TEACHER'S NAME (School Use Only) _____

PLEASE PRINT

AMPHITHEATER SCHOOL DISTRICT
HEALTH INFORMATION CARD

Full Legal Name of Student_____ Sex_____ Grade_____ School_____
(Last) (First) (Middle)

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 _____

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

☐ADHD/ADD ☐Allergies/drug ☐Allergies/food ☐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)_____ ☐Can pick up

Name_____Address_____Phone(s) _____ ☐Can pick up

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.)

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 Director of Student Services, (520) 696-5230, kmcgraw@amphi.com.