

# OWATONNA CHRISTIAN SCHOOL STUDENT-ATHLETE MEDICAL FORM

(Please Type or Print)

Today's date: \_\_\_\_\_

## STUDENT-ATHLETE INFORMATION

Patient's last name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F

Street address: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_  
( )

P.O. box: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

## INSURANCE INFORMATION

(Please attach a copy of insurance card at the bottom of this form. Please copy both sides.)

Person responsible for bill: \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Address (if different): \_\_\_\_\_ Home phone no.: \_\_\_\_\_  
( )

School Year: \_\_\_\_\_ Parent(s): \_\_\_\_\_ Parent(s) address: \_\_\_\_\_ Parent(s) phone no.: \_\_\_\_\_  
( )

Is this patient covered by insurance?  Yes  No

Please give primary insurance Company - \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Subscriber's S.S. no.: \_\_\_\_\_ Birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Group no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_ Co-payment: \_\_\_\_\_  
(only if required) ( ) \$

Patient's relationship to subscriber:  Self  Spouse  Child  Other

Name of secondary insurance (if applicable): \_\_\_\_\_ Subscriber's name: \_\_\_\_\_ Group no.: \_\_\_\_\_ Policy no.: \_\_\_\_\_

Patient's relationship to subscriber:  Self  Spouse  Child  Other

## IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): \_\_\_\_\_ Relationship to patient: \_\_\_\_\_ Home phone no.: \_\_\_\_\_ Work phone no.: \_\_\_\_\_  
( ) ( )

In event of an injury or serious illness, I request that the school contact me. If the school is unable to contact me, I grant permission to OCS personnel to release my child for immediate medical care. I will be responsible for all financial obligations incurred during such treatment. I also give approval for my child to participate in the OCS Sports Program. I understand that I must pay an athletic fee for my child to participate.

Parent/Guardian signature

Date

Place a copy of the Insurance card here.