

**Student-Athlete Health Insurance Information
Daytona State College**

(Please type or print)

Student-Athlete's Name: _____ Sport: _____

Social Security Number: _____ Date of Birth: _____ Gender: Male Female

Home Address: _____

City _____ State _____ Zip _____

Home phone # () _____ Athlete's cell phone # () _____

Medications currently taking? _____ Allergies/asthma _____

FATHER'S / GUARDIAN'S INFORMATION

Name: _____

SS#: _____

Date of Birth: _____

Address: _____

Home Phone: () _____

Employer: _____

Employer Address: _____

Work Phone: () _____

E-mail: _____

MOTHER'S / GUARDIAN'S INFORMATION

Name: _____

SS#: _____

Date of Birth: _____

Address: _____

Home Phone: () _____

Employer: _____

Employer Address: _____

Work Phone: () _____

E-mail: _____

STUDENT-ATHLETE HEALTH INSURANCE INFORMATION

Does the Student-Athlete have health insurance? Yes No

Policy Holder Name: _____ Relationship: _____

Insurance Company: _____

Policy / ID #: _____ Group #: _____

Insurance Company Claims Address: _____

City: _____ State: _____ Zip: _____ Phone #: () _____

Type of policy: HMO PPO Point of Service Other: _____

Primary Care Physician: _____ Phone #: () _____

Is preauthorization necessary for any medical diagnostic services? Yes No Phone #: () _____

Please copy the front and back of your insurance card and affix it below.

FRONT	BACK
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I hereby verify that the above information is correct and complete.

Student-Athlete Signature

Date

Parent / Guardian Signature

Date