

INSURANCE FORM FOR STUDENT ATHLETICS

Please note: Students cannot participate in PRACTICES or games until this form is completed.

Athlete's Name:*Last,**First,**M.I.* M
 F**Social Security # :** ____-____-____

Dear Parent:

Our athletic accident policy, which provides insurance for your son or daughter for injuries occurring while participating in the play or practice of intercollegiate sports in "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. This means that any claim for benefits must first be filed with the group insurance company providing coverage to your son or daughter through your employer or your spouse's employer. After they have paid all available benefits, our athletic insurance company will consider remaining amounts based on USUAL and CUSTOMARY charges.

WE, AS THE SCHOOL, **DO NOT** HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR GROUP INSURANCE.

PLEASE NOTE:

1. Most employer's group insurance allows dependent coverage to be continued to age 23 if the dependent is a full-time student. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.
2. Claims against your group insurance plan DO NOT increase your individual insurance premiums.

Father/Mother/Guardian/Spouse/Self (circle one)

Name: _____ Social Security # _____

Home Address: _____
(Street) (City, State & Zip Code)

Employer's Name: _____

Employer's Address: _____
(Street) (City, State & Zip Code)

Home Telephone # _____ Work Telephone # _____

Name of Group Insurance Company _____

Group # _____ Policy# _____ Telephone # _____

Mailing Address for Claims _____
(Street) (City, State & Zip Code)

Does your insurance require:

A second opinion for surgery? YES ____ NO ____ Is your primary insurance an HMO? YES ____ NO ____

Pre-authorization for services: YES ____ NO ____ Is your primary insurance a PPO? YES ____ NO ____

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES ____ NO ____**Father/Mother/Guardian/Spouse/Self (circle one)**

Name: _____ Social Security # _____

Home Address: _____
(Street) (City, State & Zip Code)

Employer's Name: _____

Employer's Address: _____
(Street) (City, State & Zip Code)

Home Telephone # _____ Work Telephone # _____

Name of Group Insurance Company _____

Group # _____ Policy# _____ Telephone # _____

Mailing Address for Claims _____
(Street) (City, State & Zip Code)

Does your insurance require:

A second opinion for surgery? YES ____ NO ____ Is your primary insurance an HMO? YES ____ NO ____

Pre-authorization for services: YES ____ NO ____ Is your primary insurance a PPO? YES ____ NO ____

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES ____ NO ____

I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event of an athletic injury sustained by _____.
I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent or Guardian Signature (if student is age 18 or under)

Date

GRACE UNIVERSITY STUDENT ATHLETES ONLY

Athlete's Name: <i>Last, First, M.I.</i>	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security # : ____-____-____
Sports Interested In at Grace : _____		

Have you had:	Yes	No	Health-Care History	Yes	No
Allergies (hay fever, food...)			Have you been told not to participate in any sport?		
Close relative with heart problems before age 40			Have you been a patient in a hospital for an operation or any other reason? If so, what?		
Black-out or fainting during exercise			Are you injured or ill now?		
Fracture or dislocation			Have you had any other serious injuries?		
Knee or Ankle Sprain Left or Right?			Do you take any kind of medicine every day? If so, what?		
Memory loss or unconsciousness due to a blow to your head			Is there any other pertinent information you feel we need to know?		

SPORTS PHYSICAL - TO BE COMPLETED BY A PHYSICIAN

Age _____ Height _____ Weight _____ Blood Pressure _____ Hct _____ UA _____ Eyes R _____ L _____ Ears R _____ L _____ Nose _____ Sinuses _____ Throat/ Mouth _____ Skin _____	Respiratory _____ Cardiovascular _____ Liver _____ Spleen _____ Abdomen _____ Hernia R _____ L _____ Genitalia _____ Musculoskeletal _____ Knees _____ Ankles _____ Neurological _____	Other history we should know: _____ _____ _____ _____ _____ _____ _____ _____ _____
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*I certify that I have on this date examined this student and that, on the basis of the examination requested by the school authorities and the student's medical history as furnished to me. I have found no reason which would make it medically inadvisable for this student to compete in supervised athletic activities except those **CROSSED OUT BELOW**.*

BASKETBALL SOCCER VOLLEYBALL

Dr. Signature

Date of Examination