

**SAINT LOUIS UNIVERSITY SPORTS MEDICINE  
Acknowledgement of Insurance Requirements**

I, \_\_\_\_\_, as parent, guardian or legal representative, attest that  
(name, please print)

\_\_\_\_\_ has insurance coverage under a current, in force insurance  
(student-athlete name)

policy for injuries that occur while he/she is participating in intercollegiate athletics. This coverage has limits of at least \$75,000.

**If there is a material change in coverage or expiration of coverage, I agree to notify Saint Louis University of this development and update the insurance information I have on file with Saint Louis University.**

I understand and agree that Saint Louis University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses if I/we fail to have this primary insurance coverage.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

**THIS FORM MUST BE SIGNED AND RETURNED TO THE SAINT LOUIS DEPARTMENT OF ATHLETICS BY AUGUST 1st.**

*Return to:*  
Jonathan Burch  
Director of Sports Medicine  
Saint Louis University  
Chaifetz Arena – Sports Medicine  
3330 Laclede Blvd.  
St. Louis, MO 63108  
Telephone: 314-977-3295  
FAX: 314-977-3183

**YOU MUST INCLUDE A COPY (*FRONT AND BACK*) OF YOUR CURRENT INSURANCE CARD AND THE COMPLETED EMERGENCY CONTACT AND INSURANCE INFORMATION FORM.**

*FOR YOUR CONVENIENCE, THE INSURANCE WAIVER FORM REQUIRED BY THE SAINT LOUIS UNIVERSITY STUDENT HEALTH CENTER IS ALSO ENCLOSED.*