Ardmore High School

Health Information/Proof of Insurance Form 14-15

Student's Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____Grade:_____

Parent/Guardian Contact:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone Number:_____

Cell Phone Number:_____

Work Number:_____

Medical Insurance Information:

Provider:_____

Contract Number:_____

Group Number:_____

Parent/Guardian Contact:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone Number:_____

Cell Phone Number:_____

Work Number:_____

Does Student Have:

Allergies	Yes	No	If yes,
Asthma	Yes	No	If yes,
Diabetes	Yes	No	If yes,
Epilepsy or Seizures	Yes	No	If yes,
Heart Conditions	Yes	No	If yes,
Trouble Seeing	Yes	No	If yes,
Trouble Hearing	Yes	No	If yes,
Other Known Health Problems	Yes	No	If yes,
Up to date Tetanus Shot	Yes	No	
Does Student Take Medication	Yes	No	If yes,

Note: No Trainer or Coach will administer any medication. The school nurse with written permission from you is the only school employee designated to do so.

Specify:_____

Where is location of his/her inhaler:_____

Insulin specifications:_____

Specify:_____

Specify:_____

(Circle one), Glasses Contacts Both None

(Circle one), Hearing Aide None

Specify:_____

Date of last Tetanus Shot:_____

Type:_____Rate:_____Dosage:_____

Type:_____Rate:_____Dosage:_____

Type:_____Rate:_____Dosage:_____

Student's Physician:_____

Physician's Address:_____

City:_____ State:_____ Zip:_____

Physician's Phone Number:_____

If unable to reach parent/guardian, please contact:

Name:_____

Relationship to Student:_____

Home Number:_____ Cell:_____

Signature of Student:_____

Signature of Parent/Guardian:_____