

**AMPHITHEATER SCHOOL DISTRICT  
HEALTH INFORMATION FORM**

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 _____
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 \_\_\_\_\_

**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 \_\_\_\_\_

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 \_\_\_\_\_

Amphitheater Unified School District does not discriminate on the basis of race, color, religion/religious beliefs, gender, sex, age, national origin, sexual orientation, creed, citizenship status, marital status, political beliefs/affiliation, disability, home language, family, social or cultural background in its programs or activities and provides equal access to the Boy Scouts and other designated youth groups. Inquiries regarding the District's non-discrimination policies are handled at 701 W. Wetmore Road, Tucson, Arizona 85705 by Anna Maiden, Equal Opportunity & Compliance Director, (520) 696-5164, amaiden@amphi.com, or Kristin McGraw, Executive