



Camp/Trip Medical and Emergency Information

TEACHER _____

Student Name: _____ Date of Birth: _____ Weight: _____ lbs.

Emergency contacts during hours of this trip:

Name _____ Relationship _____ Phone _____ Cell _____

Name _____ Relationship _____ Phone _____ Cell _____

Primary Physician _____ Phone _____

Insurance Carrier _____ Policy # _____

My child is allergic to: _____

Does your child have any allergies requiring an EpiPen? YES NO

Does your child have an inhaler prescribed for asthma? YES NO

*Students may carry their own inhaler or EpiPen if approved by their doctor (Ed. Code §38.015). Please see the school nurse ahead of camp to complete the proper permission paperwork.

PRESCRIPTION MEDICATIONS

If your child will need any prescription medication during camp, please complete below:

Medication	Dose/Route	Time(s) to be given						Reason for taking
		<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	<input type="checkbox"/> Bedtime	<input type="checkbox"/> Other		
		<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	<input type="checkbox"/> Bedtime	<input type="checkbox"/> Other		
		<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	<input type="checkbox"/> Bedtime	<input type="checkbox"/> Other		
		<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	<input type="checkbox"/> Bedtime	<input type="checkbox"/> Other		
		<input type="checkbox"/> Breakfast	<input type="checkbox"/> Lunch	<input type="checkbox"/> Dinner	<input type="checkbox"/> Bedtime	<input type="checkbox"/> Other		

All prescription medication must be in original labeled pharmacy container, with only enough doses required for the days at camp/trip. (AISD Medication Request form must be completed).

ALL MEDICATIONS MUST BE BROUGHT TO THE SCHOOL NURSE BY: _____

Over-the-counter (OTC) medications (such as Tylenol, Benadryl or cough drops) will only be given if permission is given below. Check those you wish to give permission to administer as needed:

Tylenol Benadryl Cough Drops Clear Calamine Topical Lotion Burn Free Topical Gel

All other OTC medication must be:

- Requested in writing by the parent/guardian on a AISD Medication Request form that includes a physician's signature who is licensed to practice in the state of Texas
- Parents should keep a copy of the medication authorization request with the physician's signature for future use during the current school year.
- A separate medication authorization form is required for each medicine
- Provided by the parent in an unopened, properly labeled, original container.

If there are any other medical issues/concerns you would like the nurse and school employees attending camp/trip to be aware of please provide details:

In my absence and if I cannot be reached in the event of an emergency, I being the parent/guardian of the above minor do hereby give permission for any emergency medical, dental or surgical care to be given. I assume all responsibility for this designation and hold the school district harmless from any liability that may result from this designation.

Parent/Guardian Signature _____ Date _____