CLEARWATER CHRISTIAN COLLEGE
ATHLETIC TRAINING
MEDICAL TRAVEL FORM

IDENTIFICATION:

Athlete's Name: _____ Sport(s) _____
Last First Mi
GENDER (circle): male / female
DATE _____ DATE OF BIRTH _____ AGE _____ SS# _____
College phone # 727-726-1153 Ext. _____ Cell Phone or other # _____
HOME PHONE # (____)_____ Parent/Guardian Home # (____)_____) work # (___)_____.
HOME ADDRESS:_____ COLLEGE ADDRESS: _____
_____ _____
City state zip City state zip

PRIMARY INSURANCE INFORMATION

(Provide us with a photo copy of the front and back of your insurance card)

Name of Medical Insurance Company _____
Address of Insurance Company _____
_____
Type of policy (circle) HMO PPO EPO Other _____
Whose name is policy under (Athlete, Mother, Father, etc)? _____
Insured Parents' Birthdate _____ SS# _____
Insured Parents' Employer _____

ID # _____ Account # _____
GROUP # _____ Issuer # _____
PLAN # _____ Contract # _____
MEMBERSHIP # _____
OTHER # given _____
Customer Service # 1-800-_____
PRIMARY CARE PHYSICIAN (if applicable…..for most HMO's)
Name: _____ Phone: _____
Address: _____ Fax: _____
_____

Clearwater Christian College School Insurance

(Provide us with a photo copy of the front and back of your insurance card)

Name of Medical Insurance Company _____
Address of Insurance Company _____
_____
Policy No. _____ Phone # _____

MEDICAL ALERT:

** Please check yes or no as it applies and explain where appropriate

MEDICAL CONDITIONS	YES	NO	If YES, please explain	Dates
Allergies				
Illnesses				
Tetanus immunizations				
Injuries (recent)				
Medications				
Surgeries				
Contact lenses				