Ann Arbor Public Schools
Health Information Form for School Sponsored Trip/Camp

To Be Completed by Parent/Guardian of Student- PLEASE PRINT LEGIBLY. If any medications are to be prescribed or an over-the-counter medication may need to be given or used, a doctor must complete the medication portion of this form (see reverse side).

Student's Name (Last, First)		Sex: M F	DOB:
Address:	City		Zip
Parent/Guardian Name:	Cell Phone:		
Address (if different):	Home Phone:		
City, State, Zip:	Work Phone:		
Parent/Guardian Name:	Cell Phone:		
Address (if different):	Home Phone:		
City, State, Zip:	Work Phone:		
Student's health insurance information – do not leave this blank!			
Insurance Company Name:			
Subscriber:	Group Number:		
Contract Number:	Phone:		
Address:			
Heath History:			
Life-threatening allergic reactions/allergies	(Y / N)	Urinary or Bowel Problems	(Y / N)
Asthma or wheezing	(Y / N)	Shortness of Breath	(Y / N)
Eczema/Rashes/Hives	(Y / N)	Mental Health Problems	(Y / N)
Seizures	(Y / N)	Menstrual Problems	(Y / N)
Heart Condition	(Y / N)	Dietary Restrictions	(Y / N)
Diabetes	(Y / N)	Allergy to Medications	(Y / N)
Bone or Joint Problems	(Y / N)	Bleeding Disorder	(Y / N)
Concussion or Head Injury	(Y / N)	Other:	
If you answered YES to any of the above questions, please explain: Religious objection to physician contact Y / N			
Date of last Tetanus immunization:			
Has your child been hospitalized in the past three months? (Y / N) If yes, explain:			
Has your child had any recent operations or injuries? (Y / N) If yes, explain:			

MEDICATIONS: ANN ARBOR PUBLIC SCHOOLS REQUIRE A PHYSICIAN SIGNATURE FOR ADMINISTRATION OF ALL PRESCRIBED MEDICATIONS AND OVER-THE-COUNTER MEDICATIONS THAT MIGHT BE GIVEN/USED ON THE TRIP. ALL MEDICATIONS MUST BE IN THEIR ORIGINAL CONTAINER.

Medication needed or used (INCLUDING OVER THE COUNTER MEDICATIONS):
List first medication:
□ Student may carry/self administer this medication if appropriate

Dosage:	Time(s) the medication is given:

Medication needed or used (INCLUDING OVER THE COUNTER MEDICATIONS):
List second medication:
□ Student may carry/self administer this medication if appropriate

Dosage:	Time(s) the medication is given:

I grant permission, for the student named above, to be given any of the medications checked below as needed. I understand that all medication, including these medications listed below and prescription medications listed on the AAPS Health Form, are to be dispensed according to manufacturer's recommendations by designated staff ONLY except as indicated on the "student may carry/self administer" checkbox above.

Yes □ No □ Sudafed	Yes □ No □ Chloroseptic Spray
Yes □ No □ Tylenol	Yes □ No □ Triple Antibiotic Ointment
Yes □ No □ Tylenol Sinus	Yes □ No □ Benedryl
Yes □ No □ Ibuprofen (Advil, Motrin IB)	Yes □ No □ Claritin
Yes □ No □ Cough Drops/Sore Throat Lozenges	Yes □ No □ Zyrtec
Yes □ No □ Maalox/Immodium	Yes □ No □ Hydro-Cortizone Anti-Itch Cream
Yes □ No □ Tums	Yes □ No □ Aloe Vera
Yes □ No □ Pepto Bismal	Yes □ No □ Calamine Lotion
Yes □ No □ Colace/Dulcolax	Yes □ No □ Dramamine

Physician/Clinician Signature:	Date:

If additional medications are needed or used, INCLUDING OVER-THE-COUNTER MEDICATIONS, please attach an additional copy of this form and fill out the student name and medication sections only.

MEDICATION WAIVER: My child has (circle relevant diagnosis) DIABETES, ASTHMA, SEIZURES, AND/OR A FOOD ALLERGY and I have declined to send any medication(s) on this trip.
Parent/guardian initial:

Additional conditions staff need to be aware of (such as seasonal/environmental allergies, reactions to insect stings or bites, fainting, bed wetting, etc.):

Are glasses worn? (Y / N) Contacts? (Y / N)	Are glasses needed? (Y / N)

I hereby give permission for my child to attend this school-sponsored trip/camp and he/she may participate in all program activities. I also give permission for a designated adult to administer the medications as directed above. I further consent to and agree to the release of the personal medical information included on this form to any and all appropriate individuals of Ann Arbor Public School in the administration of the medications indicated above. In addition, I authorize the physician who prescribed the medications to indicate above, and/or their representatives, agents, designees to communicate information to representatives of Ann Arbor Public Schools about my child's medical condition(s).

In an emergency, if a parent/guardian or other designated emergency contact person cannot be reached, I hereby give permission for the staff to seek appropriate emergency care.

I hereby release and hold harmless Ann Arbor Public Schools, its officers, agents, and employees from any liability or damages, and I hereby waive all claims or causes of action against Ann Arbor Public Schools, its officers, agents, or independent contractors, which may result from participating in the school sponsored trip/camp and/or the administration of medication as described above.

Parent/Guardian Signature:	Date: