



**INSURANCE & EMERGENCY CONTACT INFORMATION**

**2025-26**

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 \_\_\_\_\_

3. **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 and Contact Phone Number \_\_\_\_\_  
 Pharmacy Card Number \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Policy Holder \_\_\_\_\_ Policy Number \_\_\_\_\_  
 Type of insurance (circle one): Medicaid OR Commercial/Private OR Both OR None

**EMERGENCY CONTACT INFORMATION**

**4. 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 \_\_\_\_\_

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

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