Education and Workforce Development Cabinet

Office of Career and Technical Education

Student Medical Record and Insurance Verification

School:	Campbell County ATC		Program:			
Student:			Soc Sec #:		Birth Date:	
Address:				City:		
State:		Zip:		Phone #:		

Emergency Contact:			Address:			
City:			State:		Zip:	
Home Phone:		Work #:			Cell #:	
Relationship to Student:	Father:		Mother:		Brother:	
	Sister:		Other:			

Each student enrolled at the school should have some type of insurance coverage in the event of an injury. Every precaution is taken to prevent injuries; however, accidents do happen occasionally. The state provides limited insurance coverage for students enrolled in the School.

Name of Insurance Company:		Policy Number:		Group Number:	
Family Physician:			Physician's Phone #:		
Hospital:					
Do you have school insurance on the student:		Yes:		No:	
If you have a state medical card, please provide the number:					

Identify any of the conditions or diseases below that you have (please check appropriate boxes):					
	Allergies (including drug)*		Dyslexia		Physical Disabilities
	Asthma		Must Wear Brace		Orthopedic
	Color Blindness		Polio		Heart Condition
	Diabetes		Hernia		Must Wear Hearing Aid
	High Blood Pressure		Rheumatic Fever		Must Wear Glasses/Contacts
	Epilepsy		Other		

Are you presently taking any medications?	Yes		No	
If yes, please list:				
***List any allergies you have:**				

If I am unconscious and spouse or parent/legal guardian cannot be reached, I hereby give consent for the principal and/or teacher to do whatever is necessary to secure emergency medical care.

Student Signature:		Date:	
Must be signed by parent/legal guardian if student is a minor:			
Parent/Guardian Signature:		Date:	

Equal Education and Employment Opportunities M/F/D