Seminole Community College

Department of Athletics 56
100 Weldon Boulevard | Sanford, FL 32773-6199 | Phone: 407-708-2090 | FAX: 407-708-2142

Student-Athlete Contact, Physician, and Insurance Information

Year:

Sport:

Name:

Student-Athlete Name: ____________________ SSN: _______-_____-_________

Gender: Male / Female Date of Birth: _____/_____/_________ DL#________________________ STATE:_______

Student-Athlete Permanent Contact Information (e.g. Home-Town Address):

Permanent Address: ____

City: ____________________ State: _______ Zip Code: ______________

Home Phone Number: _______-_______-_________ Work Number: _______-_______-_________ Ext. _________

Student-Athlete Local Contact Information (e.g. Apartment):

Local Address: ____

City: ____________________ State: _______ Zip Code: ______________

Local Phone Number: _______-_______-_________ Work Number: _______-_______-_________ Ext. _________

Cellular Number: _______-_______-_________ Pager Number: _______-_______-_________ Ext. _________

Email Address (optional):____

First Guardian (Guardian Providing Primary Insurance):

Name: ____________________ Relation: ______________ SSN: _______-_____-_________

Date of Birth: _____/_____/_________ Home Address: ______________________________

City: ____________________ State: _______ Zip Code: ______________

Home Phone Number: _______-_______-_________ Work Number: _______-_______-_________ Ext. _________

Cellular Number: _______-_______-_________ Pager Number: _______-_______-_________ Ext. _________

Email Address (optional): ____

Employer Name:____

Employer Mailing Address:____

Second Guardian:

Name: ____________________ Relation: ______________ SSN: _______-_____-_________

Date of Birth: _____/_____/_________ Home Address: ______________________________

City: ____________________ State: _______ Zip Code: ______________

Home Phone Number: _______-_______-_________ Work Number: _______-_______-_________ Ext. _________

Cellular Number: _______-_______-_________ Pager Number: _______-_______-_________ Ext. _________

Email Address (optional): ____

Alternate Emergency Contact (Optional):

Name:____ Relation: ______________

Home Address: ____

City: ____________________ State: _______ Zip Code: ______________

Home Phone Number: _______-_______-_________ Day-Time Phone: _______-_______-_________ Ext. _________

Cellular Number: _______-_______-_________ Pager Number: _______-_______-_________ Ext. _________

Email Address (optional): ____

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Student-Athlete Contact, Physician, and Insurance Information

***Primary Care Physician*:**

Practice Name: ______________________________ Physician Name: ____

Office Number: ________-________-__________ Office FAX: ________-________-__________

PLEASE READ CAREFULLY

- I/we hereby agree to supply any and all information requested by my primary insurance provider and Seminole Community College Athletics Department, its support staff, its coaches, and Athletic Trainers (***henceforth collectively referred to as SCC***) & SCC's excess insurance company(s) in a timely manner.
- I/we hereby authorize SCC and their affiliated health care providers to release any information concerning any illness, injury, treatments, and benefits payable to my and SCC insurance carriers. I/we further hereby authorize my and SCC insurance carriers to release information regarding medical, dental, treatment, or benefits-payable-to, or any other information necessary, to SCC Athletics, their employees, and authorized agents for the purpose of validating my claim and for reporting purposes.
- I/we hereby authorize SCC and their affiliated health care providers to hospitalize and/or secure treatment for the student athlete whose name appears on this form in the event that I am unable to give consent to such treatment in order to protect and preserve my health and well being.
- ______ **I/we agree to immediately notify SCC upon any change in residential, guardian, emergency, and/or health insurance information and/or status of coverage. Failure to provide updated information may result in overpayments and/or denial of payment by/from SCC's excess insurance company(s) for healthcare services rendered. I/we further understand and accept that any/all such balance of overpayments and/or denials are my/our responsibility and will be under obligation of reimbursement and/or payment in full, upon request, all amounts outstanding to SCC, SCC's affiliated health care providers, and/or SCC's excess insurance company(s).**
- ______ **I/we understand that any information discovered to be incomplete, false, invalid and/or otherwise out-of-date may result in the student-athlete's immediate removal and suspension from participation in all athletic related activities including but not limited to team: functions, meetings, practices, conditioning, strength training, and competitions; until such information has been updated and verified with/by SCC.**
- I/we hereby certify that I/we have read and understand the above statements, that any and all questions have been answered to my satisfaction, and that the answers provided on this form and in this SCC pre-participation packet are true, complete and correct to the best of my/our knowledge.
- This authorization is valid for a period of 30 months from the date of signature or for a period of 6 months following cessation of participation; whichever is longer. A photocopy, electronic, or telecommunication reproduction of this authorization shall be deemed as effective and valid as the original.

Student-Athlete: ____ Date: ________________
Signature

Guardian signature and notary witness required if student-athlete is receiving health-benefits under the provisions of a health-benefits plan of the guardian or the student-athlete is not of legal age at the time of submitting paperwork.

Guardian: ____ Date: ________________
Signature

STATE OF ___________________________ , COUNTY OF ______________________.
The foregoing instrument was acknowledged before me this ________ day of ________________, ________, by
____.

____
Signature of Notary Public

____
Print, Type or Stamp Commissioned Name of Notary Public

Personally Known ________ OR Produced Identification ________
Type of Identification Produced ______________________________