

Name _____ Sport _____

Social Security # _____ Date of Birth _____

Trinity Valley Community College – Athlete Medical Insurance Verification

Should your son/daughter sustain an athletic injury we must first file on your insurance before filing with our insurance. To prevent any delay in treatment or complications with the claims process please fully complete, sign and attach A PHOTOCOPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS AND PRESCRIPTION CARDS. Please fill out the required information for the insured individual that carries insurance on the above named athlete.

Insured: Father/Mother/Guardian/Spouse/Self (person who carries the policy on the athlete)

Full Name _____

Date of Birth _____ Social Security # _____ - _____ - _____

Home Address _____

(Street)

(City, State & ZIP Code)

Home Phone _____ Cell Phone _____

Employer's Name _____

Employer's Address _____

(Street)

(City, State & ZIP Code)

Employer's Phone Number _____

Medical Insurance Information

Medical Insurance Company _____

Mailing Address _____

(Street)

(City, State & ZIP Code)

Group # _____ Policy/ID # _____

Phone _____ Effective Date: _____

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY?

YES ___ NO ___

Does your insurance company require: A second opinion for surgery? YES ___ NO ___

Pre-authorization for services? YES ___ NO ___

Is your primary insurance a HMO? YES ___ NO ___

Is your primary insurance a PPO? YES ___ NO ___

Primary Care Physician _____ Phone _____

Authorization:

_____ I hereby authorize a claim to be filed on my behalf under the above group medical policy

in the event an athletic injury is sustained by _____.

_____ My son/daughter is **not covered** under my group insurance policy or any other insurance policy.

I certify that the answers provided are true, complete and correct to the best of my knowledge. I authorize the release of the above information to any concerned providers. A photocopy of the authorization shall be considered as effective and valid as the original.

TVCC Athletics
Attn: Athletic Trainer/Insurance Coordinator
100 Cardinal Drive
Athens, TX 75751
903-670-2671
903-675-6380 fax

Name _____ Sport _____

Social Security # _____ Date of Birth _____

Date _____ Parent/Guardian/Insured's Signature _____

Trinity Valley Community College – Dental and Vision Insurance Verification

Should your son or daughter have an athletic injury that requires treatment by a dentist or ophthalmologist we must first file on your dental or vision insurance policy before filing with our insurance company. To prevent any delays in treatment please provide the following information as well as photocopies of the cards:

Dental Insurance Information

Name on Card _____

Dental Insurance Company _____

Mailing Address _____
(Street) (City, State & ZIP Code)

Group # _____ Policy/ID # _____

Phone _____

Vision Insurance Information

Name on Card _____

Vision Insurance Company _____

Mailing Address _____
(Street) (City, State & ZIP Code)

Group # _____ Policy/ID # _____

Phone _____

Authorization:

_____ I hereby authorize a claim to be filed on my behalf under the above group dental or vision policy in the event an athletic injury is sustained by _____.

_____ My son/daughter is not covered under my group dental or vision insurance policy or any other insurance policy.

I certify that the answers provided are true, complete and correct to the best of my knowledge. I authorize the release of the above information to any concerned providers. A photocopy of the authorization shall be considered as effective and valid as the original.

Date _____ Parent/Guardian/Insured's Signature _____

TVCC Athletics
Attn: Athletic Trainer/Insurance Coordinator
100 Cardinal Drive
Athens, TX 75751
903-670-2671
903-675-6380 fax

Name _____ Sport _____

Social Security # _____ Date of Birth _____

Trinity Valley Community College - Medical Consent

I hereby grant permission to the Trinity Valley Community College coaches and staff to render to my son or daughter any treatment, medical or surgical care that they deem reasonably necessary to the health and well-being of the athlete. This may include but is not limited to any preventative, first aid, rehabilitative, or emergency treatment.

Also, when necessary for executing such case, I grant permission for hospitalization at an accredited hospital.

Date _____ Parent Signature _____

Athlete Signature _____

Trinity Valley Community College – Assumption of Risk

I understand that any sport is inherently dangerous and that there are genuine and serious risks to anyone who engages in athletic activity.

I also understand that athletics have a high injury rate at the collegiate level. Due to the nature of the physical activity and possible collisions that are a part of athletics, I understand that the risk of serious physical injury, including catastrophic injury resulting in permanent paralysis, brain injury or death does exist.

I knowingly assume responsibility for any and all such risks and any and all resulting injuries, including death. I promise to accept and assume responsibility and risk for injury, death, illness, or disease, or damage to property arising from my traveling to, participation in, or returning from this activity. And I do hereby voluntarily choose to participate in this event in spite of the risks.

Furthermore I attest that I am physically fit and have sufficiently trained for this event. I do not have any medical record or history that could be aggravated by my participation in this activity.

If I am participating with a limiting condition (artificial limb, missing or damaged organ, plates, pins, or any orthopedic device.....) I will state it/them now: _____ .

I understand that I must be cleared by the team physician and head athletic trainer through completion of a physical examination prior to my athletic participation.

My signature below indicates I have read this entire document, understood it completely, and agree to be bound by its terms.

Athletes Signature: _____

Parent/Guardian Signature: _____

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903-675-6380 fax

Name _____ Sport _____

Social Security # _____ Date of Birth _____

Trinity Valley Community College Athlete Contact Information

First Name: _____ Nickname: _____

Middle Name: _____ Last Name: _____

Birth Date: ____ / ____ / _____ Age: ____ Sex: ____ Marital Status: S / M / D

SS#: _____ - _____ - _____ Sport: _____

Cell Phone: (____) _____ - _____

Email Address: _____ @ _____

Current TVCC Classification: ___ Incoming Freshman ___ Red Shirt Freshman ___ Sophomore

Parent/Guardian Contact Information

Father / Guardian: _____ Work Phone: (____) _____ - _____

Home Address: _____ Home Phone: (____) _____ - _____

City: _____ State: _____ Zip: _____ Cell Phone: (____) _____ - _____

Mother / Guardian: _____ Work Phone: (____) _____ - _____

Home Address: _____ Home Phone: (____) _____ - _____

City: _____ State: _____ Zip: _____ Cell Phone: (____) _____ - _____

Contact Person in Case of an Emergency (Non-Relative):

Name: _____ Relationship: _____ Home: (____) _____ - _____

Work: (____) _____ - _____ Cell: (____) _____ - _____

Family Physician: _____ Phone: (____) _____ - _____

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Name _____ Sport _____

Social Security # _____ Date of Birth _____

GENERAL MEDICAL QUESTIONNAIRE

1. Medications: Please list any and all prescription, non-prescription, vitamins or herbs you are currently taking. In addition, please explain why you take the medication.

NAME OF MEDICATION/VITAMIN/HERB REASON

2. Do you wear contacts? YES NO
***If yes, please bring an extra pair to give to the athletic training staff and/or coaches in case of a lost or damaged pair.

3. Do you use an asthma inhaler while participating in your sport?
YES NO
***If yes, please bring/send an extra inhaler to the athletic training staff and/or coaches to keep for your use during sports participation.

4. Do you have allergies? YES NO
***If yes, please explain what you are allergic to:
-
-
-

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