VERIFICATION OF MEDICAL INSURANCE COVERAGE

IT WILL BE A REQUIREMENT THAT EACH CHILD IN OUR SCHOOL FAMILY PROVIDE EITHER VERIFICATION OF MEDICAL INSURANCE COVERAGE OR THIS SLIP SIGNED BY HIS/HER PARENT ACCEPTING FULL RESPONSIBILITY FOR MEDICAL COVERAGE.

Child's Name _____ Grade in Fall _____ Date _____

Insurance Company and Medical Coverage Number _____

OR

I WILL BE ASSUMING FULL RESPONSIBILITY FOR MY CHILD'S MEDICAL COVERAGE

Date _____ Parent's Signature _____

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