

Athlete Insurance & Emergency Information

2009-2010

Athlete Name _____ Birth date ____/____/____

Family Physician _____ Phone # (____) _____

Parent Names _____ Home phone # (____) _____

Emergency Contact Information

Contact Person _____ Relationship _____

Home # (____) _____ Work # (____) _____ Cell # (____) _____

Primary Policy

Secondary Policy

Policy Holder: _____
 Birth date: ____/____/____
 Employer: _____
 Employer Phone #: (____) _____
 Insurance Co: _____
 Address: _____
 City/St/Zip: _____
 Ins. Telephone # (____) _____
 Policy ID#: _____
 Group #: _____
 Effective date: ____/____/____

 ____/____/____

 (____) _____

 (____) _____

 ____/____/____

Type of policy: (Circle one) HMO PPO POS Standard

HMO PPO POS Standard

Prescription Coverage: YES NO

YES NO

I give my permission to release information to the health provider in the event the student-athlete needs treatment off-campus.

Policy holder signature: _____ Date: ____/____/____