APPENDIX B
WALLACE COMMUNITY COLLEGE
EMERGENCY CONTACT AND INSURANCE INFORMATION FORM

Name _____

Date of Birth _____ Sport(s) _____

Student Number _____ Academic Year _____

Parent/Guardian Name _____

Address _____

Cell # _____ Home #_____ Work # _____

Insurance Policy Holder Name & DOB _____

Relationship to **student-athlete** _____

Address _____

Home # _____ Work # _____

Insurance Company Name _____

Insurance Co. Address _____

Group # _____ I.D.# _____

Effective Date of Policy _____ Expiration Date _____

Primary Physician _____ Office #_____

Policy Limit _____ Policy Deductible _____

Policy Co-Pay _____

Does policy cover athletically-related injuries? _____

I authorize any Health Care Provider, Insurance Company, Person, or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, or treatment to the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. I further authorize release of this information to WCC Athletic Department staff.

_____ _____
Parent/Guardian Signature Date

_____ _____
Student-athlete Signature Date

To ensure eligibility for participation, this form must be completed and returned immediately. Please keep a copy for your records.
Return To: Mackey Sasser, Athletic Director, 1141 Wallace Drive, Dothan, AL 36303