SMCCD Emergency Contact Information/Health Insurance Form

(* Athlete completes & signs form. Parent/Legal Guardian must sign as well if student is under 18 years of age)

Print Name: Last_____ First _____ Date of Birth : _____ - _____ - _____

Health Insurance (circle one): None or I am covered by the following policy:

Insurance Company:_____ Policy #_____ Group #_____

Insurance Company Address: _____

City:_____ State:_____ ZIP:_____

Insurance Company Phone: _____ Medical Group Name:_____

Policy is: ☐ HMO ☐ PPO ☐ Indemnity (I can go to any doctor) ☐ Medi-Cal /Health Families

Policy Holder is: _____ Date of Birth of Policy Holder: _____ / _____ /_____

If HMO, Assigned Physician:_____ M.D. Phone:( ) _____ - _____

I give permission for the following services listed below if ill or injured while competing or practicing with a San Mateo Community College District, here after referred to as SMCCD, athletic team.

1. The Sports Medicine Staff and volunteers of SMCCD or the institution that is hosting a visiting event or match to provide injury assessment, treatment and rehabilitation.
2. EMS for transportation and emergency care to the hospital.
3. The attending physician at the hospital to provide emergency services.

I have attended /received "Sports Medicine Orientation" for student athletes and fully understand what my rights are and services are available to me concerning assessment, treatment and rehabilitation for any injuries/illness' sustained while participating in athletics and appropriate use of the SMCCD athletic injury insurance.

I understand, acknowledge and agree that the SMCCD, it's employees, officers, agents, or volunteers shall not be liable for any injury/illness/death suffered by me which is incident to and/or associated with preparing for and or participating in athletic activities or transportation to or from said activities in a district owned van or bus.

I understand and acknowledge that SMCCD and the school's insurance are not responsible for injuries sustained in activities not sponsored by the SMCCD or not properly reported to the sports medicine staff. All injuries must be reported immediately, documented and kept on file by the sports medicine staff.

I understand and acknowledge that the SMCCD has limited insurance coverage which is secondary to all other policies that a student is covered for. Bills for services which are not paid by insurance are the responsibility of the student/parent/guardian.

I understand and acknowledge that filing a claim for benefits with the school athletic injury insurance for injuries not incurred while practicing or competing as an intercollegiate athlete for the SMCCD is considered insurance fraud under the law. I also understand that filing for benefits with the school athletic injury insurance when I am covered by my own personal insurance policy for such benefits is also considered insurance fraud under the law. Any person who knowingly and with the intent to defraud any insurance or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning facts material thereto, has committed a fraudulent act, shall withdraw from any sports activities and is subject to disciplinary action by SMCCD.

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I acknowledge that I have carefully read this SMCCD Sports Medicine Emergency Contact/Insurance Form and that I understand and agree to its terms.

I hereby certify under penalty of perjury that foregoing the information given on these forms is truthful, complete and correct to the best of my knowledge. I hereby certify that I have no other health insurance other than what is listed on this form.

Signature_____ Date_____/_____/_____

Signature: _____ Date _____/_____/_____

(Parent/Guardian's signature if athlete is under 18)

SMCCD Emergency Contact Information/Health Insurance Form

(* Athlete completes & signs form. Parent/Legal Guardian must sign as well if student is under 18 years of age)

Print Name: Last _____ First _____Sport _____

Student ID #: **G** ____ ____ ____ ____ ____ ____ ____ ____ *(do not enter your social security number)*

Address: _____ Email: _____

City: _____ State:_____ Zip:_____

Phone Home: ( )_____ - _____ Cell/Pager: ( )_____ - _____

Employment Status: ☐ Unemployed or ☐ Employed Work Phone: ( )_____ - _____

Employer Name & Address: _____

City: _____ State: _____ Zip:_____

Emergency Contact Person:_____ **Cell** Phone: ( )_____ - _____

Relationship to you ☐ friend ☐ relative **Home or work** Phone: ( )_____ - _____

Mother/Spouse/Partner/LegalGuardian's Name:_____
Last First

If you **did not** list a Mother/Spouse/Partner/LegalGuardian please check the correct box: ☐ Deceased ☐ Unknown

Father/Spouse/Partner/LegalGuardian's Name:_____
Last First

If you **did not** list a Father/Spouse/Partner/LegalGuardian please check the correct box: ☐ Deceased ☐ Unknown

Parent/Spouses' Address & Phone Number (if different than yours):

Address: _____

City: _____ State:_____ Zip:_____

Phone Home: ( )_____ - _____ Cell/Pager: ( )_____ - _____

Mother/Spouse/ Partner/Legal Guardian's Employment Information ☐ Check box if work is same as home address

Employment Status: ☐ Unemployed or ☐ Employed Work Phone: ( )_____ - _____

Employer Name & Address: _____

City: _____ State: _____ Zip:_____

Father/Spouse/ Partner/Legal Guardian's Employment Information ☐ Check box if work is same as home address

Employment Status: ☐ Unemployed or ☐ Employed Work Phone: ( )_____ - _____

Employer Name & Address: _____

City: _____ State: _____ Zip:_____

Signature_____ Date_____/_____/_____

Signature: _____ Date _____/_____/_____
(Parent/Guardian's signature if athlete is under 18)