Amphitheater Public Schools

Department of Health Services

School Nurse Case Management Student Health Profile

Demographics

Student Name: _____ Date of Birth: _____

Parent/Guardian: _____

Address: _____

Mother Cell/Home#:_____ Mother Work: _____

Father Cell/Home#:_____ Father Work: _____

Additional Contact Name: _____ Number: _____

School Information

School Name: *Rillito Center* Main Number: *(520)696-6420*

Student Grade: _____ Teacher/Phone: _____

School Nurse: *Anita Redford* Direct Number: *(520) 269-4449*

Hospital/Insurance/Physician Information

Hospital Preference: _____

Insurance Provide: _____ ID#: _____

Physicians/Specialists Phone

PCP: _____

Other: _____

Other: _____

Other: _____

Emergency Medical Information

Student Name: _____ Date: _____

Approximate Wt. _____

***Allergies to Medicine:**_____

Medical Diagnosis

1. _____ 4._____
2. _____ 5._____
3. _____ 6._____

Medications

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____
4. _____ 8._____

*Diet/Food Allergies:

_____

_____

Other Important Information about Student:

_____

_____

_____

_____

Parent/Guardian Treatment Consent:

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: _____