THE COLLEGE AT BROCKPORT INTERCOLLEGIATE ATHLETICS

VERIFICATION OF HEALTH INSURANCE

I understand that The College at Brockport Athletic Department does not provide health insurance for student-athletes. By signing this form I hereby certify that I have either:

☐ **A) Purchased the Brockport Health Insurance Policy.**
(Contact www.Chickering.com for Policy information) or
☐ **B) I have Health insurance policy that covers athletic related injuries up to $75,000.**

Student-Athlete Name: _____Sport: _____

Date of Birth: _____ Banner #: 800_____

Parent or Guardian Name:_____

Parent or Guardian Phone #: (_____) _____ - _____

Further, I certify that the following information is true and accurate regarding my insurance coverage:

Name of Insurance Company: _____

Insurance Policy Number: _____Group # (IF APPLICABLE): _____

Name of Policy Holder, (Self, Mother, Father): _____

DATE:_____ SIGNATURE:_____
(Student at Brockport**)**

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CONSENT FOR RELEASE OF INFORMATION

Name: _____ Sport_____ Date of Birth: _____

Do hereby grant authorization to The College at Brockport Sports Medicine Staff to release and /or obtain my injury reports and/or medical records and participation status for any and all injuries /illnesses incurred as a direct result of or affecting my participation as a member of an intercollegiate athletic team at The College at Brockport. This information, as warranted and/or appropriate would be released to one or more of the following:

Athletic Administration, Hazen Health Center, Appropriate athletic team coach, Team physician
Family and/or specialist physician, Hospitals / clinics / ambulance crew, Insurance providers
Professional scouts, Parents

I understand that in accordance with Federal and State laws, this release does not include permission to transmit information specifically related to HIV (Human Immunodeficiency Virus) the causative agent of AIDS) status, and if such information is to be released, additional specific release forms are required. I understand that this consent is valid for 1 academic year from the date of signing and that I may rescind this consent at any time with written notification.

_____ _____ _____
Student Signature **Witness** **Date:**

_____ _____
Parent signature if student is under the age of 18 **Date:**