

PLEASE PRINT

AMPHITHEATER SCHOOL DISTRICT
HEALTH INFORMATION CARD

Full Legal Name of Student _____ Sex _____ Grade _____ School Keeling
(Last) (First) (Middle) (M/F)

Resident Address _____

Mailing Address (if different) _____

Date of Birth ____/____/____ Place of Birth _____
City State Country

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

Table with 5 columns: Name, Address (If different than above), Home #, Work #, Cell #. Rows include Father, Step-Father, Mother, Step-Mother, Guardian.

Brothers/Sisters:

Name _____ Age _____ School _____ Name _____ Age _____ School _____
Name _____ Age _____ School _____ Name _____ Age _____ School _____
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 _____

Revised 5/08

(PLEASE COMPLETE REVERSE SIDE)

Stock Form #W9072

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)

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

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(s) _____

Name _____ Address _____ Phone(s) _____

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 _____

(Signature verifies that all of the information on this card is accurate.)