

Sport(s): \_\_\_\_\_

Smith College  
Student-Athlete Information Sheet

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Year of Graduation: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_

School Address: Box # \_\_\_\_\_ School Phone: \_\_\_\_\_

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**Emergency Contacts**

*Please call first:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

*Please call second:*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

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**Insurance Information**

Athlete has Smith College Insurance Policy  
Athlete's Insurance ID Number: \_\_\_\_\_

Athlete has other insurance policy  
Policy Holder Information:  
Name: \_\_\_\_\_  
Ins. Company: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  
Ins. Company Address: \_\_\_\_\_

Ins. ID #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Ins. Company Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Referral needed for Emergency Room  Yes  No  
Referral needed for office visit  Yes  No

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**Medical Information**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

\*Please list any medications you are currently taking:

Name	Dose	Frequency	Reason
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

\*Please list any allergies you may have (medications, insects, environmental, etc.):

\*Do you carry Epi-Pen Auto- Injectors for any allergic condition?  Yes  No

\*Please list any conditions you may have that emergency medical personnel should be aware of: