Midland College
Authorization to Release Medical Information

This form must be signed and returned to the athletic department before ANY student-athlete will be allowed to participate in any practice or activity at MC.

1. We/I hereby authorize any insurance, hospital, physician, or other persons who have attended or examined the undersigned student-athlete to disclose when requested to do so, all information with respect to any injury, medical condition, medical history, consultation, prescription, treatment and copies of all hospital and medical records.

2. We/I hereby authorize the MC athletic training staff to release information concerning previous injuries and medical conditions to any insurance company representatives involved in processing claims, head/assistant coach, or athletic director.

3. We/I hereby grant permission to the MC athletic training staff, head coach, athletic director, or designated physician to secure medical services that are in best interest of the student-athlete.

By our/my signature, we/I agree with all statements outlined in the medical, dental, eye policies, and payment of expenses and certify that all information I have given MC athletic department is correct to the best of our/my knowledge. We/I do hereby affirm that we/I have received a copy of the MC medical policies and procedures and acknowledge that we/I are/am familiar with them as set forth within. A photocopy of all documents in the policy will be considered as effective and valid as the original.

_____ _____

Date Signature of Student-Athlete

_____ _____

Date Signature of Parent/Guardian
(If student-athlete is under 18 years of age)

Notice to All Athletes:

This is to inform you, the participating athlete, that in the event of an injury during a sports related accident, Midland College will be more than happy to assist you in getting you medical assistance and the claims paid. However, all requested information must be provided by yourself or your parent, to all involved parties. All required forms must be filled out completely for MC, the treating physician and or hospital, and also for the insurance company. When correspondence from medical providers, insurance companies, etc. is sent to you, when an athletic related injury is involved, please make sure the athletic trainer receives the material to insure proper payment is made. Failure to do so will result in all charges being transferred to the patients responsibility. Should you have any questions, please contact the Athletic Department.

I, _____ have read the above statement and understand that I am ultimately responsible for seeing that my medical bills are paid. I also understand that failure to pay medical bills could result in a negative mark on my credit history.

Signature _____ Date _____

Men's Basketball, Baseball, Golf
Women's Basketball, Softball,
Volleyball

(*Please Circle One*)

Student Information

******Please Print Clearly – Do not leave any blanks on any of the requested information******

Name: _____

Local Address: _____

City: _____ State:_____ Zip:_____

Local Telephone: _____ Cell Telephone: _____

SS#: _____ Date of Birth: _____

Drivers License No: _____ State Issued: _____

Email Address: _____

Medical condition/allergies: _____

Emergency Contact Information

If in the event we can't reach your parents, we will need two other contact people. Please list them below

Name: _____
Address: _____
Relation to Student: _____
Home Telephone: _____ Work Telephone: _____
Cell Telephone: _____ Pager: _____

Name: _____
Address: _____
Relation to Student: _____
Home Telephone: _____ Work Telephone: _____
Cell Telephone: _____ Pager: _____

Parent/Guardian Information

******Please print clearly-Do not leave blanks******

Mothers Name: _____

Address: _____

City/State/Zip: _____

Home Telephone: _____Work Telephone: _____

Cell Phone: _____ Email: _____

Place of Employment: _____

Date of Birth: _____ S.S.#: _____

Fathers Name: _____

Address: _____

City/State/Zip: _____

Home Telephone: _____Work Telephone: _____

Cell Phone: _____ Email: _____

Place of Employment: _____

Date of Birth: _____ S.S.#: _____

Insurance Information

******If the student has no primary insurance, please sign this statement of no coverage******

Statement of No Coverage

My son/daughter _____ is not covered by any private, personal, or group health insurance.

Signature of Parent _____ Date _____

******If the student has primary insurance, please attach a front and back copy of the card and fill in all requested information below******

Name of Policy Holder: _____

Policy Holder Employer: _____

Policy Holder Date of Birth: _____ S.S.#: _____

Primary Insurance: _____

Claims Mailing Address: _____

Insurance Company Telephone No.: _____

Group No.: _____ Policy: _____

Effective Date of Policy: _____

Is there a referral required: _____

If so please list primary card physician name and telephone number: _____

_____