Allegany College of Maryland Athletics Emergency Contact/Insurance Form

Athlete Name: _____ Today's Date: _____

Sport(s): _____ Date of Birth: _____

Home Address: _____

Student's Email: _____ Phone #: _____

Emergency Contact Information

Mother/Guardian Name: _____ Father/Guardian Name: _____

Address: _____ Address: _____

Phone #: _____ Phone #: _____

Preferred Emergency Contact (Circle One): Mother/Father/Guardian/Other

If preferred contact other than parent/guardian:

Name: _____ Relationship: _____ Phone #: _____

Student-Athlete Primary Insurance Information

Athlete primary insurance information will be used by our Athletic Trainer to facilitate filing ACM secondary insurance forms, scheduling medical appointments with physicians/medical offices, and emergency medical treatment.

Do you possess primary health insurance? **YES**___ **NO**___

****If YES, please attach a copy (Front & Back) of Primary Insurance Card****

Policy Holder Name: _____ Insurance Company Name: _____

Insurance Company Address: _____

Policy Number: _____ Group ID Number: _____

Does your primary insurance require you to go to certain doctors and/or hospitals? **YES**___ **NO** ___

If yes, please explain: _____

Does your primary insurance require a physician referral to be seen by a specialist? **YES** ___ **NO**___

If yes, please explain: _____

Athlete Social Security Number: _____