2023-2024 TEXAS CITY I.S.D. MEDICAL INFORMATION FORM

Attention: This form **MUST be filled out COMPLETELY,** signed by either a Physician, licensed Physician Assistant, Registered Nurse-APN, or Doctor of Chiropractic (physical examination), signed by both student and parent/guardian in **BLUE or BLACK INK,** and on file in the **Athletic Training Room, BEFORE** the student will be allowed to participate in any class period practice, tryout, practice, scrimmage and/or competition. PHYSICAL must be DATED AFTER APRIL 1, 2023.

Questions? Call the Texas City ISD Athletic Training Room 409-916-0800 Ext. 2504/2513.

STUDENT INFORMATION

Last Name:_____ **First Name:**_____ **Middle Name:**_____

Sex:(M/F)_____ **Age:**_____ **Birthdate:** ____/____/_____ **Student ID#:** _____ **Grade:**_____
(FOR 2023-2024 SCHOOL YEAR)

Home Address:_____
(Street Address or P.O. Box) (City) (State) (Zip Code)

Home Phone: (_____**)** _____ **-**_____ **Student Cell:(**_____**)** _____ **-**_____ **Student Email:**_____

PARENT/GUARDIAN INFORMATION

Father's Name:_____ **Email:**_____
(last name) (first name) (middle int.)

Home Address: ☐ (check if same as athlete)_____
(Street Address or P.O. Box) (City) (State) (Zip Code)

Home Phone: (_____**)** _____ **-**_____ **Bus. Phone:(**_____**)** _____ **-**_____ **ext.**_____ **Cell: (**_____**)** _____ **-**_____

Mother's Name:_____ **Email:**_____
(last name) (first name) (middle int.)

Home Address: ☐ (check if same as athlete)_____
(Street Address or P.O. Box) (City) (State) (Zip Code)

Home Phone: (_____**)** _____ **-**_____ **Bus. Phone:(**_____**)** _____ **-**_____ **ext.**_____ **Cell: (**_____**)** _____ **-**_____

EMERGENCY CONTACT

*In case of emergency, please notify: (Please list emergency contact **other than parent/guardian** and relationship to student.)*

Name:_____ **Address:**_____ **Relationship:**_____

Home Phone: (_____**)** _____ **-**_____ **Bus. Phone: (**_____**)** _____ **-**_____ **ext.**_____ **Cell: (**_____**)** _____ **-**_____

INSURANCE INFORMATION

Please check to indicate type of health insurance coverage and list all policy information for student: (REQUIRED by state law)

☐ **NO Insurance Provider Coverage**

☐ **Current Insurance Provider Coverage** (please provide copy of insurance card and list details below)

Primary Insurance Company:_____ **Phone: (**_____**)** _____ **-**_____
(i.e. BCBS, United Healthcare, Aetna, Humana, Medicaid, etc.)

Type: ☐ HMO ☐ PPO ☐ POS **Other:**_____ ☐ **Referral required to see specialist**
(i.e. Health Select, CHIP, AmeriGroup, Star Health, etc.)

Policy Holder:_____ **Group #:**_____ **Policy #:**_____