



School Year: _____
 Sport: _____
 Student ID #: _____
 Grade: _____

STUDENT-ATHLETE MEDICAL RELEASE & INSURANCE FORM
 (Please print)

Student - Athlete's Name:

_____ Date of Birth: _____ Age: _____

Address: _____ City/ State: _____ Zip Code: _____

Mother/Guardian's Name:

_____ Cell Phone: _____

Email: _____ Home Phone: _____

Mother/Guardian's Employer: _____ Employer's Phone: _____
(If not applicable, please indicate N/A)

Father/Guardian's Name:

_____ Cell Phone: _____

Email: _____ Home Phone: _____

Father/Guardian's Employer: _____ Employer's Phone: _____
(If not applicable, please indicate N/A)

Consent is given for school personnel to use their judgment, in securing medical aid,
 in the event parent/guardian cannot be contacted: (Please check) Yes No

Student's Physician: _____ Phone: _____

Preferred Hospital: _____ Known Allergies & Conditions: (Please list below)

If parents cannot be reached, please call:

Name _____ Phone _____ Relationship _____

Is your child covered under a family medical insurance plan? (Please check) Yes No

Primary Insured's Name _____ Insurance Company _____

Insurance Policy Number _____

I have read and understand the insurance booklet. I understand my student-athlete may not attend and/or participate in a sport until their insurance payment and all other necessary forms are received by the school. I also understand school's cannot refund/return insurance payments, for any reason.

 Parent/Guardian's Signature:

 Parent/Guardian's Printed Name:

DATE: _____

*Please return this completed form and applicable payment to your school's Athletic Office.