



**STATESBORO HIGH SCHOOL TRAVEL /  
INSURANCE FORM 2018-2019**

In order to provide the best possible medical care for your child, a medical record will be established for him/her. If your child should become injured while playing sports, this form will provide important information to coaches and medical personnel. Please complete and sign as indicated.

**EMERGENCY CONTACT INFORMATION**

Student's Name (Legal) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
LAST FIRST MI

Student's Preferred Name \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ HS Graduation Year: 20 \_\_\_\_

Address: \_\_\_\_\_, GA \_\_\_\_\_  
Street City Zip

Student's Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Student's Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Child Lives With: \_\_\_\_ Father \_\_\_\_ Mother \_\_\_\_ Both \_\_\_\_ Other: \_\_\_\_\_

Father/Guardian's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Father/Guardian's Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

Mother/Guardian's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Mother/Guardian's Cell Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

Parent/Guardian Contact E-Mail Address: \_\_\_\_\_

Emergency Contact (must be 21 or older): \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Contact Cell Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Office Phone # (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

**INSURANCE INFORMATION** (Please select one of the following)

I have personal insurance and assume all responsibility for medical cost.

Primary Insurance Co: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

I have NO personal insurance but will assume all responsibility for medical cost.

**\*\*PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD\*\***

Medical Conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications & Condition: \_\_\_\_\_

**PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT'S ABSENCE**

\*I give permission for school representatives to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation treatment by certified athletic trainers at home and/or away competitions.

Print Parent Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Please complete/sign/date every line (if applicable) in order for your student athlete to be eligible to participate.*