

West Feliciana High School Athletics

STUDENT-ATHLETE INFORMATION & EMERGENCY CONTACT

(Please write legibly using blue or black ink)

Name: _____ Date of Birth: ____/____/____

☐ Male ☐ Female

SS #: ____ - ____ - ____

Sport(s): _____ ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

Home Address: _____

City State Zip Code

Primary Contact: _____ Relationship: _____

Cell Phone # Alternate Phone #

Secondary Contact: _____ Relationship: _____

Cell Phone # Alternate Phone #

In an emergency, I authorize the Ochsner Health System and affiliated providers to contact the person(s) listed above.

Guardian's Signature _____ Date _____

Allergies: _____

Other Medical Issues (i.e., asthma, medications, etc.): _____

INSURANCE INFORMATION FORM

POLICY HOLDER/SUBSCRIBER's INFORMATION

Subscriber Name: _____ Subscriber's DOB: ____/____/____ SS#: _____

Home Address: _____

Phone # : _____

Employer: _____

Employer Address: _____

Insurance Company: _____ Insurance Company Phone #: _____

Insurance Address: _____

Policy/ID#: _____ Group #: _____

Effective Date: _____ Expiration Date: _____

Type of Insurance: ☐ HMO ☐ PPO ☐ Indemnity ☐ Other _____

Does this policy include dental coverage? ☐ YES ☐ NO

Primary Care Physician: _____ Physician Phone #: _____