

PARENT /GUARDIAN/ STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO → Name of College/University Madison Area Technical College

Attention Athletic Department

**This form is to be completed by the
Parents, Guardians or Student**

Address 3550 Anderson Street

City Madison State WI Zip 53704

Note: Please complete all blanks on this form.

If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete _____ Sport _____

Social Security No or Passport No _____ Date of Birth _____

Address _____ Phone () _____

(While attending MATC) _____ (While attending MATC) _____

Home Address _____ Home Phone () _____

City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION

MOTHER/GUARDIAN INFORMATION

Father's Name _____ Mother's Name _____

Social Security No. _____ Social Security No. _____

Date of Birth _____ Date of Birth _____

Address _____ Address _____

Employer _____ Employer _____

Address _____ Address _____

Telephone () _____ Telephone () _____

Medical Insurance _____ Medical Insurance _____

Company or Plan _____ Company or Plan _____

Address _____ Address _____

Policy Number _____ Policy Number _____

Telephone () _____ Telephone () _____

Is this plan an HMO or PPO? Yes No Is this plan an HMO or PPO? Yes No

Is pre-authorization required to obtain treatment? Yes No Is pre-authorization required to obtain treatment? Yes No

Is a second opinion required before surgery? Yes No Is a second opinion required before surgery? Yes No