WILLIAM & MARY
NATIONAL INSTITUTE OF
AMERICAN HISTORY & DEMOCRACY

Student Health Form

Instructions: This form must be completed before you arrive on campus. NIAHD will share this form and information with medical personnel if a student needs medical assistance. This form may also be used to show proof of insurance as required under federal law.

Student Name _____ **Banner ID** _____

Age _____ **Course**_____ **Session** _____
(on move-in day)

Home Address _____

City _____ State _____ Zip Code _____

Country _____ Phone_____

Contact Information

Primary Contact Name_____

Phone _____ **Email**_____

Secondary Contact Name _____

Phone _____ **Email**_____

Medical History

Allergies

_____

_____

_____

Special Health Conditions or Diseases

_____

_____

_____

Dietary Restrictions or Preferences

_____

_____

_____

Medications

_____

_____

_____

Important: No member of the NIAHD staff is trained to assist students taking medications. All medications must be self-administered.

Are there any other physical, psychological, or emotional concerns that our program staff should be aware of?

_____

_____

_____

Primary Health Care Provider

Pediatrician/Physician_____

Office Address_____

City _____ **State**_____ **Zip Code**_____

Country _____ **Phone**_____

Insurance Coverage

Insurance Provider _____

Insurance ID #_____

Copy of Insurance Card

Do you get your health insurance through the U.S. Military? ☐ Yes ☐ No

If you are in the military, please make sure that your child has their military ID with them when they come to Williamsburg. It is not necessary for you to provide a copy of your military ID below.

All others, please, provide a copy of your insurance card below. You may insert digital images, staple printed copies, or attach on a separate sheet.

Copy of Insurance Card (FRONT)	Copy of Insurance Card (BACK)

Immunization Record

William & Mary requires an immunization record to be submitted with your Student Health Form. You may complete the form below or you may attach a copy of the most current immunization record that the student has on file with his/her/their pediatrician.

Measles, Mumps, and Rubella
(Please fill in the dates for either the combined vaccine or the individual vaccines)

MMR #1
(after first birthday)
Date: ____/____/____

MMR #2
(after 1980, AND after first birthday)
Date: ____/____/____

Measles
(both doses after first birthday)
Date:____/____/____

Date:____/____/____

Mumps
(both doses after first birthday)
Date:____/____/____

Date:____/____/____

Rubella
Date:____/____/____

Hepatitis B, Polio, Tetanus, Diphtheria, Pertussis, and COVID-19

Hepatitis B
Date:____/____/____

Date:____/____/____

Date:____/____/____

Polio
Date:____/____/____

Date:____/____/____

Date:____/____/____

Tetanus Booster (Tdap)
Date:____/____/____

COVID-19
(single dose of J&J; both doses of Pfizer or Moderna)
Date: ____/____/____

Date: ____/____/____

COVID-19 Booster
Date: ____/____/____

Permission for Treatment

I grant permission to necessary medical personnel, including, but not limited to, physicians, physicians' assistants, nurse practitioners, and nurses practicing within the scope of their duties at Urgent Care Facilities, Walk-In Clinics, and Emergency Rooms to treat me for medical illnesses or preventative health care. Additionally, I authorize these same medical providers to hospitalize and/or secure treatment for me in the event of surgical, medical, or psychiatric emergency if I am unconscious or incompetent at the time.

If you, the student, are 18 or older, please sign the form here:

Student Name _____
(Please Print)

Student Signature_____ **Date**_____

If you, the student, are under 18, you must also have a parent / guardian consent:

Parent/Guardian Name_____
(Please Print)

Parent/Guardian Signature _____ **Date** _____