THIS FORM MUST BE COMPLETED AND RETURNED TO THE ATHLETICS DEPARTMENT PRIOR TO BEING AUTHORIZED TO PARTICIPATE IN ANY INTERCOLLEGIATE SPORT ACTIVITY. PARTICIPATION IN AN INTERCOLLEGIATE SPORT ACTIVITY OF ANY KIND WILL BE FORBIDDEN IF YOU FAIL TO COMPLETE, SIGN & RETURN THIS FORM.

FOOTHILL-DEANZA COMMUNITY COLLEGE DISTRICT

RECORD OF OTHER INSURANCE FORM

All sections must be completed.

Student's Name _____ Date of Birth _____

Student's Home Address _____ School ID # _____

City, State, Zip _____ Home Telephone _____

Student's Employer Name _____ Employer's Telephone _____

Employer's Address _____ City, State, Zip _____

Mother's Name _____ Date of Birth _____

Mother's Home Address _____

City, State, Zip _____ Home Telephone _____

Mother's Employer Name _____ Employer's Telephone _____

Employer's Address _____ City, State, Zip _____

Father's Name _____ Date of Birth _____

Father's Home Address _____

City, State, Zip _____ Home Telephone _____

Father's Employer Name _____ Employer's Telephone _____

Employer's Address _____ City, State, Zip _____

YOUR PERSONAL MEDICAL INSURANCE INFORMATION ("PRIMARY INSURANCE")

Subscriber Name _____ Date of Birth _____

Subscriber's Relationship to Student (i.e. Mother, Father, Spouse) _____

Subscriber's Home Address _____

City, State, Zip _____ Home Telephone _____

Subscriber's Employer's Name _____ Employer's Telephone _____

Employer's Address _____ City, State, Zip _____

Type of Policy: ❑ Individual ❑ Group ❑ Other _____

Type of Coverage: ❑ HMO * ❑ PPO | POS | EPO ❑ TRICARE ❑ HDHP (High-deductible health plan) ❑ Other (explain) _____

Insurance Company Name _____ Group # _____

Insurance Company Address _____ Policy | ID # _____

❑ Yes, I am covered by this policy ❑ No, I am not covered by this policy

*** If you are covered by an HMO, it may be helpful to reassign the Primary Care physician to a local physician near to our school.**

ATTACH COPIES (FRONT & BACK) OF INSURANCE ID CARDS AND RETURN WITH THIS FORM

IF YOU INDICATED YOU ARE NOT COVERED BY ANY INSURANCE, PLEASE COMPLETE THE FOLLOWING:

When were you last covered by any medical insurance? _____ Who were you covered by? _____

Are you presently covered by Medicaid or any other federal or state government healthcare plan? _____

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT THE FOREGOING ANSWERS I HAVE DESIGNATED TO THE ABOVE QUESTIONS ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

ACCEPTED AND AGREED

_____ _____

PRINT – Student-Athlete Name Date

_____ SIGN HERE _____

SIGNATURE – Student-Athlete Date

_____ SIGN HERE _____

SIGNATURE - Parent/Guardian (if under 18 years old) Date

Print Form