



JOHNSON COUNTY SCHOOLS
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ATHLETIC AND STUDENT ACCIDENT NOTIFICATION OF INJURY

PART I — SCHOOL REPORT

Date of Accident: _____ Time of accident: _____

Name of school child attends: _____ Telephone: _____

Name of student: _____ Grade: _____

Social Security # _____ Birthdate: _____ Gender: _____

Part of body injured: _____ Right _____
Left _____

Describe the nature of the injury

Name of Activity/Class: _____

Person completing this form: _____ Title: _____ Date: _____

PART II — TO BE COMPLETED BY CLAIMANT — OR PARENT IF CLAIMANT IS A MINOR

Name of parent(s)/guardian(s): _____

Address: _____ City: _____

State: _____ Zip: _____ Daytime telephone# _____

Authorization: I hereby authorize any physician or hospital that has treated or attended the above claimant to furnish the insurance company and its representatives any information requested. A photocopy of this authorization is to be considered valid.

Signature of parent/guardian: _____ Date: _____

EMAIL ADDRESS: _____

**Johnson County School System
Accident/Emergency Report**

Student Name: _____ **Date:** _____

School: _____ **Grade:** _____ **Age:** _____

Teacher: _____ **Time of Incident:** _____

Time Parent Contact Initiated: _____ **Contact Made:** _____

Parent or Guardian Name: _____

Address: _____

Phone #: _____

Place of Accident: _____

Description of Today's Accident **Date:** _____ **Time:** _____

Description: _____

**Observations/Student
Condition:** _____

**Intervention/Treatment
Administered:** _____

Witness (es): _____

Signature-Person Filing Report: _____

Signature-Parent or Guardian: _____

Signature-Person Picking Up Child: _____

Signature-Principal: _____

Email Addresses of Parent or Guardian: _____ (REVISED 3-18-2022)



ATHLETICS & STUDENT ACCIDENT PROGRAM

LIMITS AND BENEFITS

The Student Accident coverage provided by TNRMT has **no deductible** and a medical maximum benefit of **\$25,000 per accident**. Specific sublimits apply for covered expenses (**see schedule of benefits**).

All benefits are provided on a **Full Excess** basis for covered expenses. This means that covered expenses will be paid when they are *"in excess of any other plan providing medical expense benefits."* Thus, parents must submit all bills to their primary provider first. The TNRMT policy will consider the unpaid balances for covered expenses up to the limits of the policy. A **PROOF OF LOSS**, (claim form) must be submitted within 90 days. No claim will be considered if **PROOF OF LOSS** is not submitted within 365 days after the accident.

Parents will receive a letter from (TNRMT) within seven days of the claim being submitted. This letter must be completed and returned to TNRMT within 90 days for the processing of your claim to begin.

BENEFITS

Maximum Limit	Plans Purchased by School District (Full Excess)	\$25,000 per Accident
Physicians		
Surgery/fracture care fees		U&C (\$6,000 Max.)
Non-surgical visits or consultations		\$125 per visit
Physical therapy		\$50 visit/Max \$1,000
Hospital		
In-patient room and board		Semi-private room
In-patient miscellaneous charges		\$6,000 per injury
Out-patient charges (non-surgical)		\$1,000 per injury
Out-patient charges (surgical)		\$5,000 per injury
Diagnostic X-rays, MRIs, CAT Scans		\$2,000 per injury
Dental		
Amount payable for each injured sound, natural tooth		\$1,000 per tooth
Orthopedic Appliances		\$1,500 per injury
Ground Ambulance Service		\$1,000 per injury
Maximum Motor Vehicle Accident Benefit		\$1,000 per injury

Benefits described are provided by Tennessee Risk Management. This is not a contract of insurance.

TNRMT contact info is as follows (please allow them time to receive our claim report and attempt to contact you):

888-743-4336 (Ask for Student Accident Team Member)

studentaccident@tnrmt.com