Holy Cross College

Department of Athletics

GENERAL ATHLETE INFORMATION

Name: _____
Last First Middle

Sport: _____ Date of Birth: ____/____/____

Height:_____ Weight:_____ Grade: ____

CONTACT INFORMATION

Current Address _____
Street

_____
City State Zip Code

Telephone Number: (___) _____ E-mail: _____

Father's Name: _____ Mother's Name: _____

Parent's Address _____
Street

_____
City State Zip Code

Telephone Number: (___) _____

PERSONAL HEALTH CARE INFORMATION

Primary/Specialist Physician: _____

Name of Clinic: _____

Address: _____

Phone Number: (___) _____ Fax: (___) _____

INSURANCE INFORMATION

Please check with your insurance carrier to be sure coverage is extended to you as a student over the age of 18. Additional athlete insurance may be needed. Adequate insurance coverage is required. Student health information is available at the office of Student Affairs. Holy Cross College does not cover medical bills.

Name of Insurance: _____ Policy Number: _____

Insurance Holder: _____ Date of Birth of Holder: ___/___/___

Address of Insurance Company: _____

Phone Number of Insurance Company: (___) _____

** Attach copy of Insurance card front/back to this form please.*

SIGNATURES

I herby state that all my information is correct to the best of my knowledge. I understand the risk of injuries that can occur as a result of participation in intercollegiate athletic activities and assume all such risks. I further permit to release the information of this report along with communicate my health conditions to proper medical personnel and Holy Cross College who has a legitimate need to know. I give my legal consent to have medical treatment by medical authorities in the event I require medical care.

_____ _____

Student Athlete Signature Date

[If under 18 years of age need signature below] (Signature satisfies Parent/Guardian agreement for above statement)

_____ _____

Parent/Guardian Signature Date