

**PARENT INFORMATION FORM  
2009 - 2010**

**PARENTS/GUARDIAN TO COMPLETE & RETURN TO:**  
Please complete All Blanks.

**Rockhurst University  
ATTN: Athletic Department  
1100 Rockhurst Road  
Kansas City, MO 64110**

**FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not (deceased, divorced, unknown).**

**I. Student – Athlete Information:**

Name of Student /Athlete: \_\_\_\_\_

Year in School \_\_\_\_\_ Social Security# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Student ID#(If known) \_\_\_\_\_ Sport: \_\_\_\_\_

Permanent Address: \_\_\_\_\_  
City State/Zip

Permanent Address Phone#: \_\_\_\_\_ Phone# During School Year: \_\_\_\_\_

Address During School Year: \_\_\_\_\_  
Box # City State/Zip

On Campus \_\_\_\_\_ Off campus \_\_\_\_\_

Email address: \_\_\_\_\_ Cell phone # \_\_\_\_\_

Rockhurst e-mail address: \_\_\_\_\_

**II. Parents Information**

Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

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

E-mail Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

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

\_\_\_\_\_

Telephone: \_\_\_\_\_ Telephone: \_\_\_\_\_  
**(OVER)**

**III. Insurance Information**

Father/Guardian Company/Plan: \_\_\_\_\_ Mother/Guardian Company/Plan: \_\_\_\_\_

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

\_\_\_\_\_

Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Is the company or plan listed above considered (Please check one) \_\_\_\_\_ Health Maintenance Organization (HMO)  
\_\_\_\_\_ Preferred Provider Organization (PPO)  
\_\_\_\_\_ Other

Does your insurance or plan require a second opinion before surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

I/We the parents of \_\_\_\_\_, a participant in Rockhurst University Athletics received and read the

insurance information letter dated \_\_\_\_\_ from Rockhurst University. **I/We understand our son/daughter is covered by an EXCESS COVERAGE POLICY with a \$5,000.00 DEDUCTIBLE, while participating for Rockhurst University Athletics. We further understand, WE ARE RESPONSIBLE FOR THE \$5,000.00 DEDUCTIBLE FOR EACH INJURY INCURRED whether the student athlete is covered by our personal insurance policy and/or through the Rockhurst Student Insurance.**

I/We hereby authorize Rockhurst University and their designated insurance provider to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photo static copy of this authorization shall be deemed as effective and valid as the original. I/We authorize the university or its insurance agent pay the medical vendors direct for any bills incurred from accidents covered under the coverage purchased by the University.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 2009.

Parent/Guardian Signature: \_\_\_\_\_

Student/Athlete's Signature: \_\_\_\_\_

**Student/Athletes will not be allowed to participate in practices or games unless this form is signed.**