Annunciation Austin

Education Enriched through Faith and Family

Medical Information

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1. *About the Student (please provide for each student)*

Student's Name: _____, _____
(Last) (First) (M.I.)

Medical Conditions: _____
(That May Affect Your Child's Performance in School)

_____

Medications: _____

_____

Allergies: _____

_____

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2. Medical Providers

Primary Physician: _____ Phone: _____

Physician's Address: _____

_____

Preferred Hospital: _____ Phone: _____

Hospital Address: _____

_____

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P.O. Box 160721, Austin, TX 78716
www.annunciationaustin.org
info@annunciationaustin.org

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3. *Medical Insurance*

Medical Insurer: _____
(The name of the insurance company providing medical coverage)

Primary Beneficiary: _____
(Ordinarily the parent through whom the children are insured)

Group Name: _____
(Ordinarily the primary beneficiary's employer)

Individual/Group Number: _____

Insurer's Telephone #: _____
(The number to call to approve medical services)

Claims Address: _____

_____

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4. *Important*

Please attach the following (and check the boxes):

☐ A photocopy of the insurance card (front and back).

☐ An up-to-date copy of the child's immunization record signed by a physician, or a letter from a physician explaining the absence of immunizations. (*Note:* Appropriate documentation of the child's immunization status is a condition of enrollment.)

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5. *Signature*

Parent's Name: _____
(Please print.)

Signature: _____ Date: _____

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