



**TO BE COMPLETED BY SCHOOL OFFICIAL**

In order to determine if this student qualifies for health coverage, please complete the following information:

Student's Name: \_\_\_\_\_ Academic Term: \_\_\_\_\_

Full time Student:  Yes  No Anticipated Date of Graduation: \_\_\_\_\_

Current Semester Began: \_\_\_\_\_ Semester Ends: \_\_\_\_\_

If student is pre-enrolled for next semester as a full time student, please enter the date the next semester begins: \_\_\_\_\_, ends: \_\_\_\_\_

If the current school term was not completed, please indicate the date attendance ceased: \_\_\_\_\_

I certify that the child is enrolled as a full time student during the period(s) currently or pre-rolled for: \_\_\_\_\_

Requirement for full-time status is: \_\_\_\_\_ Units/Hours

Date: \_\_\_\_\_

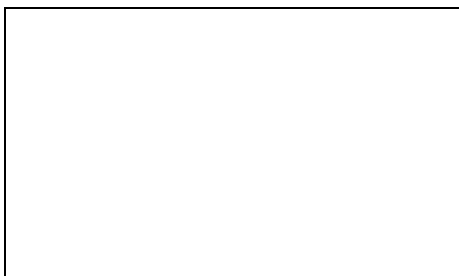
Signed: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_



Seal

**This form must include a college or university seal to be valid.**