

STUDENT/ATHLETE INSURANCE STATEMENT



Return to: Athletic Director
Mott Community College
1401 E. Court Street
Flint, MI 48503
(810) 762-0417

PARENTS TO COMPLETE

NO ATHLETE WILL BE ALLOWED TO COMPETE ON A COLLEGE TEAM UNTIL THIS FORM IS COMPLETED AND RETURNED TO THE ATHLETIC DEPARTMENT

Name of Athlete _____ Sport _____

Home Address _____
City ZIP Code

Local Address _____
(if not same as above) City ZIP Code

Father/Guardian _____ Mother/Guardian _____
Address _____

Employer _____

Medical Ins. Co. _____

Policy Number _____

Is your son/daughter allergic to any drugs? _____ Which? _____

List all surgeries and/or serious illness that your son/daughter has had:

_____ Date _____
_____ Date _____
_____ Date _____

I hereby authorize Mott Community College and First Agency of Kalamazoo, Michigan to inspect or secure copies of case history records, laboratory reports, diagnosis, x-ray, and any other data covering this and/or previous confinements and/or disabilities. A photo static copy of this authorization shall be deemed as effective and valid as the original.

Signature _____ Date _____