The University of Iowa Athletic Training Services

Student-Athlete Contact & Medical Information Form

First Year Student-Athletes Only

Please fill out **ALL** of the information **completely** to provide us with your Student-Athlete information for the upcoming academic year. Failure to return this completed form will cause delays in your pre-season physical exam and medical clearance to participate in athletics at The University of Iowa.

Contact Medical Insurance Coordinator, at 319.335.9393 if you have any questions.

For Office Use Only

Received _____

Missing Inform.? Yes _____ No _____

Missing: _____

_____

Health Insurance? Yes _____ No

AthleteConnection? Yes _____ No

To UIHC/Pharm.

Scan/Attach to SIMS file

Wants SHIP? Yes _____ No _____

HOSP # : _____

PLEASE FILL IN ALL INFORMATION BLANKS COMPLETELY.

STUDENT ATHLETE'S FULL NAME (First, Middle Initial & Last)

UNIVERSITY STUDENT ID# (8-digit # starting w/zero)

GENDER ☐ FEMALE ☐ MALE

DATE OF BIRTH

CHOOSE SPORT FROM DROP-DOWN LIST

RACE

ETHNICITY

PRIMARY LANGUAGE

YEAR in COLLEGE ☐ FR ☐ SO ☐ JR ☐ SR ☐ 5th Yr. SR ☐ Grad. Student

☐ SCHOLARSHIP ☐ INVITED WALK-ON ☐ TRANSFER ☐ GRAY TEAM ☐ TRY-OUT

CAMPUS INFO

My son/daughter will be living in this Residence Hall: (please choose)

My son/daughter will be living OFF CAMPUS at this address:

CELL PHONE #

EMAIL ADDRESS (Required)

Have you every been a patient (or were you born at The University of Iowa Hospitals and Clinics? ☐ YES ☐ NO

EMERGENCY CONTACT(S)

PARENT(S)/GUARDIAN(S) FIRST & LAST NAME(S)

RELATIONSHIP(S) TO STUDENT-ATHLETE

HOME STREET ADDRESS

CITY STATE ZIP CODE COUNTRY

HOME PHONE # CELL PHONE #

PRIMARY EMAIL ADDRESS (Please provide for contacting)

INSURANCE INFORMATION

Please include ENLARGED, front & back copies OF EACH OF YOUR CURRENT HEALTH INSURANCE CARDS that covers your son or daughter.

Student-Athlete's Full Name _____ Sport _____

Please Check the Boxes Below that Apply to You:

- ☐ We have the health insurance coverage listed below.
- ☐ We have OUT-OF-NETWORK benefits.
- ☐ We have health insurance coverage and would also like to sign up for the University's SHIP insurance.
- ☐ We do not have health insurance coverage and would like to sign up for the SHIP insurance through the University.

MEDICAL INSUR.

Insurance COMPANY NAME		ADDRESS			
IDENTIFICATION #		GROUP #		PHONE #	
Policyholder's FULL NAME		**Policyholder's BIRTHDATE**			
Policyholder's EMPLOYER & WORK #		**EFFECTIVE DATE of Insurance**			

☐ We do not have PRESCRIPTION insurance. ☐ Same as Medical Insurance information.

PRESCRIPTION INSUR.

Insurance COMPANY NAME		ADDRESS			
IDENTIFICATION #		GROUP #		PHONE #	
Policyholder's FULL NAME		**Policyholder's BIRTHDATE**			
Policyholder's EMPLOYER & WORK #		**EFFECTIVE DATE of Insurance**			

☐ We do not have DENTAL insurance. ☐ Same as Medical Insurance information.

DENTAL INSUR.

Insurance COMPANY NAME		ADDRESS			
IDENTIFICATION #		GROUP #		PHONE #	
Policyholder's FULL NAME		**Policyholder's BIRTHDATE**			
Policyholder's EMPLOYER & WORK #		**EFFECTIVE DATE of Insurance**			

☐ We do not have VISION insurance. ☐ Same as Medical Insurance information.

VISION INSUR.

Insurance COMPANY NAME		ADDRESS			
IDENTIFICATION #		GROUP #		PHONE #	
Policyholder's FULL NAME		**Policyholder's BIRTHDATE**			
Policyholder's EMPLOYER & WORK #		**EFFECTIVE DATE of Insurance**			