CONFIDENTIAL – STUDENT INFORMATION CHART

MUST BE RETURNED TO SCHOOL BY: Tuesday, Sept. 5th

STUDENT'S NAME: ______________________________________

Address: ____

Telephone No. ____

MEDICAL COVERAGE?: Yes ___ No ___

If yes, give: Name of Plan ____
Plan Number ____
Medicaid No. _______________________________________
Hospital Preference: __________________________________

NAME OF FAMILY PHYSICIAN: ________________________________
Telephone No. of physician: _______________________________________

NAME OF FAMILY DENTIST: ___________________________________
Telephone No. of dentist: ____

OTHER AUTHORIZED MEDICAL TECHNICIANS: ______________________
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IS STUDENT ON MEDICATION OR ALLERGIC TO MEDICATION?
Yes ___ No ____
If answer is yes, specify medication or allergies: ________________________________

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IS SCHOOL AUTHORIZED TO ADMINISTER MEDICATION:
Yes ____ No ____
If answer is yes, is a signed release on file authorizing the administration of medication?
Yes ____ No ____

FOR EMERGENCY PURPOSES: Telephone numbers (or other information) for purposes of contacting parents in case of emergency:

Father's place of employment ____
Telephone No. ____

Mother's place of employment ____
Telephone No. ____

Home Telephone No. ____

IF PARENTS CANNOT BE REACHED:

Name and telephone number of authorized person to call:

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