

LOYOLA WOLFPACK ATHLETICS
2009- 2010 Emergency/Medical/Insurance Information

Please Print

Student's Name: _____ SSN: _____
Address (local): _____
City: _____ State: _____ Zip: _____ Phone: _____
Height: _____ Weight: _____ Date of Birth: _____

▪ Father's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (h): _____ (w) _____ (c) _____

E-mail: _____

▪ Mother's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (h): _____ (w) _____ (c) _____

E-mail: _____

****Emergency Name and Number (other than parents):** _____

A copy (back & front) of a current health insurance card must accompany this form

Insurance Company: _____

Policy #: _____ Group #: _____

Physical/Medical Conditions Noted (past surgeries): _____

Allergic to Medications: _____

As a parent or legal guardian of _____, I hereby give my consent for him/her to participate in intercollegiate athletics at Loyola University New Orleans. I also grant permission for treatment deemed necessary for a condition arising during participation in these activities by the athletic trainer and/or medical doctor. I understand that every effort will be made to contact me in an emergency.

Signature of Parent/Guardian

Date