



AVILA UNIVERSITY DEPARTMENT OF ATHLETICS
Athlete Contact and Emergency Information and Health Insurance

PLEASE PRINT NEATLY.....THANK YOU.

Athlete's Full Legal Name: Sport:
Social Security Number: Date of Birth:
Local Address While Attending Avila:
City:
State: Zip:
Phone: Is this a cell? Other:

IN CASE OF EMERGENCY PLEASE NOTIFY:

PRIMARY:

Name:
Relationship:
Address:
City:
State: Zip:
Home Phone:( )
Work Phone:( )
Cell Phone:( )

SECONDARY: (Different Address than Primary)

Name:
Relationship:
Address:
City:
State: Zip
Home Phone:( )
Work Phone:( )
Cell Phone:( )

Athlete Insurance Information

Name of Insurance Company:
Policy/ID Number:
Group Number:
Address of Insurance Company:
Phone Number of Insurance Company:
Policy Holder's Name:
Employer:
Plan Type (please check): HMO PPO Other

Release of Information
Important- Please Read!

I authorize the Athletic Training Staff of Avila University to choose a physician, hospital, medical, or therapeutic care in the event of injury to myself (son/daughter) while participating in athletics at Avila University. I authorize Avila University to contact my parents/guardian, if they are the primary insurance policy holder, regarding any injury and/or insurance information or claims. I understand that Avila University carries excess insurance with a \$1500 deductible for athletic injuries incurred while participating as a member of the University. I further understand that I need primary insurance which, it or myself, is responsible for the \$1500 deductible for each injury incurred.

Yes: No:

Athlete signature

Date

Parent/guardian signature

Date