FOURTH BAPTIST CHRISTIAN SCHOOL

STUDENT-ATHLETE MEDICAL INSURANCE FORM

(Please Type or Print)

STUDENT-ATHLETE INFORMATION

Patient's (Student's) last name:	First:	Middle:	Medical Alert:

Birth date:	Age:	Sex:	Home Ph #:	Cell # and circle whose it is:
/ /		❑ M ❑ F	( )	( ) MOM DAD

Street address:		P.O. box:
City:	State:	ZIP Code:

INSURANCE INFORMATION: *(Please attach a copy of insurance at the bottom of this form. Copy both sides).*

Person responsible for bill:	Birth date:	Address (if different):	Home Cell #:
	/ /		( )

School Year:	Parent(s):	Parent(s) address:	Parent(s) Cell #:
2014-15			( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please give primary insurance > Provider Name:

Subscriber's name:	Subscriber's ID #.:	Birth date:	Group #:	Policy #:	Co-payment:
		/ /			$

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group #:	Policy #:

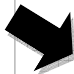
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other > Explain:

IN CASE OF EMERGENCY…

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:	Work phone #:
		( )	( )

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 FBCS 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 son to participate in the FBCS Sports Program. I understand that in order to play that I must pay an athletic fee of $150 for Varsity/Junior Varsity sport per child and $125 for Junior High Sport per child.



Parent/Guardian signature *Date*

Place a copy of the Insurance card below in the boxes provided.

FRONT	BACK