Sam Houston State University
Personal Medical and Insurance Information

Personal Information

Full Legal Name: _____ Sport_____
SAM ID:_____ SSN:_____ DOB:_____
Local Address: _____ Zip: _____
Cell Phone#:_____ Cell Phone Provider: _____
Year of Enrollment_____ Field Classification: _____
Current Email Address: _____

Emergency Contact Information

Father's Name:_____ Contact Number:_____
Mother's Name:_____ Contact Number:_____
Permanent Address:_____ APT #_____
City:_____ ST:_____ Zip:_____

Primary Medical Insurance Information:

This information will be used by any and all providers that you are sent to for either injury or illness that may or may not be specifically related to athletic participation for Sam Houston State University.
Please attach a copy of the front and back of your insurance card as well.
Insurance Company Name: _____
Insurance Company Claims Mailing Address:_____
_____
Insurance Contact Number:_____
Policy/ID #:_____
Group #:_____
Primary Insured Name:_____
Primary Insured Dated of Birth:_____
Primary Insured SSN:_____

Medical Alerts:

Drug Allergies:_____
Food Allergies:_____
Asthma (Type):_____
Sickle Cell Trait Carrier:_____
ADD/ADHD:_____
Diagnosed Cardiac Issue:_____
Other Medical Emergent Condition Not Listed:_____

Current Medication/Supplements(s): Please list all prescription drugs, dose and/or over the counter drugs you take regularly and the condition or reason you take it:

1._____
2._____
3._____
4._____
Note: You must update this list as medications are added, dropped or changed.