

**PERSONAL INFORMATION / MEDICAL TREATMENT & INFORMATION RELEASE FORM**

Parent/Guardian To Complete and Return to:  
North Georgia College & State University  
Hwy. 60, South  
Memorial Hall  
Att: Jessica M. Poole, M.Ed, ATC  
Dahlonega, GA 30597

**FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS.**  
*(NOTE: Complete all blanks with information or N/A if not applicable).*

1. Name of Athlete: \_\_\_\_\_ Sport: \_\_\_\_\_  
College Address: \_\_\_\_\_  
College Phone: \_\_\_\_\_ email address: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

2. **Father/Guardian:** \_\_\_\_\_  
Home Address: \_\_\_\_\_ email address: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  HMO  PPO  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Policy No.: \_\_\_\_\_

3. **Mother/Guardian:** \_\_\_\_\_  
Home Address: \_\_\_\_\_ email address: \_\_\_\_\_  
Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  HMO  PPO  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Policy No.: \_\_\_\_\_

Athlete's Primary Care Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

Permission is hereby granted to the North Georgia College & State University Department of Athletics to proceed with any needed medical or minor surgical treatment, radiographic examinations, immunizations and drug testing for the above-named student-athlete. In the event of a serious illness, the need for major surgery or significant accidental injury, I understand that an attempt will be made to contact my parents/guardians in the most expeditious manner possible. If unable to communicate with them, the treatment necessary for the best interest of the above-named student-athlete may be given.

Also, permission is hereby granted to the North Georgia College and State University Department of Athletics and K&K Insurance Company to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

We authorize that North Georgia College & State University or The Hartford Insurance Company pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by North Georgia College & State University.

Parent's Signature: \_\_\_\_\_

Student's Signature: \_\_\_\_\_