



**INSURANCE & EMERGENCY CONTACT INFORMATION**  
**2024-25**

1. Scholar's Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Scholar's Cell Phone # \_\_\_\_\_ Cell Phone Carrier \_\_\_\_\_  
Cell Phone Model and Production Year \_\_\_\_\_  
Scholar's personal email \_\_\_\_\_ AHS Student ID # \_\_\_\_\_

2. Print Name of **Parent/Guardian 1**: \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Email Address 1 \_\_\_\_\_ Email Address 2 \_\_\_\_\_  
Work Address \_\_\_\_\_  
Work Phone \_\_\_\_\_

Print Name of **Parent/Guardian 2**: \_\_\_\_\_  
Home Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Email Address 1 \_\_\_\_\_ Email Address 2 \_\_\_\_\_  
Work Address \_\_\_\_\_  
Work Phone \_\_\_\_\_

**2. Medical insurance is required by ABC of Andover.**

Include a copy of your daughter's insurance card (front and back) and pharmacy card. In addition, please send an official insurance card with your child.

Name of insurance company \_\_\_\_\_

Card Number \_\_\_\_\_

Pharmacy Card Number \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy Number \_\_\_\_\_

Type of insurance (circle one): Medicaid OR Commercial/Private

**EMERGENCY CONTACT INFORMATION**

**3. Emergency Contact(s):**

List other emergency contact (not the parent/guardian listed above)

Print Name \_\_\_\_\_  
Address \_\_\_\_\_  
Timezone \_\_\_\_\_  
Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Relationship to Scholar \_\_\_\_\_

List an emergency contact if you travel out of the country or will be in a different timezone than Boston MA US Eastern Time.

Print Name \_\_\_\_\_  
Address \_\_\_\_\_  
Timezone \_\_\_\_\_  
Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Relationship to Scholar \_\_\_\_\_

4. Parent/Guardian 1 Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian 2 Signature: \_\_\_\_\_ Date \_\_\_\_\_