

UNIVERSITY OF MAINE AT FORT KENT
INSURANCE INFORMATION

Name: _____	SS# _____	D.O.B. _____
Home address: _____	City: _____	State: _____ Zip _____
Home Phone: () _____	Year of school _____	

In signing this form, you are authorizing hospitals, physicians, rehabilitation clinics, and any other health care professional to release medical information to the Sports Medicine staff and team physicians concerning your health and welfare. This medical information may relate to your past, present, and future injuries or illnesses that may or have already occurred while participating in athletics at the University of Maine at Fort Kent.

Also, by giving you're the authorization for the release of medical information, you permit the Sports Medicine staff at UMFK to disclose information to concerning your health to coaches and potential professional scouts of the opportunity should arise in the future. This consent does not permit the Sports Medicine to discuss your health condition or playing status with the media.

DATE _____ Print Name _____

Sign Name _____

Medical Consent

You give permission to University of Maine at Fort Kent team physician, and or consulting physician as well as the sports Medicine staff to render any treatment that may be necessary regarding your health and well-being.

You authorize the medical staff at UMFK to render the necessary services which may include surgical or medical care provided by the team physician or consulting physician. You realize that you are authorizing the athletic trainer to render any treatment that may fall under the headings of preventative first aid, rehabilitation, and emergency treatment. You also are aware that by giving consent for proper care, you are giving permission for hospitalization when necessary at an accredited hospital.

DATE _____ Print Name _____

Sign Name _____

Insurance Company: _____	Phone: _____
Address: _____	City: _____ State: _____ Zip _____
Policy# _____	Group# _____
Effective Date _____	Deductible _____
Primary Care Physician: _____	Phone: _____
Address _____	City: _____ State: _____ Zip: _____
Policy Holder: PARENT GUARDIAN SELF	
Name _____	SS# _____ D. O.B. _____
Home Phone _____	Work _____
Address: _____	City: _____ State: _____ Zip: _____
Policy Holder Employer Information:	
Name (CO): _____	Phone _____
Address: _____	City: _____ State: _____ Zip: _____

I certify that the above information is accurate and correct. My signature on this form shall be considered verification of enrollment. I understand that it is my responsibility to notify the Sports Medicine Staff of any changes that may occur. I authorize the Sports Medicine Staff at the University of Maine at Fort Kent to release the above insurance information to healthcare providers.

Policy Holder Signature

Date