WALLACE COMMUNITY COLLEGE
EMERGENCY CONTACT and INSURANCE INFORMATION FORM

Name _____

Date of Birth _____ Sport(s) _____

Student Number _____ Academic Year _____

Parent/Guardian Name _____

Address _____

_____ Cell Phone _____

Home Phone _____ Work Phone _____

Policy Holder Name & DOB _____

Relationship to Student-Athlete _____

Address _____ Home Phone _____

_____ Work Phone _____

Insurance Company Name _____

Insurance Co. Address _____

Group # _____ I.D.# _____

Effective Date of Policy _____ Expiration Date _____

Primary Physician _____

Office Number _____

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, treatment, 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.
You should keep a copy of these documents for your records.

Return To: Mackey Sasser, Athletic Director
1141 Wallace Drive
Dothan, AL 36303

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