2300 East 13<sup>th</sup> Street, Hays, KS 67601  
785.623.2600

Lance Krannawitter - Athletic Director  
[lancekrannawitter@usd489.com](mailto:lancekrannawitter@usd489.com)

**HAYS HIGH SCHOOL/HAYS MIDDLE SCHOOL ATHLETIC-ACTIVITY DEPARTMENT  
SUBSTANCE ABUSE POLICY AGREEMENT  
U.S.D.489  
HAYS, KANSAS**

Hays High School/Hays Middle School will act in accordance with the USO 489 Substance Abuse Polley for all violations of chemical use/abuse. The Kansas State High School Activities Association guidelines will be followed with respect to student activity participants. This policy is intended to clearly state that the school will address incidents as presented to the administration and will not "police" the community looking for violators.

1. Student participants who possess and/or use controlled substances (other than those prescribed by a physician) during the season shall be excluded from participation In the next KSHSAA sponsored event. An alcohol/drug evaluation must be completed in order to avoid suspension of additional future events.
2. Students In violation of the rule for a second time will be dismissed from his/her present activity and must participate in follow-up activities as prescribed in the alcohol/drug evaluation in order to be eligible for participation for any upcoming season. Third time offenders will not be allowed to participate In any KSHSAA sanctioned activity for the remainder of the school year.
3. Violation of the rules as noted must be verified by the student Involved, a staff member, a law enforcement officer, or the parents of the student involved if penalties are to be imposed.
4. An alcohol/drug evaluation must be completed with all recommendations adhered to by the offender to avoid suspension from future events. For the student to return in good standing, the treatment facility and/or evaluator must provide a statement to the school prlnclpal noting that the offender has successfully completed the recommended program.

X \_\_\_\_\_

Parent/Guardian Signature

\_\_\_\_\_ Date

X \_\_\_\_\_

Student Signature

\_\_\_\_\_ Date

Rev: 11/23

**KSHSAA RECOMMENDED CONCUSSION & HEAD INJURY INFORMATION RELEASE FORM  
2023-24**

**This form must be signed by all student athletes and parent/guardians before the student participates in any athletic or spirit practice or contest each school year.**

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

<b>Symptoms may include one or more of the following:</b>		
<ul style="list-style-type: none"> <li>• Headaches</li> <li>• “Pressure in head”</li> <li>• Nausea or vomiting</li> <li>• Neck pain</li> <li>• Balance problems or dizziness</li> <li>• Blurred, double, or fuzzy vision</li> <li>• Sensitivity to light or noise</li> </ul>	<ul style="list-style-type: none"> <li>• Feeling sluggish or slowed down</li> <li>• Feeling foggy or groggy</li> <li>• Drowsiness</li> <li>• Change in sleep patterns</li> <li>• Amnesia</li> <li>• “Don’t feel right”</li> <li>• Fatigue or low energy</li> </ul>	<ul style="list-style-type: none"> <li>• Sadness</li> <li>• Nervousness or anxiety</li> <li>• Irritability</li> <li>• More emotional</li> <li>• Confusion</li> <li>• Concentration or memory problems (forgetting game plays)</li> <li>• Repeating the same question/comment</li> </ul>

<b>Signs observed by teammates, parents, and coaches include:</b>	
<ul style="list-style-type: none"> <li>• Appears dazed</li> <li>• Vacant facial expression</li> <li>• Confused about assignment</li> <li>• Forgets plays</li> <li>• Is unsure of game, score, or opponent</li> <li>• Moves clumsily or displays incoordination</li> <li>• Answers questions slowly</li> </ul>	<ul style="list-style-type: none"> <li>• Slurred speech</li> <li>• Shows behavior or personality changes</li> <li>• Can’t recall events prior to hit</li> <li>• Can’t recall events after hit</li> <li>• Seizures or convulsions</li> <li>• Any change in typical behavior or personality</li> <li>• Loses consciousness</li> </ul>

**What can happen if my child keeps on playing with a concussion or returns too soon?**

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one (second impact syndrome). This can lead to prolonged recovery, or even to severe brain swelling with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. And concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student-athlete’s safety.

**If you think your child has suffered a concussion**

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately and an urgent referral to a health care provider should be arranged (if not already onsite). No athlete may return to activity after sustaining a concussion, regardless of how mild it seems or how quickly symptoms clear, without written medical clearance from a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO). Close observation of the athlete should continue for several hours. You should also inform your child’s coach if you think that your child may have a concussion Remember it is better to miss one game than miss the whole season. **When in doubt, the athlete sits out!**

**Cognitive Rest & Return to Learn**

The first step to concussion recovery is cognitive rest. This is essential for the brain to heal. Activities that require concentration and attention such as trying to meet academic requirements, the use of electronic devices (computers, tablets, video games, texting, etc.), and exposure to loud noises may worsen symptoms and delay recovery. Students may need their academic workload modified while they are initially recovering from a concussion. Decreasing stress on the brain early on after a concussion may lessen symptoms and shorten the recovery time. This may involve staying home from school for a few days, followed by a lightened school schedule, gradually increasing to normal. Any academic modifications should be coordinated jointly between the student’s medical providers and school personnel. After the initial 24-48 hours from the injury, under direction from their health care provider, patients can be encouraged to become gradually and progressively more active while staying below their cognitive and physical symptom-exacerbation thresholds (i.e., the physical activity should never bring on or worsen their symptoms). No consideration should be given to returning to full sport activity until the student is fully integrated back into the classroom setting and is symptom free. Occasionally a student will be diagnosed with post-concussive syndrome and have symptoms that last weeks to months. In these cases, a student may be recommended to start a non-contact physical activity regimen, but this will only be done under the direct supervision of a healthcare provider.

**Return to Practice and Competition**

The Kansas School Sports Head Injury Prevention Act provides that if an athlete suffers, or is suspected of having suffered, a concussion or head injury during a competition or practice, the athlete must be immediately removed from the competition or practice and cannot return to practice or competition until a Health Care Professional has evaluated the athlete and provided a written authorization to return to practice and competition. The KSHSAA recommends that an athlete not return to practice or competition the same day the athlete suffers or is suspected of suffering a concussion. The KSHSAA also recommends that an athlete’s return to practice and competition should follow a graduated protocol under the supervision of the health care provider (MD or DO).

For current and up-to-date information on concussions you can go to:  
<http://www.cdc.gov/concussion/HeadsUp/youth.html>  
<http://www.kansasconcussion.org/>

For concussion information and educational resources collected by the KSHSAA, go to:  
<http://www.khsaa.org/Public/General/ConcussionGuidelines.cfm>

X \_\_\_\_\_  
**Student-athlete Name Printed**

\_\_\_\_\_  
**Student-athlete Signature**

\_\_\_\_\_  
**Date**

X \_\_\_\_\_  
**Parent/Legal Guardian Printed**

\_\_\_\_\_  
**Parent/Legal Guardian Signature**

\_\_\_\_\_  
**Date**