Athletes Full Legal Name ____Sport(s) ___________________

Home Address ____ City __________________ State _____ Zip _________

Home Phone # (_____) __________________ Date of Birth ______________ Social Security # _______-_____-_______

Cell Phone # (____)________________________

Parents Information

Please print clearly, or type all information requested. Do not leave any lines blank. This information is very important.

Fathers Full Name____________________________________	Mothers Full Name____________________________________
Address ____	Address ____
____	____
Social Security # ______________-__________-_____________	Social Security # ______________-__________-_____________
Date Of Birth____	Date Of Birth____
Employer ____	Employer ____
Address ____	Address ____
____	____
Day Time Phone Number________________________________	Day Time Phone Number________________________________

Medical Insurance Information

Insurance Company ___________________________________	Insurance Company ___________________________________
____	____
Claims Address ______________________________________	Claims Address ______________________________________
____	____
Policy # ____	Policy # ____
Certificate/ ID # _____________________________________	Certificate/ ID # _____________________________________
Group # ____	Group # ____
Phone #____	Phone #____
Is this the Primary Coverage for the athlete? YES ___ NO_____	Is this the Primary Coverage for the athlete? YES ____ NO____
Is this an HMO? _____ Or PPO? _____	Is this an HMO? _____ Or PPO? _____
Is pre-authorization required to see doctor? YES____NO_____	Is pre-authorization required to see doctor? YES____NO_____
Is a second opinion required before surgery? YES____NO____	Is a second opinion required before surgery? YES____NO____
List any specific Providers or Hospitals on the back of this form.	List any specific Providers or Hospitals on the back of this form.

WITH MY SIGNATURE BELOW.

- **I hereby authorize Bellarmine University and First Agency, Inc. of Kalamazoo, MI to inspect or secure copies of case histories, lab reports, diagnoses, X-rays and other data on this and/or previous injuries and/or disabilities.**
- **I grant authorization to First Agency and its agents or those designated as such to be Permitted Use and Disclosure of Health Information. This authorization is valid for the duration of one year from date listed below, and can be revoked only in writing by the Claimant. All parties shall abide by all HIPAA Standards and provisions.**
- **I consent to any emergency medical treatment that may be necessary, and to bill my insurance provider for services provided.**
- **A Photo static copy of this form shall be deemed as valid as the original.**

Parent/ Guardian Signature ____ Date ________________

Student Athlete Signature ____ Date ________________