

**Form F: Club Sports Medical Information and Release Form**

Club Name \_\_\_\_\_

Participant's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Current Status:     Student                       Graduate Student                       Faculty/Staff

CPO: \_\_\_\_\_ Telephone number: ( \_\_\_\_ ) \_\_\_\_\_ Student ID #: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

**I. Emergency Contact Information**

Contact Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Telephone-Daytime: ( \_\_\_\_ ) \_\_\_\_\_ Nighttime: ( \_\_\_\_ ) \_\_\_\_\_

**II. Medical/Hospitalization Insurance Coverage Information**

Relevant emergency medical information (asthma, allergies to medication, previous history of seizures, heart or kidney disease, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please check all that apply:

- I am subscribed to the Wheaton College Student Health Insurance Policy.
- I have coverage through my parents' health insurance or a personal health insurance policy. If so, please answer the following:

Name of Agency providing coverage: \_\_\_\_\_

Policy number: \_\_\_\_\_

Dates for which coverage is provided: From \_\_\_\_\_ to \_\_\_\_\_

Are you sure it covers you out of your home state and/or out of Illinois?

Yes                           No

**By signing below, I verify that: a) I have no physical impairments that might put myself or others in danger by my participation in club sports activities; b) I will abide by all College and applicable club sports regulations regarding my participation; and c) if I become injured in the course of my participation, and am unable to seek treatment for myself, I hereby give permission for emergency medical treatment to be sought for me by representatives of Wheaton College.**

\_\_\_\_\_  
(Signature of Participant)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
(Signature of Parent/Guardian if Participant is a minor)

\_\_\_\_\_  
Date Signed