

Dear Parent(s) or Legal Guardian:

The Bloomington Area Career Center and its administrative agent (Bloomington Public Schools District #87) does not provide health or accident insurance coverage for students participating in Bloomington Area Career Center programs. It is the responsibility of the parent or legal guardian of each Bloomington Area Career Center student to provide health and accident insurance coverage for their Bloomington Area Career Center student. We need for the parent(s) or legal guardian(s) of each BACC student to verify health and accident insurance coverage information for the 2012-2013 school year.

Please complete the form below.

If your son/daughter who is participating in Bloomington Area Career Center does not currently have health and accident insurance coverage, you may wish to apply for coverage through a plan offered by your school district. However the student insurance is provided, we must have on file in our office signed verification that every Bloomington Area Career Center student is covered with health and accident insurance.

Again, please complete the attached Bloomington Area Career Center Parent Permit/Insurance Waiver Form and return it to the Bloomington Area Career Center office. If you have any questions please contact the Bloomington Area Career Center office.

Thank you,

Tom Frazier
Director

Bloomington Area Career Center Parent Permit/Insurance Waiver Form

Name of Student _____
Last First M

The student named above has my permission to participate in the Bloomington Area Career Center for the 2012-2013 school year.

Parent/Guardian Signature Date

Insurance:

_____ We have taken out student accident insurance through our home school district _____
Name of High School

_____ We have our own insurance: _____
Name of Company

(Each student must have their own insurance or take out the school insurance program to be eligible to participate in BACC)

In case of an emergency and I cannot be reached, I give my permission to have properly trained medical professionals treat my son/daughter.

Parent/Guardian Signature Date

Additional Information: _____

Student Emergency Information below must be completed by parent/guardian:

Emergency Contact (other than parent) _____

Address _____ City _____ Zip _____

Family Doctor _____

Hospital Preferred _____

Please list any type of medical information which might be needed in case of an emergency
(Health Problems/Allergies, Medications)

