| File # | | | |
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SISC TACKLE FOOTBALL CLAIM FORM

☐ Tackle Football Accident ☐ Supplemental Coverage

Mail To: SISC Tackle Football, P.O. Box 1847,

Bakersfield, CA 93303-1847 - (661) 636-4710

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| 10.535.000 | O BE COMPLETED BY SCHO | OL OFFI | CIAL | | | | | |
| Did the accident occur (Check Yes or No) | | | | Name and Title of Supervising School Authority: | | | | |
| Α. | | | | Name | | | | |
| D | tackle football practice? | ☐ Yes | □ No | Title | | | | |
| В. | During school sponsored tackle football competition? | ☐ Yes | | Signature | | | | |
| C. | | u ies | □ No | School District | | | | |
| ٠. | supervised tackle football transportation? | ? □Yes | □ No | School Name _ | | | | |
| | | . 👅 103 | 140 | | | | | |
| | FUDENT INFORMATION | | 3.70 | | | | | |
| STU | IDENT'S FULL NAME | | MAILING ADDRES | SS | CITY | | ZIP | |
| DAT | E OF BIRTH GRADE | | | SEX | | TELEPH | ONE NUMBER | |
| | | | | IM F | | | | |
| 1. | Give full description of injury. Tell when, v | vhere, and h | now it happened | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | Give exact date and time when injury occ | curred Date | a ' | | Time | 2.1 | 22 | n m |
|) | Olve exact date and time when injury occ | uneu. Dan | | | _ IIIIIe | a.i | III. | p.m. |
| | | | | | | | | |
| | When did you first consult a physician for | this conditio | on? Date: | | | | _ | |
| 3. | | | | RMATION | SIS | C Accident C | _ overage is se | condary |
| 3. | When did you first consult a physician for D BE COMPLETED BY PAREN | | | RMATION | SISC | C Accident C | overage is se | condary ance. |
| 3. | O BE COMPLETED BY PAREN | NT - PAR | ENT INFOR | | to | o your private | e health insur | condary rance. |
| 3. T (| D BE COMPLETED BY PAREN Father's Name | NT - PAR | ENT INFOR | | _ EMPLOY | your private YED; Yes | health insur | condary rance. |
| 3. T (| Father's Employer | NT - PAR | ENT INFOR | | _ EMPLOY | o your private | health insur | condary rance. |
| 3. T (| Father's Name Father's Employer Individual and/or | NT - PAR | ENT INFOR | Employer | EMPLOY | o your private (ED; Yes) | e health insur | condary rance. |
| 3. T (| Father's Name Father's Employer Individual and/or Group Insurance Company | NT - PAR | ENT INFOR | Employer | EMPLOY r Telephone (| o your private (ED: Yes) | e health insur | condary rance. |
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IMPORTANT – PARENT'S RESPONSIBILITY: Injuries MUST be treated by a properly authorized Physician or Dentist. All hospital and doctor bills must be itemized.