St. Clair County Community College

Medical Information Form

Athlete's Name: ____
(last) *(first)* *(middle)*

Birthdate: ____________________ Sport(S): ____

Street Address: ____

City: ___________________________________ State: __________ Zip: _____________

Email: ______________________________________ Phone Number: ______________________

List any medical conditions you have (diabetes, asthma, depression, etc.) and family history of heart conditions.

____ ____
____ ____
____ ____

List any previous surgeries you have had (indicate the type and approximate date).

____ ____
____ ____
____ ____

List all medications you are currently taking (including over-the-counter, supplements, etc.).

____ ____
____ ____
____ ____

List all allergies (latex, medications, environmental, food).

____ ____
____ ____
____ ____

Emergency Information

In case of emergency, this information is vital to getting you the help you need!

Family Doctor: ____ Phone: _____________________

Address: ____
(Street Address) *(City)* *(State)* *(Zip)*

Person to contact in case of emergency:

Name: ____ Relationship: ____________________

Phone Number: __________________________ Alternate Number: _________________________

Insurance Information

Are you covered by a medical insurance policy? Yes No

If yes, please answer the following questions:

Is this plan an HMO or PPO? Yes No

Is pre-authorization required to obtain treatment? Yes No

Is a referral needed before treatment by an orthopedic specialist? Yes No

Is there a treatment exception clause because you are away at school? Yes No

Name of Insured: ___________________________________

Primary Insurance: ___________________________________ Policy Number: _____________________

Secondary Insurance: _________________________________ Policy Number: _____________________

I certify that the information I provided on both sides of this form is complete and accurate to the best of my knowledge.

____ ____________________

Student-Athlete's Signature Date