

2024-2025 TEXAS CITY I.S.D. MEDICAL INFORMATION FORM



Attention: This form **MUST be filled out COMPLETELY**, signed by either a Physician, licensed Physician Assistant, Registered Nurse-APN, or Doctor of Chiropractic (physical examination), signed by both student and parent/guardian in **BLUE or BLACK INK**, and on file in the **Athletic Training Room, BEFORE** the student will be allowed to participate in any class period practice, tryout, practice, scrimmage and/or competition. **PHYSICAL must be DATED AFTER APRIL 1, 2024.**

Questions? Call the Texas City ISD Athletic Training Room 409-916-0800 Ext. 2504/2513.

STUDENT INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____
Sex: (M/F) _____ Age: _____ Birthdate: ____/____/____ Student ID#: _____ Grade: _____
(FOR 2024-2025 SCHOOL YEAR)
Home Address: _____
(Street Address or P.O. Box) (City) (State) (Zip Code)
Home Phone: (____) _____ - _____ Student Cell: (____) _____ - _____ Student Email: _____

PARENT/GUARDIAN INFORMATION

Father's Name: _____ Email: _____
(last name) (first name) (middle int.)
Home Address: ☐ (check if same as athlete) _____
(Street Address or P.O. Box) (City) (State) (Zip Code)
Home Phone: (____) _____ - _____ Bus. Phone: (____) _____ - _____ ext. _____ Cell: (____) _____ - _____
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Mother's Name: _____ Email: _____
(last name) (first name) (middle int.)
Home Address: ☐ (check if same as athlete) _____
(Street Address or P.O. Box) (City) (State) (Zip Code)
Home Phone: (____) _____ - _____ Bus. Phone: (____) _____ - _____ ext. _____ Cell: (____) _____ - _____

EMERGENCY CONTACT

In case of emergency, please notify: (Please list emergency contact **other than parent/guardian** and relationship to student.)

Name: _____ Address: _____ Relationship: _____
Home Phone: (____) _____ - _____ Bus. Phone: (____) _____ - _____ ext. _____ Cell: (____) _____ - _____

INSURANCE INFORMATION

Please check to indicate type of health insurance coverage and list all policy information for student: (REQUIRED by state law)

☐ NO Insurance Provider Coverage

☐ Current Insurance Provider Coverage (please provide copy of insurance card and list details below)

Primary Insurance Company: _____ Phone: (____) _____ - _____
(i.e. BCBS, United Healthcare, Aetna, Humana, Medicaid, etc.)

Type: ☐ HMO ☐ PPO ☐ POS Other: _____ ☐ Referral required to see specialist
(i.e. Health Select, CHIP, AmeriGroup, Star Health, etc.)

Policy Holder: _____ Group #: _____ Policy #: _____