

Athletic Health Insurance Form 2009-2010
Emmanuel College Athletic Department
400 The Fenway • Boston, MA 02115 • 617-735-9847

STUDENT-ATHLETE INFORMATION

Name: _____ SSN: _____ DOB: _____
Permanent Address: _____ City: _____ ST: _____ Zip _____
Home Phone Number: (____) _____
School Address: _____
School Phone Number: (____) _____ Cell Phone Number: (____) _____
Sport Team(s) _____

INSURANCE COMPANY INFORMATION

Company Name: _____
Address: _____
Phone Number: (____) _____ Policy Number: _____ Group Number: _____
Policy Owner Policy Owner _____ DOB: _____
Relationship to athlete: _____
Primary Care Physician: _____ Phone Number: (____) _____
Does your insurance company require referrals to see a specialist? YES NO

Please list any other requirements your insurance company has for you to receive care: _____

EMERGENCY CONTACT INFORMATION

Please indicate the individual we should contact in the event of an emergency:

Name: _____ Phone: (____) _____ Relationship: _____

*I verify by my signature below that all the information reported here and on the health insurance form is current and accurate.

Signature

Date

Athletes will not be permitted to practice or compete until all forms have been submitted and have undergone a physical examination.