LABETTE COMMUNITY COLLEGE
STUDENT/PARENT(S)/GUARDIAN INFORMATION FORM

NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).
FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS.

I. Name of Athlete: ______________________ Sport: ______________________

Social Security No. or Passport No.: ______________________ Date of Birth: ____/____/____

Address while attending LCC: ______________________ Cell Phone: ______________________

Home Address: ______________________ Home Phone: ______________________

II. Father/Guardian: ______________________ Mother/Guardian: ______________________

Social Security No.: ______________________ Social Security No.: ______________________

Date of birth: ____/____/____ Date of birth: ____/____/____

Address: ______________________ Address: ______________________

______________________ ______________________

Employer: ______________________ Employer: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Telephone (work): ______________________ Telephone (work): ______________________

III. Medical Insurance Company or Plan ______________________ Medical Insurance Company or Plan ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Policy Number: ______________________ Policy Number: ______________________

Phone Number: ______________________ Phone Number: ______________________

PLEASE ATTACH A PHOTOCOPY (FRONT AND BACK) OF YOUR INSURANCE CARD WITH THIS FORM.
IF YOU DO NOT HAVE HEALTH INSURANCE COVERAGE SEE BACK SIDE OF THIS FORM.

Is the plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider ? ☐ Yes ☐ No

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Does your insurance or plan require a second opinion before surgery? ☐ Yes ☐ No

IV. Emergency contact names and phone numbers: ______________________

____

Other information you feel would be beneficial in an emergency situation: ______________________

____

____

V. I/We hereby authorize Labette Community College Insurance to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original.

I/We authorize that the college or its insurance agency to pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the college.

In case of emergency, I give my permission for the Labette Community College trip sponsor to release information and to approve necessary medical treatment after attempting to contact my parent(s)/guardian or other listed contact person.

BOTH SIGNATURES ARE REQUIRED

Student Signature: ______________________ Date: ______________

Parent(s)/Guardian Signature: ______________________ Date: ______________

PLEASE COMPLETE REVERSE SIDE OF THIS FORM (IF APPLICABLE)