PROOF OF INSURANCE

STUDENT NAME

_______________________________________Grade_______

DATE OF BIRTH_______________________________________

Best phone # to use of Parent/Guardian______________________

E-Mail Address ____

FATHER'S NAME____

MOTHER'S NAME____

ADDRESS____

CITY _________________________________ZIP CODE___________

DOCTOR'S NAME_____________________PHONE#_____________

CLINIC OR HOSPITAL

PHONE#____

INSURANCE COMPANY________________________________

POLICY NUMBER____________________________________

Allergies: ____

List any medications take daily or regularly: ____________________

____

Vision: glasses/contacts ______________________

Hearing: ___________________________________