St. Paul School
1825 Church Lane | 510.233.3080
San Pablo, CA 94806 | www.st-paulschool.org

Verification of Insurance Coverage for Student

Print Student Name: _____ Date of Birth: _____

Primary Policy Holder Name:_____

Health Insurance Company Name:_____

Policy Number: _____ Phone Number: _____

My Child's Physician: _____ Phone Number: _____

My Child's Dentist: _____ Phone Number: _____

Allergic to any medications ☐ YES ☐ NO If yes, please explain: _____

_____

Allergic to any foods or products ☐ YES ☐ NO If yes, please explain: _____

_____

My child is currently on medication prescribed for long-term continuous use and/or have the following PRE-EXISTING ILLNESSES, ALLERGIES OR HEALTH CONCERNS – please attach a separate sheet, if applicable:

(_____) _____
condition medication

(_____) _____
condition medication

→ **NOTE:** If your child is required to take **ANY** medication during school hours, you must fill out, sign, and return to the Office a ***MEDICATION AUTHORIZATION*** form**.**

You may NOT send medication with your child to self-medicate.

Parent/Guardian Signature: _____**Date**: _____

Print Parent/Guardian Name: _____