Medical and Income

REQUIRED for the organization to receive funding for the youth program - Thank you for completing! Information will be kept confidential.

Family Information

Family Size: _____

Single Female Head of Household: Yes No

Single Male Head of Household (circle): Yes No

Free or Reduced Lunch (circle): Yes No

Ethnic/Racial Information for child/ren:

White/Non-Hispanic: _____

Black/Non-Hispanic: _____

Asian: _____

Native American: _____

Please indicate if your child/ren are Hispanic: Yes No

Annual Household Income:

$24,900 or below: _____

$41,500 or below: _____

$66,400 or below: _____

Above $66,400: _____

Other: _____

Child's Legal Name: _____

Birthday: _____ School: _____ Grade: _____

Health Information

I, voluntarily request that NTL be aware of the following health issues and/or that my child requires prescription medication in an emergency situation such as, but not limited to, allergy to bee stings, diabetic reaction, asthma attack, etc. I authorize NTL's full disclosure of this information.

Medical Problem/ Allergies: _____

Medications your child may be taking: _____

Do you have health insurance? Yes No

Preferred Hospital: _____

Insurance Company: _____ Policy #: _____

Physician's Name: _____ Phone #: _____