Oxford Academy and Central School
Oxford, New York 13830 · 607-843-2025 · FAX 607-843-3241

DAVID S. RICHARDS, Ph.D.,
Superintendent
JOSEPH L. GUGINO,
Business Administrator

Oxford Academy & Central School Medical Insurance Information

Oxford Academy and Central School pupils are insured by the Pupil Benefits Plan, established and sponsored by the New York State Public High School Athletic Association and supervised by the New York State Insurance Department.

This policy is an "excess coverage" policy. Excess coverage means that if you have a medical insurance plan, your plan must be used first. The policy is also a schedule policy. There is a set rate for each medical service provided. If your own insurance does not fully cover a problem, our insurance will pay according to the established schedule.

If you do not have family insurance, our insurance will only pay according to the Pupil Benefits Plan Schedule of fees. Any costs above the fees become the responsibility of the family.

If your child is injured at school or at a school sponsored activity, you will receive a Pupil Benefits Claim form from the school Business Office. If, after submitting your bills to your Insurance Company you have a claim to file with Pupil Benefits, the parent should follow the following steps:

1. Have the physician or dentist complete the bottom half of the claim form marked Statement of Physician or Dentist.
2. Complete and sign all information on the back of the claim form marked Parent.
3. For charges in excess of all final payments under other policy(s) attach: (a) A copy of all benefits paid. (b) A copy of rejection of benefits.
4. Submit to the school the completed claim, including all charges at the earliest possible date.

Important

1. Pupils shall report injury to the teacher, school nurse or coach at the time of injury.
2. When the pupil receives medical treatment, advise the school nurse at once.
3. Report of the injury shall be made within 30 days to be eligible for a claim.
4. Final date for submission of claim to the Plan Office shall be one year from the date of injury.

Oxford Academy & Central School

CONFIDENTIAL INITIAL HISTORY QUESTIONNAIRE

This sheet needs to be filled out and returned to the Health Office on or before the student's first day of school.

Child's Name:_____ Date:_____

Date of Birth: _____ Sex: _____

ALLERGIES: (Please list all allergies and responses ie. Rash, vomiting, etc)

Please include ALL allergies (medication, food, insects)

_____

_____

_____

PAST ILLNESSES: (Please circle)

Chickenpox	Meningitis	Tuberculosis	Hepatitis
Mononucleosis	Rheumatic Fever	Pneumonia	No Illnesses

Other_____

CHRONIC ILLNESSES: (Please circle)

Asthma	Cancer	Epilepsy/Seizures	Cystic Fibrosis
Diabetes	Heart Disease	Intestinal Disease	Kidney Disease
Liver Disease	High Blood Pressure	HIV/AIDS	Hyperactivity
Sickle Cell Anemia	No Illness	Other _____	

HOSPITALIZATIONS, ACCIDENTS, SURGERIES, BROKEN BONES: (Please list)

_____

_____

_____

MEDICATIONS:

Name of Medication Amount/how often taken Prescribing doctor

_____

_____

_____

HEALTH PROBLEMS:

_____

_____

_____

FAMILY HISTORY: (Please note relation to student)

Seizure disorder_____ Anemia_____ Tuberculosis_____ Asthma_____

Kidney Disease_____ Cystic Fibrosis_____ Cancer_____ Birth Defects_____

High Blood pressure_____ Diabetes_____ Obesity_____

Developmental Delays_____ High Cholesterol_____

Death before the age of 50 (other than accident)_____

FAMILY CONCERNS: _____

_____

_____

_____

Name:_____Date of Birth_____

Last First Middle

Father's Name_____phone _____

Home Address _____

Work Place _____phone_____

Mother's Name_____phone_____

Home Address_____

Work Place_____phone_____

Legal Guardian_____

Phone_____Address_____

Work place_____phone_____

Where should child be sent in case of illness?

Name_____phone_____

address_____

Where should child be sent in case of unexpected school closing?

Name_____phone_____

address_____

Contact in case of Emergency?

Name_____phone_____

Name_____phone_____

Name_____phone_____

Name of Preferred Hospital (if choice is possible)_____

Medical Provider_____

Dentist _____

_____

Signature of Parent or Guardian date