SPAULDING ACADEMY & FAMILY SERVICES
MEDICAL INSURANCE INFORMATION
HEALTH SERVICES

MEDICAL INSURANCE Child's Name: _____

To better serve your child and prepare for possible emergencies, we need assurance of medical coverage before admission. Please provide copies of all insurance cards.

Healthy Kids Certificate/Medicaid #: _____

**SECONDARY INSURANCE**

Medical Insurance Company: _____

Address: _____

Certificate #: _____ Group #: _____

Effective Date: _____

Employer Name: _____

Subscriber Name: _____

Subscriber's Date of Birth: _____

Present Primary Care Physician: _____

Address: _____ Phone: _____

**If this coverage does not encompass the cost of medications or medical consultations, the parents or legal guardian becomes the guarantor of costs incurred.**

**If coverage changes, the parent or legal guardian is responsible for informing the Health Services Department of that change immediately and provide an original card.**

_____ ____/____/_____
**Signature of Mother/Guardian** **Date**

_____ ____/____/_____
**Signature of Father/Guardian** **Date**