Maggie Walker Athletic Emergency Form

Athlete's Name: _____________________________ Male Female DOB: ____________

_________________________ _______________ __________ _____________
Permanent Home Address City State ZIP

_________________________ _______________ __________ _____________
Local Mailing Address City State ZIP

____________________ ______________________ ________________________
Home Phone # Athlete Cell Phone # Athlete E-mail

SSN: ______________________ Sport: _______________

Policy Holder's Information **(REQUIRED)**	Secondary (if applicable)
Name: ____________________________________ Home Address: ______________________________ ______________________________________ Home Phone ( ) ________________________ Work Phone ( ) ________________________ Insurance Co. _______________________________ Policy Holder's ID #: ______________________ Policy Group #: ____________________________ Claims Phone #: ____________________________ Mailing Address for Claims: ________________ ____ Policy holder's relationship to athlete: _________ ____ Is your dependent son / daughter covered under this policy? Yes No **Policy Holder's DOB:** _________ What type of insurance do you have? (circle) Traditional HMO PPO POS Other Does your insurance cover prescriptions? YES NO Does your insurance require a referral from your PCP (primary care physician) to see another Dr. or Specialist? YES NO If yes list: Primary Care Physician: ______________ Phone Number: ______________________	Name: ____________________________________ Home Address: ______________________________ ______________________________________ Home Phone ( ) ________________________ Work Phone ( ) ________________________ Insurance Co. _______________________________ Policy Holder's ID #: ______________________ Policy Group #: ____________________________ Claims Phone #: ____________________________ Mailing Address for Claims: ________________ ____ Policy holder's relationship to athlete: _________ ____ Is your dependent son / daughter covered under this policy? Yes No **Policy Holder's DOB:** _________ What type of insurance do you have? (circle) Traditional HMO PPO POS Other Does your insurance cover prescriptions? YES NO

	Parent Information	**Secondary Emergency Contact Person(s)**
Name(s)		
Address		
City St ZIP		
E-mail(s)		
Work/Cell #s		