Success Unlimited Academy
Athlete Information Sheet

DATE: _____

ATHLETE'S NAME		DOB:
ADDRESS:		
CITY, STATE & ZIP		
ATHLETE'S CELL #:	HOME #:	
PARENT'S NAME:	WORK #:	
CELL #:	PARENT'S EMAIL:	
LAST SCHOOL ATTENDED	GRADE LEVEL FOR FALL	
ADDITIONAL EMERGENCY CONTACT:	EMERGENCY CONTACT CELL #:	
RELATIONSHIP TO ATHLETE:		
PHYSICIAN'S NAME:	PHYSICIAN'S #:	
INSURANCE CARRIER:	POLICY #:	GROUP #:
INSURANCE POLICY HOLDER'S NAME:	POLICY HOLDER'S DOB:	
POLICY HOLDER'S EMPLOYER	POLICY HOLDER'S SSN:	
ANY KNOWN ALLERGIES: (i.e. allergies to medications, insect bites, etc.)		

ANY KNOWN MEDICAL CONDITIONS WE SHOULD BE AWARE OF: (i.e. Diabetes, Asthma, etc.)
I certify that, to the best of my knowledge, the information that I have provided is complete and correct. I will promptly inform SUA Athletic Department of any changes in insurance or demographic information.
ATHLETE'S SIGNATURE:
PARENT'S SIGNATURE