



**ABOUT THE CONFERENCE/LEAGUE INSURANCE COVERAGE**

**SECTION VI.**

**PARENTAL CONSENT**

I/We the parents/guardians of the minor named in Section II Candidate for a position on a SCJA AFC Team, hereby give my/our approval to his/her participation in any and all SCJA AFC activities during the current season. I/We assume all risks and hazards incidental to such participation, including transportation to and from such activities. I/We do hereby waive, release, absolve, indemnify, and agree to hold harmless the team, the Chapter, and the SCJA AFC including sponsors and other related participants, for any injury to my/our child. SCJA AFC has advertising, modeling and photo copyrights.

**MEDICAL TREATMENT AUTHORIZATION**

The SCJA AFC has Secondary Excess Accident-Medical Group Insurance coverage, with a deductible amount for each injury incurred. The SCJA AFC group insurance is "**SECONDARY EXCESS COVERAGE**," over any valid collectable coverage provided by the parent's separate personal or employee's dependent group insurance. The SCJA AFC secondary group covers one year from date of first treatment, for each injury, with dental coverage, for sound natural teeth, including dental X-rays. Abdominal hernia and pre-existing conditions are excluded. In executing the foregoing release, I/we, the under- signed acknowledge and represent that I/we understand that any claim for injuries which arises out of our child's participation, must be reported to the Team or Chapter Officials "**IMMEDIATELY**". The insurance claim form must be filled out and delivered to the Conference Insurance Commissioner "**WITHIN 30 DAYS**" from the date of injury. I/We have read the foregoing release, understand it and signed it voluntarily.

**THE NAME OF OUR OWN AND/OR EMPLOYMENT GROUP INSURANCE COMPANY IS:**

\_\_\_\_\_

**POLICY NUMBER:**

\_\_\_\_\_

(IF NO INSURANCE, List Father's or Mother's Soc. Security No.)

In the event of injury to MY/OUR Child, I/We hereby grant authority to a qualified Doctor of Medicine to render such medical treatment as said Doctor of Medicine deems necessary under the circumstances. **PLEASE LIST ALL**

**ALLERGIES:** \_\_\_\_\_

**A. IMPORTANT NOTICE (State required "Disclosure" statement; C.I.C. Section 10270.2)**

THIS IS AN EXCESS PLAN – The Medical Expense Benefit of this Plan (Program) is an "EXCESS" type benefit that picks up where other coverage leaves off. If you have any other individual, franchise, blanket or group (except automobile medical payments insurance) coverage which provides benefits of services for, or by reason of, medical or dental care or treatment, then this Plan (Program) will pay ONLY the medical expenses not provided or reimbursable under your other coverage. The premium for this Plan (Program) has been reduced, taking this into account.

If you have any other coverage, you should first submit you claim under that coverage. You should submit a claim under this Plan (Program) only if you have no other coverage or if your other coverage does not fully provide or pay for your medical care or treatment. Failure to submit the claim to your primary carrier can result in delaying payment by SCJA AFC insurance carrier.

B. The Conference/League insurance is "EXCESS" only. This means that the Parents/Guardians OWN INSURANCE MUST BE NOTIFIED OF THE INJURY. If the Parents/Guardians have insurance WITH PRE-PAID MEDICAL PLANS, such as Kaiser or Ross Loos, the injured person MUST BE TAKEN TO THE PRE-PAID MEDICAL FACILITIES, for treatment.

C. If insured's Parent's/Guardians HAVE NO OTHER 1<sup>st</sup> OR PRIMARY INSURANCE; the Conference/League group insurance may be used. BUT THERE IS A \$1000.00 DEDUCTIBLE FOR EACH INJURY.

D. The Conference/League group insurance PAYS ONLY TO THE HOSPITALS AND DOCTORS unless receipts are submitted showing proof of payment by Parent/Guardian to the Hospital/Medical Treatment center. The following forms are required to process the claim. 1. Insurance Claim Form. 2. Chapter AD report of injury. 3. Copy of Parent/Guardian Insurance card. 4. HIPPA Form (on www.scjaaf.com). 5. Copy of any medical bills. 6. Copy of player's contract.

E. Any and all claims MUST be reported to your Chapter AD. The Chapter AD will then notify SCJA AF.

\_\_\_\_\_  
Name (Please Print)

\_\_\_\_\_  
Relationship to Minor (Parent or Legal Guardian)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed

Jr All American of Southern California Conference  
Mandatory Medical Release Form

Chapter Name UPLAND Division \_\_\_\_\_

This form must be **dated AFTER March 26, 2021 AND within 4 months prior to first day of practice** and submitted to your Local Chapter. Section I must be completely filled out by the parent or legal guardian. Section II must be completed in its entirety ONLY by a duly qualified Doctor of Medicine, Doctor of Osteopathy, Nurse Practitioner, or Physician's Assistant. **A Doctor of Chiropractic and a Registered Nurse are not considered to be qualified to give a physical to a player and a physical will not be accepted from one.**

**Section 1: FILLED OUT BY PARENT OR LEGAL GUARDIAN (Legal name must match proof of age.)**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Circle M / F

**PARTICIPANTS MEDICAL HISTORY**

- |   |         |   |          |
|---|---------|---|----------|
| 1. Are there any injuries requiring medical attention?              | Yes/ No | 6. Are there any past surgeries/scheduled surgeries?                      | Yes / No |
| 2. Is the participant currently under the care of a doctor?         | Yes/ No | 7. Is the participant currently taking any medication?                    | Yes / No |
| 3. Does the participant have any allergies (bee sting, penicillin)? | Yes/ No | 8. Does the participant have asthma/require inhaler                       | Yes / No |
| 4. Is the participant diabetic/ require medication for Diabetes?    | Yes/ No | 9. Does the participant wear glasses or contact lenses?                   | Yes/ No  |
| 5. Does/ has the participant have/had seizures?                     | Yes/ No | 10. Does the participant have any physical limitation/ medical condition? | Yes/ No  |
|   |         | 11. Does the participant wear a brace or other medical support            | Yes/ No  |

**If you answered YES to any question above, please provide the question number and an explanation below:**

I hereby certify that this information is accurate to the best of my knowledge. I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that it is my responsibility to obtain written clearance from my child's physician on official medical stationery in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signed \_\_\_\_\_ Print Name: \_\_\_\_\_  
Relationship to Participant: \_\_\_\_\_ Dated: \_\_\_\_\_

**Section II: THIS SECTION IS TO BE COMPLETED ONLY BY A STATE LICENSED MEDICAL PROFESSIONAL**  
**If there are any cross outs, white out, or information written over on this form, this form will be denied and a new physical required.**

Participant's Name: \_\_\_\_\_  
(Please check the following if healthy or note otherwise): Height \_\_\_\_\_ Weight \_\_\_\_\_ (lbs.) B/P \_\_\_\_\_  
Ears \_\_\_\_\_ Mouth \_\_\_\_\_ Nose \_\_\_\_\_ Throat \_\_\_\_\_ Respiratory \_\_\_\_\_ Cardiovascular \_\_\_\_\_ Neurological \_\_\_\_\_  
Eyes \_\_\_\_\_ / \_\_\_\_\_ Hernia(optional) \_\_\_\_\_  
Notes: \_\_\_\_\_

**I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be involved in participating in SCJAAF Football or Cheer Program. I hereby swear and attest that this individual is physically fit, and I have found no medical reason which would prevent this individual from safely participating in SCJAAF Football activities for the 2021 season. I am therefore clearing this individual for athletic participation without limitation.**

Signed \_\_\_\_\_ Print Name: \_\_\_\_\_  
Date: \_\_\_\_\_ Date Physical was actually performed: \_\_\_\_\_

**A Doctor of Chiropractic and a Registered Nurse are not considered to be qualified to give a physical to a player and a physical will not be accepted from one.**

Address: \_\_\_\_\_ Mandatory Dr. Stamp Here:  
City: \_\_\_\_\_ State: \_\_\_\_\_  
Telephone: \_\_\_\_\_





# UPLAND HURRICANES JR ALL-AMERICAN FOOTBALL & CHEER

A Chapter of the Southern California Jr. All American Conference  
1042 N. Mountain Avenue Suite B-440 Upland, CA 91786

www.uplandjaaf.com | information@uplandjaaf.com | Direct (909) 978-7779



## ZERO TOLERANCE POLICY

This policy is to inform the participant and the parents of participants of the Upland Hurricanes Youth Football and Cheer program of our "**Zero Tolerance Policy**". The Hurricanes Board of Directors has given full discretion to coaches and board members to enforce this policy. The following will not be tolerated:

- Possession/consumption of alcoholic beverages, possession/use of illegal substances on the premises at any Association, League or Conference function, including home or away games, and practices or events where the children are present.
- Protesting a game official, judge or Commissioners decision in an aggressive demonstrative manner, or any behavior which might incite negative, violent or aggressive fan involvement.
- Use of abusive or profane language or actions at any time at any Association, League, or Conference function.
- Treatment of the program, board members, coaches, all children and adults while at any Association/League/Conference function with disrespect.
- Any physical violence, or verbal abuse or harassment towards any parent, coach, official, board member or player.

Failure to follow this policy will result in immediate dismissal from the event and/or season for a participant and/or his/her parents. Depending on the gravity of the incident, dismissal may be immediate for a participant or parent with the possibility of notification given to the local police departments and/or local recreation departments.

By signing below, I am representing myself and my entire family and/or any friends who may attend the event that my child is participating in. I will enlighten my friends & family and enforce this policy. I acknowledge receipt of the Upland Hurricanes Zero Tolerance Policy. I will abide in accordance with the policy or risk dismissal of participation of my child/children.

_____	_____	_____
Player's Signature	Date	Printed name
_____	_____	_____
Parent's Signature	Date	Printed name

## REFUND POLICY

The Board of Directors of the Upland Hurricanes Youth Football & Cheer program hold a financial responsibility to all its members in upholding our mission and league standards. Decisions and expenses for every upcoming season occur months before players even step onto the practice field. In return, we ask that all our families recognize their commitment to our program and adhere to our refund policy outlined below.

### Flag/Tackle Football:

- Before June 30<sup>th</sup> - FULL REFUND
- July 1<sup>st</sup> through July 23<sup>rd</sup> - Refund less a \$50 Non-Refundable fee
- **After July 24<sup>th</sup> - NO REFUNDS. NO EXCEPTIONS!**

### Cheer:

- Before June 30<sup>th</sup> - FULL REFUND
- July 1<sup>st</sup> through Uniform Fitting Date - Refund less a \$50 Non-Refundable fee
- **After Uniform Fitting - NO REFUNDS. NO EXCEPTIONS!**

_____	_____	_____
Parent's Signature	Date	Printed name

