GSCC STUDENT INFORMATION

Academic Year _____

Emergency Contact and Insurance Information Form

Student Name _____ Social Security # _____

Address _____ Phone Number _____

Date of Birth _____ Sport _____

Parents/Guardians Name _____

Address _____

Home Phone _____ Cell _____ Emergency #_____

Father's Employer Name _____ Work #_____

Mother's Employer Name _____ Work #_____

Primary Physician Name _____ Phone Number_____

Address _____

Insurance Information

Policy Holder Name and DOB _____

Relationship to Student-Athlete _____

Insurance Company Name _____

Address _____

Phone Number _____ Policy/Group Number _____

Policy Holder's Name _____ ID Number _____

Effective Date of Policy _____ Expiration Date of Policy_____

Does this policy cover athletic-related injuries?_____

Authorization to Release Information

I/We certify that the foregoing information is true and correct. I/We authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to the Insurance 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 the GSCC Athletic Department staff for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be valid as the original.

_____ _____ _____ _____

Parent/Guardian Signature Date **Student/Athlete Signature** Date

Please attach a copy of your insurance card.