San Ysidro School District EST - 1887
QUALITY EDUCATION AND OPPORTUNITY FOR ALL STUDENTS TO SUCCEED

Manuel Bojorquez
Assistant Superintendent of
Educational Leadership and Pupil Services
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Dear students, Parents, and Guardians,

State law requires the San Ysidro School District (SYSD) to provide annual notification to students, parents, and guardians of their rights and responsibilities pertaining to their child's education. Please read this Annual Notification. The parent or guardian is required to acknowledge their receipt of this notice by signing and returning the signature page to their child's school or District program. The parent's or guardian's signature is an acknowledgment that they have been informed of their rights and does not indicate the parent's or guardian's consent for their child to participate or not participate in any particular program listed within the Annual Notification.

Some legislation requires additional notification to the parents or guardians during the school term prior to a specific activity. A separate letter will be sent to the parents or guardians prior to any of these specified activities or classes, and the student will be excused whenever the parents or guardians file with the principal of the school a statement in writing requesting that their child not participate. Other legislation grants certain rights that are to be spelled out in this Annual Notification.

SYSD and its Board recognize that parent or guardian involvement in their child's education promotes student achievement and contributes greatly to the student's success. This Annual Notification contains information on the various ways parental involvement is both permitted and encouraged by federal and state laws, as well as SYSD's policies. SYSD is committed to providing a quality education to all its students in a safe and healthy environment. SYSD looks forward to a successful and positive school year, made possible by the dedicated efforts of its administrators, teachers, paraeducators, support staff, students, parents, and guardians.

Please read this Annual Notification carefully and return the signed forms to your student's school as soon as possible.

Sincerely,

Manuel Bojorquez
Assistant Superintendent, Educational Leadership and Pupil Services
San Ysidro School District

San Ysidro School District EST - 1887
QUALITY EDUCATION AND OPPORTUNITY FOR ALL STUDENTS TO SUCCEED

ACKNOWLEDGMENT OF RECEIPT AND REVIEW OF ANNUAL NOTIFICATIONS 2025-2026 SCHOOL YEAR

Dear Parent/Guardian:

The San Ysidro School District is required to annually notify the parents and guardians of rights and responsibilities in accordance with Education Code section 48980.

If you have any questions or if you would like to review specific documents mentioned in the notice, please contact an administrator at your child's school. They will be able to give you more detailed information and assist you in obtaining copies of any materials you wish to review.

Please complete the "Acknowledgment of Receipt and Review" form below and return it to your child's school.

This annual notification is also available in an electronic format (www.sysdschools.org) and can be provided to you upon request. If the notice is provided in an electronic format, the parent or guardian shall submit to the school this signed acknowledgement of receipt of the notice. Signature of the notice is an acknowledgment by the parent or guardian that they have been informed of his or her rights but does not indicate that consent to participate in any particular program has either been given or withheld.

ACKNOWLEDGMENT OF RECEIPT AND REVIEW

Pursuant to Education Code section 48982, the parent/guardian shall sign this notice and return it to the school. Signature on the notice is an acknowledgment by the parent or guardian that they have been informed of his or her rights but does not necessarily indicate that consent to participate in any particular program or activity has been given or withheld.

Student Name:_____

School: _____ Grade: _____

Parent/Guardian Name: _____

Address: _____

_____

Home Telephone Number:_____

_____ _____

Signature of Parent/Guardian (if student is under 18) Signature of Student (if student is 18 or older)

SAN YSIDRO SCHOOL DISTRICT
RELEASE FORM FOR DIRECTORY INFORMATION
2025-2026

PARENTS: PLEASE READ AND COMPLETE THE INFORMATION BELOW AND RETURN IT TO YOUR SCHOOL PRINCIPAL

Student Name: _____ Date of Birth: _____

Address: _____

City: _____ Zip Code: _____

Telephone No.: _____ Grade: _____

School: _____

The primary purpose of directory information is to allow the San Ysidro School District to include this type of information from your child's education records in certain school publications. Directory information includes the pupil's name, address, telephone number, date of birth, e-mail address, major field of study, participation in officially recognized activities and sports, dates of attendance, degrees and awards received, and the most recent previous public or private school attended by the pupil, or height and weight of athletes, information that is generally not considered harmful or an invasion of privacy released.

The Family Education Rights and Privacy Act (FERPA) and Education Code section 49073 permits the San Ysidro School District to disclose appropriately designated "directory information" without written consent, unless you have advised the San Ysidro School District that you do not want your student's directory information disclosed without your prior written consent.

Student Directory Information

❑ I do not wish to have any directory information released to any individual or organization.

❑ I do not wish to release the name, address and telephone number of the student names above to the agencies I check below.
- ❑ PTA (if applicable)
- ❑ Health Department
- ❑ Elected Officials
- ❑ Third Party Providers of Online Educational Tools (Used within the classroom for educational purposes only.)
- ❑ United States Armed Forces*
- ❑ Universities or Other Institutions of Higher Education*

☐ I am a homeless and unaccompanied youth over the age of 14, or am a parent of a homeless and unaccompanied youth and authorize the release of my directory information in accordance with the law and SYSD policy.

Media Release

❑ The student may be interviewed, photographed, or filmed by members of the media.

❑ The student may NOT be interviewed, photographed, or filmed by members of the media.

_____ _____

Signature of Parent/Guardian (if student is under 18) Signature of Student (if student is 18 or older)

_____

Signature of Student
(if over the age of 14 and homeless and unaccompanied youth.)

SAN YSIDRO SCHOOL DISTRICT
2025-2026 PARENTAL OPTIONS

PARENTS: PLEASE READ AND COMPLETE THE INFORMATION BELOW AND RETURN IT TO YOUR SCHOOL

Student Name:_____ Date of Birth: _____

Address: _____

City: _____Zip Code:_____

Telephone No.:_____Grade: _____

School: _____

Physical Examination

The San Ysidro School District may require physical examinations of students enrolled in San Ysidro School District programs or activities. Any physical examination required by the San Ysidro School District shall be kept confidential. A parent or guardian having control or charge of any child enrolled in public schools may file annually with the principal of the school in which s/he is enrolled a statement in writing, signed by the parent or guardian, stating that s/he will not consent to a physical examination of the child.

- ❑ I **do not** want my child to undergo a physical exam for San Ysidro School District programs or activities.
- ❑ I grant consent for my child to undergo a physical exam for San Ysidro School District programs or activities.

Sexual Health and HIV/AIDS Prevention Education

Students enrolled in San Ysidro School District programs or activities may receive instruction in health education, including comprehensive sexual health education and HIV prevention and including information regarding sexual harassment, sexual abuse and human trafficking. Parents or guardians may submit a written request to excuse their child from participation in any class involving comprehensive sexual education or HIV prevention education, or from participation in any anonymous, voluntary, and confidential test, questionnaire, or survey on pupil health behaviors and risks.

I would like my child **excused** from:

- ❑ Participation in any anonymous, voluntary, and confidential test, questionnaire, or survey on pupil health behaviors and risks.

All instructional materials are available for review. You may also request a copy of the California Healthy Youth Act (California Education Code sections 51930–51939).
This instruction will be provided by (name of school district personnel/outside consultants).
If you do not want your student to participate in comprehensive sexual health or HIV prevention education, please provide a signed, written note to (insert district name, principal, teacher, etc.) by (insert date here).

Right to Refrain From Harmful or Destructive Use of Animals

Pursuant to Education Code section 32255, et seq., any student with a moral objection to dissecting or otherwise harming or destroying animals, or any parts thereof, shall notify his or her teacher regarding this objection. The student must obtain a note from his or her parent or

guardian requesting exemption from participation in an education project involving the harmful or destructive use of animals.

- ❑ I would like my child excused from participation in an education project involving the harmful or destructive use of animals
- ❑ My child may participate in an education project involving the harmful or destructive use of animals.

Signature of Parent/Guardian (if student is under 18)

Signature of Student (if student is 18 or older)

Acknowledgement of Parent or Guardian of Specific School Activities

(Please sign and return to your child's school.)

STUDENT'S NAME _____
SCHOOL _____
GRADE _____

Student is on a continuing medication program. (Please check) Yes____ No____

IF YES, you have my permission to contact my physician.

PHYSICIAN'S NAME_____
PHYSICIAN'S TELEPHONE _____
MEDICATION _____
DOSAGE _____

I hereby acknowledge receipt of information regarding my rights, responsibilities and protections. I also attest under penalty of perjury that I am a resident of the district, as previously verified, or attend under an approved Interdistrict Attendance Agreement.

SIGNATURE OF PARENT OR GUARDIAN _____

DATE_____

SAN YSIDRO SCHOOL DISTRICT
2025-2026 ANNUAL PESTICIDE NOTIFICATION REQUEST

PARENTS: PLEASE READ AND COMPLETE THE INFORMATION BELOW AND RETURN IT TO YOUR SCHOOL PRINCIPAL

Parents/guardians can register with the school to receive notification or individual pesticide applications. Persons who register for this notification shall be notified at least seventy-two (72) hours prior to the application, except in emergencies, and will be provided the name and active ingredient(s) of the pesticide as well as the intended date of application.

Parents/guardians seeking access to information on pesticides and pesticide use reduction developed by the Department of Pesticide Regulation pursuant to California Food and Agricultural Code section 13184, can do so by accessing the Department's web-site at www.cdpr.ca.gov.

SYSD's Integrated Pest Management Plan may be viewed at www.sysdschools.org.

Student Name:_____ Date of Birth: _____

Address: _____

City: _____ Zip Code:_____

Telephone No.:_____ Grade: _____

School: _____

- ❑ I would like to be pre-notified every time a pesticide application is to take place at the school. I understand that the notification will be provided at least 72 hours before the application.
- ❑ I do not need to be notified every time a pesticide application is to take place at the school. I understand that the notification will be posted at least 24 hours before the application.

_____ _____

Signature of Parent/Guardian (if student is under 18) Signature of Student (if student is 18 or older)

SAN YSIDRO SCHOOL DISTRICT
TECHNOLOGY ACCEPTABLE USE AGREEMENT

While using SYSD PROVIDED TECHNOLOGY either at home or school, all District students are expected to observe the requirements of the District's Use of Technology in Instruction and Student Use of Technology policies. These requirements are set forth in District Board Policy and Board Policy/Administrative Regulation.

In particular, you should be aware that the District is providing content-filtering for any internet usage your student may engage in while using District-provided technology at home. Students and parents/guardians are therefore responsible to ensure that students engage in responsible use. The District is not liable for any inappropriate content that may be accessed during this period of time.

Inappropriate conduct by students in regards to the use of District-provided technology includes, but is not limited to:

- Accessing material that is obscene, pornographic or harmful to minors.
- Use of District-provided technology and/or resources to harass or bully others.
- Destruction or damage to equipment, software, or data belonging to the District or others.

All District-provided technology are the sole, exclusive property of the District. Any cost involved in replacement or repair of a computer is the responsibility of the student and/or parent(s)/guardian(s).

Parent or Legal Guardian Printed	Parent or Legal Guardian Signature	Date

SAN YSIDRO SCHOOL DISTRICT
CONCUSSION AND HEAD INJURY INFORMATION SHEET
AND SIGNATURE FORM
2025-2026

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 complication 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 the loss of consciousness. Signs and symptoms of a concussion may show up right after the injury and 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 a concussion yourself, seek medical attention right away.

Signs and symptoms of a concussion may include one or more of the following:

Headaches	Amnesia
Pressure in the head	Slurred speech
Nausea and vomiting	Fatigue or low energy
Neck pain	Loss of consciousness
Balance problems or dizziness	Nervousness or anxiety
Blurred, double, or fuzzy vision	Irritability
Sensitivity to light or noise	Ringing in the ears
Feeling sluggish or slow	Confusion
Feeling foggy or groggy	Concentration or memory problems
Drowsiness	Change in sleep pattern
Sadness/More emotional	Repeating the same comment/question
Seizures/convulsions	Shows behavior or personality changes

What can happen if my child keeps on playing with a concussion or returns to school?

Athletes with the signs and symptoms of a 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. This can lead to prolonged recovery, or even severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key for student/athlete safety.

If you think your child has suffered a concussion

Pursuant to Education Code section 49475, any athlete even suspected of suffering a concussion shall be immediately removed from the athletic activity for the remainder of the day. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance from a licensed healthcare provider. If the licensed health care provider determines that the athlete sustained a concussion or a head injury, the athlete shall also complete a graduated return-to-play protocol of no less than seven days in duration under the supervision of a licensed health care provider.

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***."

For current and up-to-date information on concussions, you can go to:
https://www.cdc.gov/heads-up/?CDC_AAref_Val=https://www.cdc.gov/headsup/youthsports/index.html

This sheet shall be signed and returned by the athlete's parent or guardian before the athlete may participate in practice or competition for any contact sport.

Student-athlete Name Printed	Student-athlete Signature	Date
Parent or Legal Guardian Printed	Parent or Legal Guardian Signature	Date

Adapted from the CDC and the 3rd International Conference on Concussion in Sport Documents created 05/20/10.

SAN YSIDRO SCHOOL DISTRICT
SUDDEN CARDIAC ARREST
INFORMATION SHEET
2025-2026

Sudden Cardiac Arrest (SCA) is a life-threatening emergency that occurs when the heart suddenly stops bearing. It strikes people of all ages – including children and teens – and can lead to death in minutes if the individual does not get help immediately. **Survival depends on people nearby calling 911, starting CPR[1], and using an available AED[2] as soon as possible**.

SCA is not the same as a heart attack. Here are some key differences:

SCA VICTIM:	**HEART ATTACK VICTIM:**
Unresponsive	Responsive
Not breathing normally	Breathing
Needs CPR/AED	Does not need CPR/AED

Recognizing SCA as it occurs is imperative to survival; it is the third leading cause of death in the United States. It affects 1,000 people every day, and only 1 in 10 currently survive. However, the administration of CPR and AED from bystanders can improve the survival rate to 5 in 10.

If an athlete has passed out or fainted during an athletic activity, the athlete shall immediately be removed from the athletic activity for the remainder of the day, and shall not be permitted to return to any athletic activity until the athlete receives written clearance to return to athletic activity from a licensed healthcare provider. If the licensed healthcare provider suspects that the athlete has a cardiac condition that puts the athlete at risk for sudden cardiac arrest or other heart-related issues, the athlete shall remain under the care of the licensed healthcare provider to pursue a follow-up testing until the athlete is cleared to play.

Each athlete and the athlete's parent/guardian must sign and return this information sheet before initiating practice or competition. However, athletes 18 years of age or older do not need to have a parent/guardian sign, and athletes 6 years of age or younger only need the signature of their parent/guardian.

_____	_____	_____
Student-athlete Name Printed	Student-athlete Signature	Date
_____	_____	_____
Parent or Legal Guardian Printed	Parent or Legal Guardian Signature	Date

Adapted from the Sudden Cardiac Arrest Foundation. Learn more at sca-aware.org.

[1] CPR: Cardiopulmonary resuscitation is when you push hard and fast on the center of chest to make the heart pump; compression may be given with or without rescue breaths.
[2] AED: Automated external defibrillator is a device that analyzes the heart and if it detects a problem may deliver a shock to restart the heart's normal rhythm.

SAN YSIDRO SCHOOL DISTRICT

2025-2026 ORAL HEALTH ASSESSMENT FORM

California law (Education Code section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	**Last Name:**	**Middle Initial:**	**Child's birth date:**
Address:			**Apt.:**
City:			**ZIP code:**
School Name:	**Teacher:**	**Grade:**	**Child's Sex:** □ **Male** □ **Female**
Parent/Guardian Name:	**Child's race/ethnicity:** □ **White** □ **Black/African American** □ **Hispanic/Latino** □ **Asian** □ **Native American** □ **Multi-racial** □ **Other**_____ □ **Native Hawaiian/Pacific Islander** □ **Unknown**		

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)
IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	**Caries Experience (Visible decay and/or fillings present)** □ **Yes** □ **No**	**Visible Decay Present:** □ **Yes** □ **No**	**Treatment Urgency:** □ **No obvious problem found** □ **Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation)** □ **Urgent care needed (pain, infection, swelling or soft tissue lesions)**

_____ _____ _____
Licensed Dental Professional Signature ***CA License Number*** ***Date***

Section 3: Waiver of Oral Health Assessment Requirement
To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

□ I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:

□ Medi-Cal/Denti-Cal □ Healthy Families □ Healthy Kids □ Other _____ □ None

□ I cannot afford a dental check-up for my child.

□ I do not want my child to receive a dental check-up.

Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement:

► _____
Signature of parent or guardian ***Date***

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school of your child's first school year.

STUDENT INSURANCE
A VENBROOK COMPANY

Voluntary Student Accident Medical Insurance

K-12 Schools 2025-26

Accidents aren't supposed to happen, but they do.

School recess, after-school care, intercollegiate sports, field trips, and general school-related activities can all lead to unexpected injuries. Your school offers Voluntary Accident Insurance Plans, providing affordable protection during school hours or around the clock to ensure your loved ones get the care they need without financial hardship to your family. Choose from coverage options ranging from Low to High and find the plan that best fits your family's needs and budget.

Any enrolled student is eligible for coverage.

- School Time Accident Only
- Optional Football Coverage
- 24-Hour Accident Only
- 24-Hour Dental

Voluntary Accident plans offered by your school are considered excess plans.

Enrolling is easy and only takes a few minutes.

Go online at https://bit.ly/3Q5hrzi

1. Click on "Enroll Online".
2. Select your state and click "Look Up".
3. Select your school or district from the list.
4. Review the available plan options and make your selections.
5. Complete the online application.
6. Pay a one-time, annual cost via credit or debit card.
7. Print the confirmation of purchase as your proof of coverage.

STUDENT INSURANCE
A VENBROOK COMPANY

Filing a Claim:

Complete the Gerber Life claim form with details of the injury and any additional insurance*

- Access a claim form at k12specialmarkets.com/claimforms.
- Select your state and click "Look Up" to select your school or district.
- Forms requires a parent and a school official's signature. Be sure to include any information about private or additional insurance coverage, if applicable.
- Submit your completed form by mail, fax or electronically.
- An acknowledgment letter will be sent to the address on file, accompanied with a claim number.
- Reference your claim number when submitting any bills for treatment or medical care received from a provider.

** If you have private insurance, this voluntary accident plan will be secondary to your existing insurance. If you are covered by state-funded insurance (such as Medi-Cal/Medicaid, Medicare, or military insurance), or if you are uninsured, this plan will act as primary coverage and help cover eligible expenses.*

About Student Insurance:

Since 1950, Student Insurance (SI) has delivered competitive pricing on comprehensive Student Accident Insurance coverage to the K-12 segment. SI is dedicated to helping families manage the unexpected costs of student injuries through flexible, easy-to-access coverage options. Comprehensive policy details regarding benefits, exclusions, and limitations are available by contacting your school or district office.

Please note: Students are able to purchase coverage only if their school district is a policyholder with the insurance company.

How can we help?
Contact a Student Healthcare Expert
at: SIRep@studentinsuranceusa.com
to learn more.

Student Insurance
6320 Canoga Ave, 12th Floor
Woodland Hills, CA 91367
Studentinsuranceusa.com

Youth Insurance Agency, Inc. DBA Student Insurance | CA License 0386216
6320 Canoga Ave, 12th Floor • Woodland Hills, CA 91367 • www.studentinsuranceusa.com

2025 – 2026 STUDENT ACCIDENT INSURANCE COVERAGE

OPTIONAL SCHOOL TIME ACCIDENT COVERAGE - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option); Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity.
Annual Premium: Plan "Low" – $14.00 Plan "Medium" – $28.00 Plan "High" – $43.00

OPTIONAL 24-HOUR ACCIDENT COVERAGE - Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. Coverage is provided for participation in Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option).
Annual Premium: Plan "Low" – $82.00 Plan "Medium" – $105.00 Plan "High" – $210.00

OPTIONAL FOOTBALL COVERAGE - Covers Accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is covered when going directly and uninterruptedly to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Refer to benefits and limitations described inside this brochure. Optional Football Coverage begins on the date of premium receipt and ends on the last day of practice or competition. Ninth Graders who play with 9th graders ONLY are not charged extra for football coverage. Their Optional School-Time or Optional 24-Hour Accident Coverage will apply if purchased.
Annual Premium: Plan "Low" – $85.00 Plan "Medium" – $115.00 Plan "High" – $215.00

OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage) – Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is $25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of $1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth. **Annual Premium: $8.00**

COVERAGE PERIOD – Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted **(no pro rata premiums available)**.

SCHEDULE OF BENEFITS

Coverage for Injuries due to Accidents only

Maximum Benefit:	**Plan "Low"**	**Plan "Medium"**	**Plan "High"**
School-Time Option	$25,000	$50,000	$100,000
24-Hour Option	$25,000	$50,000	$100,000
Football Option	$25,000	$50,000	$100,000
Injuries Involving Motor Vehicles	$10,000	$10,000	$ 10,000
Death Benefit/Double Dismemberment	$10,000	$20,000	$ 20,000
Single Dismemberment	$ 5,000	$10,000	$ 10,000
Loss Period for Medical Benefits	Treatment must begin within 60 days from the date of Injury		
Benefit Period for Medical and AD&D/Loss of Sight Benefits	1 Year	1 Year	1 Year
Excess Coverage Applicability	Full Excess	Full Excess	Full Excess
Hospital/Facility Services - Inpatient			
Hospital Room and Board (Semi-Private Room Rate)	65% RE*	75% RE*	80% RE*
Inpatient Hospital Miscellaneous	65% RE*	75% RE*	80% RE*
Hospital/Facility Services - Outpatient			
Free-Standing Ambulatory Surgical Facility	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Outpatient Hospital Miscellaneous (Except physician services and x-rays paid as below)	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Hospital Emergency Room	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Physician's Services			
Surgical	65% RE*	75% RE*	80% RE*
Assistant Surgeon	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Anesthesiologist	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Physician's Outpatient Treatment in connection with Physical Therapy and/or Spinal Manipulation	65% RE* / $25 Visit/5 Visit Max.	75% RE* / $30 Visit/7 Visit Max.	80% RE* / $40 Visit/8 Visit Max.
Physician's Non-surgical Treatment (Except as above)	65% RE*	75% RE*	80% RE*
Other Services			
Registered Nurses' Services	65% RE*	75% RE*	80% RE*
Prescriptions - outpatient	65% RE*	75% RE*	80% RE*
Laboratory Tests – Outpatient	65% RE*	75% RE*	80% RE*
X-rays, includes interpretation – Outpatient	65% RE*	75% RE*	80% RE*
Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation	65% RE*	75% RE*	80% RE*
Ground Ambulance	65% RE*	75% RE*	80% RE*
Durable Medical Equipment (includes Orthopedic Braces & Appliances)	65% RE*	75% RE*	80% RE*
Dental Treatment to sound, natural teeth due to covered injury	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Replacement of eyeglasses, hearing aids, contact lenses, if medical treatment is also received for the covered injury.	$150 Maximum	$500 Maximum	$700 Maximum

***RE means Reasonable Expense**

GER_0418 EFTB(0009)

2025 – 2026 ENROLLMENT APPLICATION (please print or type)

Student's Last Name _____ Student's First Name _____ Student's Middle Initial _____ Grade _____

Address _____ City _____ State _____ Zip _____

Telephone Number _____ Birthdate _____

School System _____ Name of School _____

Check your selection:

Plan "Low"	❑ School-Time $14.00	❑ 24-Hour Accident $ 82.00	❑ Football $ 85.00	❑ 24-Hour Dental $8.00
Plan "Medium"	❑ School-Time $28.00	❑ 24-Hour Accident $105.00	❑ Football $115.00	❑ 24-Hour Dental $8.00
Plan "High"	❑ School-Time $43.00	❑ 24-Hour Accident $210.00	❑ Football $215.00	❑ 24-Hour Dental $8.00

Please make check payable to Gerber Life Insurance Company

Total Enclosed: _____

Signature of Parent or Guardian _____ Date _____

EXCESS COVERAGE PROVISION The Company will pay Reasonable Expenses that are not recoverable from any Other Plan. The Company will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or similar provisions. The amount from Other Plans includes any amount, to which the Insured is entitled, whether or not a claim is made for the benefits. This Blanket Student Accident Insurance is secondary to all other policies. This provision will not apply if the total Reasonable Expenses incurred for Hospital and Professional Services Benefits are less than the amount stated in the Schedule of Benefits under Excess Coverage Applicability.

MEDICAL BENEFITS When a covered Injury to a student results in 1) treatment by a legally qualified Physician or surgeon (other than a member of the immediate family or person retained by the school) or 2) Hospital confinement, and treatment begins within 60 days from the date of Injury, the Company will pay the benefit as shown in the Schedule of Benefits, subject to the Excess Coverage Provision above. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the Accident are covered. Benefits for any one Accident shall not exceed in the aggregate the maximum stated in the Medical Benefit plan purchased. Expenses incurred after one year from the date of Injury are not covered, even though the service is a continuing one, or one that is necessarily delayed beyond one year from the date of Injury.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT When a covered Injury results in any of the Losses to the Insured which are stated in the Schedule of Benefits for Accidental Death, Dismemberment, or Loss of Sight then the Company will pay the benefit stated in the schedule for that Loss. The Loss must be sustained within 365 days after the date of the Accident.

The maximum benefit payable under this provision is stated in the Schedule of Benefits under Maximums and Benefit Period: 1) Life 2) Both Hands or Both Feet or Sight of Both Eyes; 3) Loss of One Hand and One Foot; 4) Loss of One Hand and Entire Sight of One Eye; 5) Loss of One Foot and Entire Sight of One Eye; 6) Loss of One Hand or Foot; 7) Loss of Sight in One Eye; 8) Loss of Thumb and Index Finger of the Same Hand. Half of the maximum benefit will be paid for the Loss of one Hand, one Foot or the Sight of one eye. Loss of Hand or Foot means the complete Severance through or above the wrist or ankle joint. Loss of Sight means the total, permanent Loss of Sight in One Eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means. Loss of Thumb and Index Finger of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). Severance means the complete separation and dismemberment of the part from the body. If the Insured suffers more than one of the above covered losses as a result of the same Accident the total amount the Company will pay is the maximum benefit. Benefits paid under this provision will be paid in addition to any other benefits provided by the Policy. Benefits under this provision are subject to all other provisions of the Policy, including all Coverage and Limitations, Maximums and Exclusions.

DEFINITIONS Injury means bodily injury caused by an Accident. The Injury must occur while the Policy is in force and while the Insured is covered under the Policy. The Injury must be sustained as stated on the face page of the Policy, except where specifically stated otherwise in the Policy. **Accident** means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Insured is covered under the Policy. **Other Plan** means any other valid and collectible insurance or self-funded plan such as: individual and family type insurance coverage; group, blanket or franchise insurance, group hospital, medical service, pre-payment, trustee, Union Welfare; Blue-Cross, Blue Shield, group practice or other pre-payment coverage; labor-management plans, or employee benefit organization plans; self-funded ERISA plan, Workers' Compensation Law, Occupational Disease Law or any similar legislation; Medicare; or "No-Fault" auto legislation, where applicable. **Reasonable Expense** means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided. Such services and supplies must be recommended and approved by a Physician.

EXCLUSIONS No Benefits are payable for Hospital and Professional Services for the following: 1) Injuries which are not caused by an Accident; 2) Treatment for hernia, regardless of cause, Osgood Schlatter's disease, or osteochondritis; 3) Injury sustained as a result of operating, riding in or upon, or alighting from a two-, three-, or four-wheeled recreational motor vehicle or snowmobile; 4) Aggravation, during a Regularly Scheduled Activity, of an Injury the Insured suffered before participating in that Regularly Scheduled Activity, unless the Company receives a written medical release from the Insured's Physician; 5) Injury sustained as a result of practice or play in interscholastic tackle football and/or sports, unless the premium required under the Football and/or Sports Coverage provision has been paid; 6) Any expense for which benefits are payable under a Catastrophic Accident Insurance Program of the State Interscholastic Activities Association; 7) Treatment performed by a member of the Insured's Immediate Family or by a person retained by the School; 8) Injury caused by war or acts of war; suicide or intentionally self-inflicted Injury, while sane or insane; violating or attempting to violate the law; the taking part in any illegal occupation; fighting or brawling except in self defense; being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; or being under the influence of any drugs or narcotic unless administered by or on the advice of a Physician; 9) Medical expenses for which the Insured is entitled to benefits under any (a) Workers' Compensation act; or (b) mandatory no-fault automobile insurance contract; or similar legislation; 10) Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain; and 11) Expenses incurred for experimental or investigational treatment or procedures.

RETAIN THIS DESCRIPTION FOR YOUR RECORDS

This is not a Policy, rather a brief description of the benefits provided under the master policy issued to the school. Please refer to the master policy for further details. **IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. This brochure has been designed to illustrate the highlights of this insurance. All information in this brochure is subject to the provisions of Policy Form COL-11(CA), underwritten by Gerber Life Insurance Company (the Company). If there is any conflict between this brochure and the Policy, the Policy will prevail. Please see the Master Policy for individual state details.**

HOW TO FILE A CLAIM

Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company. Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss.

In the event of an Accident, students should: 1) Secure treatment at the nearest medical facility of their choice; 2) If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits notice from your primary carrier, send it to us; 3) Obtain a receipt (if payment of any bills were made) and itemized copy of charges from the provider of medical services and send copies of their itemized bills and the fully completed and **signed** accident claim form to the claims office – mail all correspondence to WEB-TPA, P.O. Box 2415, Grapevine, TX 76099-2415; and 3) **Call 1-866-975-9468** with any Claims questions.

UNDERWRITTEN BY:
Gerber Life Insurance Company
White Plains, NY 10605

MARKETING AGENT:
Student Insurance
6320 Canoga Ave, 12th Floor
Woodland Hills, CA 91367
(310) 826-5688

To apply for coverage, please enroll on-line with a credit card at www.k12specialmarkets.com ***or cut along the dotted line, complete the form and mail it, along with your check or money order, to the Please Return To: address shown below.***

Please Return To: Student Insurance
c/o K12Special Markets Plan Administrators
1055 Main Street, Suite 101
Stevens Point, WI 54481

PLEASE READ THIS INFORMATION CAREFULLY. It is important.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED

NOTE: The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis, and in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

Claim Guidelines: The following guidelines must be followed.

♦Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

♦If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

1) HCFA-1500 (standard form used by Providers; sample attached)
2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
3) ADA Dental Claim Form and a letter from the dentist verifying the injured tooth was whole, sound and natural. (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Organization/School name found on the claim form
3. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

♦If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

♦Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident. File claim electronically by clicking here.

♦If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

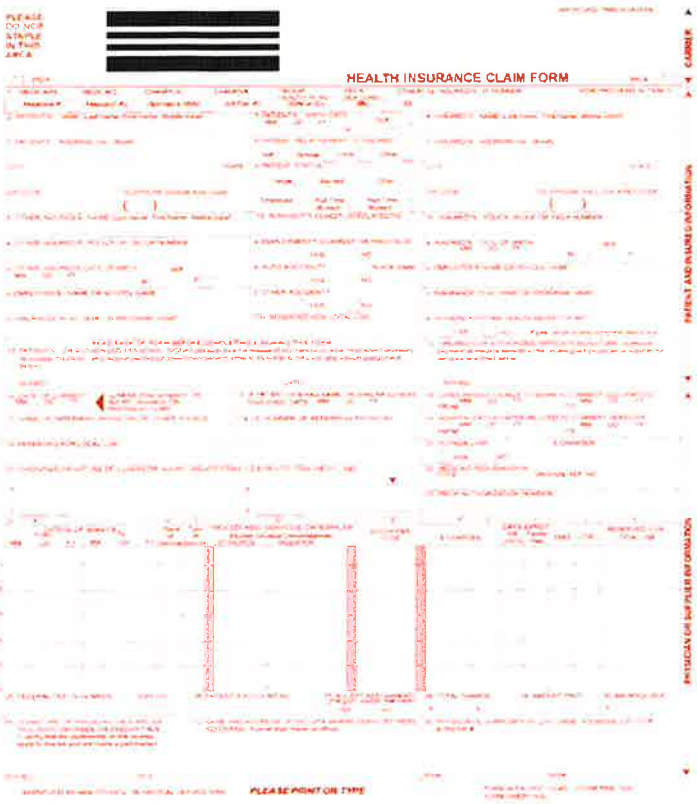
♦Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

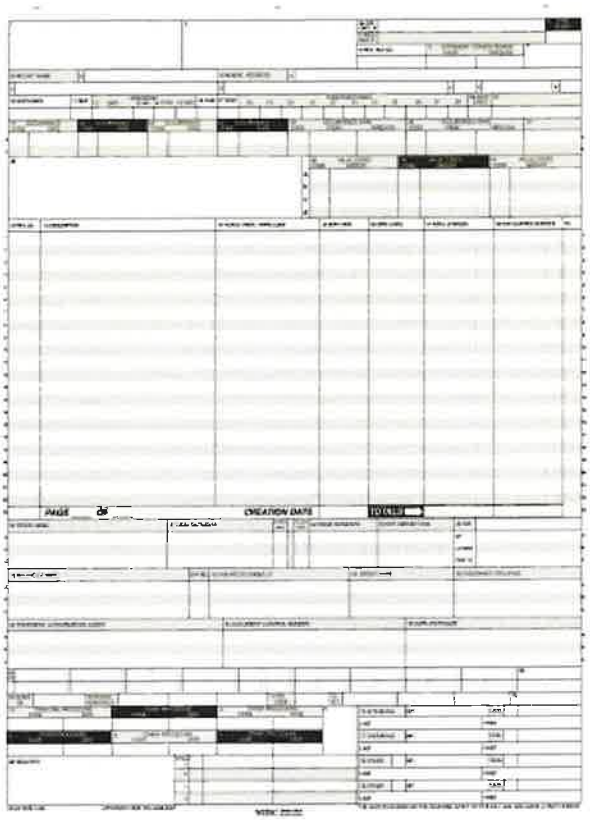
1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

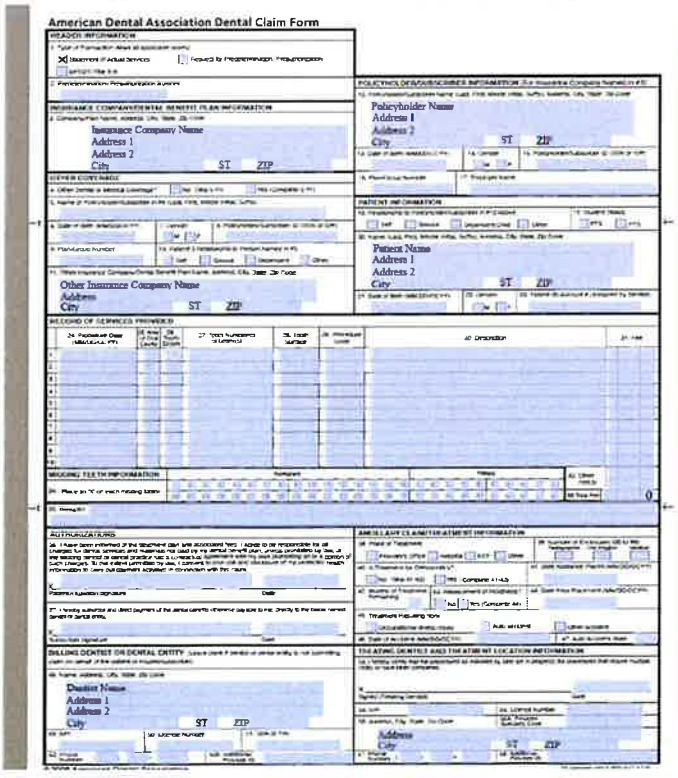
SAMPLE HCFA 1500



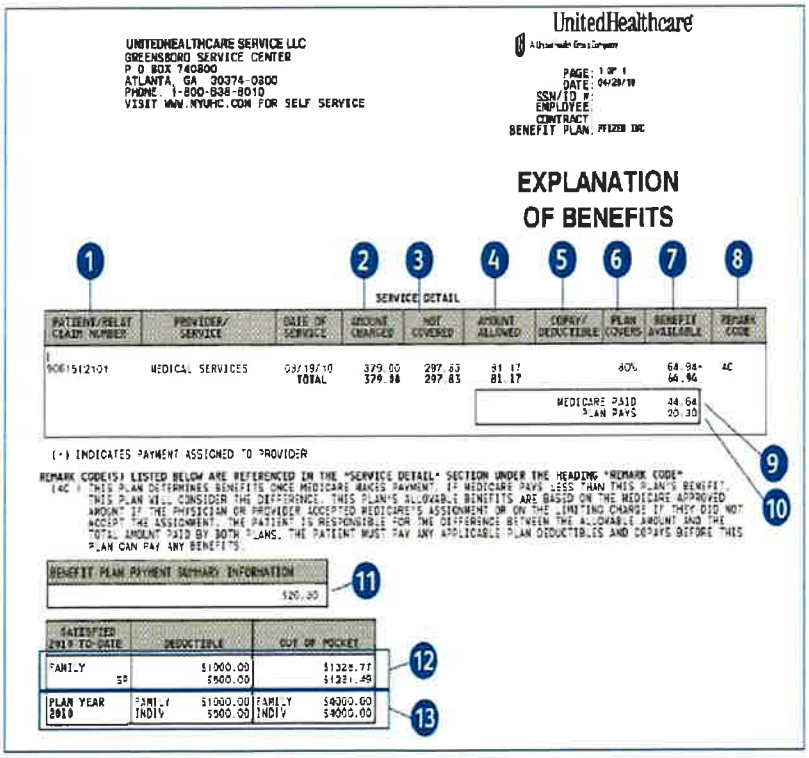
SAMPLE UB-04



SAMPLE ADA DENTAL CLAIM FORM



SAMPLE EOB (EXPLANATION OF BENEFITS)



Gerber Life Insurance Company

CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2
ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE
SEND ALL CORRESPONDENCE TO:

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Fax: 469-417-1969
Email: benefit.assist@webtpa.com
File Electronically: Click Here

IMPORTANT NOTICE:
This plan of insurance is secondary, in most instances, to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: **The accident policy benefits are limited and may not provide 100% coverage.**

IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED

PART 1-A – TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District/College Name San Ysidro School District Policy Number 05-4215-25

School/Team/League Name _____ Phone No. ( )_____

Address _____ Email _____

_____ Type of Activity/Sport _____

If Athletics, designate ☐P.E. Class ☐Intramural ☐Interscholastic ☐Intercollegiate ☐Game ☐Jr. Varsity ☐Varsity ☐Youth ☐Adult ☐Practice ☐Other _____

Name of injured person/student _____

Date of Accident _____ Accident Time _____

Date of First Treatment _____ Has treatment been completed? ☐Yes ☐No

Where and how did accident occur? (Please be specific) _____

_____

_____

_____

Part of body Injured _____ ☐Right or ☐Left At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? ☐Yes ☐No

Under whose supervision? _____ Was he/she a witness? ☐Yes ☐No

Authorized Signature _____ Title _____ Date _____

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B – TO BE COMPLETED IN FULL BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Injured Party/Student Legal Name _____ Preferred/Nickname:_____

Date of Birth _____ Age _____ Grade Level _____ ☐Male ☐Female

Claimant is a ☐Student ☐Player ☐Coach ☐Official/Umpire ☐Volunteer ☐Child Care ☐Participant ☐CE Student (# of credits_____)

Address of Injured Person or Parents/Guardian _____

_____

Phone No. ( )_____ Email Address _____

If Injured party is over age 18: Employer Name and Address _____

_____

Phone No. ( )_____ ☐Self Employed ☐Unemployed

Father/Guardian Name _____

Employer Name and Address _____ Phone No. ( )_____

_____ ☐Self Employed ☐Unemployed

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Mother/Guardian Name _____

Employer Name and Address _____ Phone No. ( )_____

_____ ☐Self Employed ☐Unemployed

If Dental Injury: Please submit verification from the dentist that the tooth/teeth are whole, sound and natural.

Is claimant covered under any other medical and or dental insurance policy? ☐Yes ☐No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐Yes ☐No

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company	**Address**	**Policy #**

Are benefits due for this claim under these other insurance coverages? ☐Yes ☐No **(See IMPORTANT NOTICE at top of form on page 1)**

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree? ☐Yes ☐No If yes, please give name, address and phone number of responsible party _____

_____

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

Signature: Injured Person, Parent or Guardian _____ Date: _____

SIGNATURE IS REQUIRED

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: Injured Person, Parent or Guardian _____ Date: _____