

Kentucky Department of Education

*Office of Career and Technical Education and Student Transition*

Student Medical Record and Insurance Verification

|  |  |  |  |
| --- | --- | --- | --- |
| School: | Clark 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