PLEASE PRINT

AMPHITHEATER SCHOOL DISTRICT
HEALTH INFORMATION CARD

Full Legal Name of Student_____ Sex F Grade_____ School Copper Creek Elementary School
(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:

	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 _____

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)** _____

_____

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

Please list ***<u>all</u>*** 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.)