Visual Art Academy -MEDICAL & HEALTH INSURANCE INFORMATION

(Please make a photocopy of your insurance card(s) and enclose with this form for use in case of emergency)

Primary Insurance Information:

Child's Full Name:

Name of Insurance Company:

Insurance Company Address:

Insurance Company Phone #:

Policy Holder's Name:

Policy Holder's Social Security Number:

Group #:

Child's Relationship to Policy Holder:

Secondary Insurance Information:

Name of Insurance Company:

Insurance Company Address:

Insurance Company Phone #:

Policy Holder's Name:

Policy Holder's Social Security Number:

Group #:

Child's Relationship to Policy Holder:

Mother home phone

Mother work phone

Mother cell phone

Father home phone

Father work phone

Father cell phone

Emergency contact name

Emergency contact phone

Is your child taking any medication? Yes No

If yes, please list the medication and how frequently it must be taken.

	Medication type	**Frequency**
1		
2		
3.		

Does your child have any medical conditions, such as diabetes or asthma, of which we should be aware?

Yes No If yes, please describe.

Name of child's physician:

Physician phone:

Is your child eligible to be seen at Chief