AMPHITHEATER SCHOOL DISTRICT
HEALTH INFORMATION CARD

Student **Full Legal** Name ______________________________ Sex ____ Grade ____ School ____________
Last First Middle M/F

Resident Address ______________________________

Mailing Address (if different) ______________________________

Date of Birth _____/_____/______ Place of Birth ______________________________
City State County

Name/Address of Person(s) with whom Student may reside:

	Name	Address (If different than above)	Home #	Work #	Cell #
Father					
Step-Father					
Mother					
Step-Mother					
Guardian					

Brothers/Sisters:

Name	Age	School	Name	Age	School

Any legal restricted custody decision the school health office should be aware of? If yes, describe: ______________

Language(s) spoken by Student ______________ Language(s) spoken at home ______________

PLEASE CHECK THE FOLLOWING ITEMS, IF THEY PERTAIN TO YOUR STUDENT:

❑ADHD ❑Allergies/drug ❑Allergies/food ❑Allergies/seasonal ❑Asthma ❑Birth defects ❑Blood disorder ❑Bowel/bladder

❑Diabetes ❑Glasses/contacts ❑Headaches/migraines ❑Hearing problem ❑Heart condition ❑Orthopedic

❑Psychiatric disorder ❑Seizure disorder ❑Other **(If any items were checked, please explain)** ______________

<u>If your student is to take medication at school, a signed consent form is required.</u>

Please list ***all*** medication(s) student is now taking at home or school: ______________

What health or physical problem might affect school attendance or participation in **PE**? ______________

Has your student ever been involved in a special education program? If yes, please explain ______________

INSURANCE COVERAGE: ❑None ❑AHCCCS ❑Kids Care ❑Indian Health Services ❑Other Health Plan ______________

Doctor ______________ Phone ______________ Hospital Preference ______________

If parent/guardian cannot be reached, name a relative or friend with a LOCAL PHONE who will be responsible for your student if he/she is hurt or becomes ill at school. (Please notify the school health office of any information changes on this card.)

Name ______________ Address ______________ Phone ______________

Name ______________ Address ______________ Phone ______________

If emergency medical action or treatment is required, and parent/guardian cannot be contacted, I hereby authorize my child to be given emergency medical care as deemed necessary by school officials. I understand that any expenses incurred will be paid for by the parent/guardian or by insurance coverage provided by the parent/guardian, and that payment of any medical expense is not the responsibility of the school or the school district.

Parent/Guardian Signature ______________________________ Date ______________