



Emergency Contact and Insurance Information Form

Name _____

Date of Birth _____ Sport _____

SSN _____ Academic Year _____

Parents/Guardians Name _____

Address _____

Home Phone _____ Cell _____ Work _____

Policy Holder Name and DOB _____

Relationship to Student-Athlete _____

Address _____ Home Phone _____

Work Phone _____

Insurance Company Name _____

Insurance Company Address _____

Group # _____ I.D.# _____

Effective Date of Policy _____ Expiration Date of Policy _____

Policy Limit _____ Policy Deductible _____ Policy Co-Pay _____

Does this policy cover athletic-related injuries? _____

I authorize any Health Care Provider, Insurance Company, Person, or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment, or benefits payable to NAHGA, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I further authorize release of this information to WSCC Athletic Department staff and the WSCC Athletic Coordinator for the purpose of validating and determining benefits payable.

Parent/Guardian Signature _____ Date _____ Student/Athlete Signature _____ Date _____

This form must be completed and returned immediately to Ms. Deborah Spann, Athletic Coordinator. You should keep a copy of these documents for your records. Please attach a copy of your insurance card.