Athlete's Emergency Information and Insurance Authorization

NAME ____ FR SO JR SR 5th
(Last) (First) (Middle) Year (Eligibility)
SPORT _______________ DOB ____/____/_____ SS#____________________

Local Address: ____
Phone: __________________ (City, State, Zip)
Permanent Address: ____
Phone: ____________________ (City, State, Zip)

Emergency Contacts

Father's Name: ____________________________ Phone: (H)__________________
(W)__________________
Address: ____
(City) (State) (Zip)
Mother's Name: ____________________________ Phone: (H)__________________
(W)__________________
Address: ____
(City) (State) (Zip)
If the above person(s) cannot be contacted, who would most likely know where they can be reached?
Name: ________________________ Relation: ______________ Phone:_________________

Medical Conditions, Allergies, or Medications

Do you have any allergies? ____ Yes ____ No
If yes, please list your allergies and medication(s) you take

____

Do you have any conditions for which medication is regularly taken? ____ Yes ____ No
If yes, please list condition(s) and medication(s) you take

____

Do you have any other medical conditions the athletic training staff needs to be aware of?
____ Yes ____ No If yes, please list condition(s) and medication(s) you take

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Permission for Medical Care

In case of serious injury or illness, I understand that reasonable effort will be made to contact the above mention person. If contact cannot be made I hereby give permission to the team physician of Montana State University Athletics to administer medical treatment, including surgery, if this be deemed advisable.

Athlete's Signature: ______________________________________ Date:__________

Medical Information and Insurance Authorization

I hereby authorize any hospital, physician, or other person attending or examining me to disclose when requested to do so by NAIU, Montana State University, or their representatives any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.
I hereby authorize MSU and its athletic trainers to release this form and the information on it to any health professional who is treating me, my coaches, MSU Athletic Directors, insurance companies, other athletic trainers that may be providing services to me and any other person that I authorize in writing to receive such information.
Athlete's Signature: _____________________________________ Date:___________