



Concordia University
Sports Medicine
Athlete & Insurance Information

PLEASE PRINT

STUDENT NAME: _____

SPORT: _____ ACADEMIC YEAR: 2007-08

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

The acknowledgement of Insurance Requirements must be read and understood and this form completed PRIOR to the student-athlete participating in practice and/or competition

PARENT/GUARDIAN NAME: _____

PARENT/GUARDIAN ADDRESS: _____

PARENT/GUARDIAN PHONE: _____ HOME: () _____ WORK: () _____

NAME OF POLICY HOLDER _____

RELATIONSHIP TO STUDENT-ATHLETE: _____

ADDRESS: _____

POLICY HOLDER PHONE: _____ HOME: () _____ WORK: () _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

GROUP #: _____ I.D.#: _____

EFFECTIVE DATE OF POLICY: _____ EXPIRATION DATE: _____

PRIMARY PHSICIAN: _____

OFFICE NUMBER: _____

POLICY LIMIT: _____

POLICY DEDUCTIBLE: _____

POLICY CO-PAY: _____

DOES THE POLICY COVER ATHLETICALLY-RELATED INJURIES? _____

I HAVE READ AND AGRE TO COMPY WITH THE PROVISIONS OF THE ACKNOWLEDGEMENT OF INSURANCE REQUIRMENT:

PARENT/ GUARDIAN SIGNATURE: _____ DATE: _____

STUDENT ATHLETE'S SIGNATURE: _____ DATE: _____

THIS FORM MUST BE COMPLETED AND RETURNED BY AUGUST 1, 2007

RETURN TO:

TED TRZYNKA, HEAD ATHLETIC TRAINER
CONCORDIA UNIVERSITY, ST. PAUL
275 SYNDICATE ST. N.
ST. PAUL, MN 55104

YOU SHOULD KEEP A COPY OF THESE DOCUMENTS FOR YOUR OWN RECORDS