



MEDICAL INSURANCE FORM

Please Print

Name of Player _____

Name of Parents _____

Parent's Cell # _____

Name of Insurance Company _____

Policy # _____

Family Physician _____

Allergies to Medication _____

_____ By signing this document, I am certifying that I have and will keep medical coverage on the above athlete or athletes while they are participating in track and field. I will notify Coach Murry in writing of any changes on Medical Insurance Coverage that should occur from the date signed until July 2019.

_____ If I do not have medical insurance, I would like to purchase school insurance for my child. (see Coach Murry)

Signature of Parent/Guardian: _____

Date: _____