NHAS

Health Information Form

Student's Name___________________________

Physician's Name_______________________ Phone________________________________

Dentist's Name___________________________ Phone________________________________

Health Insurance Provider___________________ Policy #______________________________

My child is up to date on all required immunizations and physical exams and able to participate fully in the program as described. No_____ Yes_____

Does your child wear contact lens? No_____ Yes_____

Is your child fully vaccinated against Covid-19? No_____ Yes_____

If yes - Date of 1st vaccine_______________ Date of second vaccine________________

Does your child have any of the following the program staff should be aware of:

Medical Condition	No____	Yes____
Illness	No____	Yes____
Injuries	No____	Yes____
Allergies	No____	Yes____
Disability	No____	Yes____
Necessary modifications to the program	No____	Yes____
Inhaler	No____	Yes____
Emergency medication	No____	Yes ____
*Medication to be given while at the program	No____	Yes____

*If yes, please complete the Medication administration form

If you answered yes to any of the above, please explain: _________________________________

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NHAS reserves the right to request additional information on the interest of student participation.

Guardian Signature_______________________________ Date___________________

Print Name______________________________________