

**McKinney Independent School District  
Co-Curricular/Extracurricular Emergency Medical Form**

Co-curricular/extracurricular activities are considered an extension of the school day therefore McKinney ISD policies continue to be in effect. This includes policies for medication usage. The following guidelines are in effect for all secondary activities and trips.

**Student Name:** \_\_\_\_\_ **ID#** \_\_\_\_\_ **Grade:** \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Emergency number(s) \_\_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(Street) (City/State) (Zip)

Father's Name: \_\_\_\_\_ Emergency number(s): \_\_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(Street) (City/State) (Zip)

Insurance Company: _____	Phone: _____
Name of Insured: _____ SS # of insured: _____	
Employer of Insured: _____	
<i>Please provide applicable numbers:</i>	
Certificate Number: _____	Group Number: _____
Payor Number: _____	Policy Number: _____

**Health History: (Check...give approximate dates, if applicable)**

- Frequent ear infections \_\_\_\_\_
- Headaches \_\_\_\_\_
- Heart defects/disease \_\_\_\_\_
- Seizure disorder \_\_\_\_\_
- Bleeding/clotting disorders \_\_\_\_\_
- Hypertension \_\_\_\_\_
- Emotional disturbances \_\_\_\_\_

- Diseases:**
- Diabetes \_\_\_\_\_
  - Sickle Cell \_\_\_\_\_
  - Asthma \_\_\_\_\_

- Allergies:**
- Hay fever \_\_\_\_\_
  - Poison ivy, etc. \_\_\_\_\_
  - Insect stings \_\_\_\_\_
  - Penicillin \_\_\_\_\_
  - Other drugs \_\_\_\_\_

Disabilities, diseases, chronic or recurring illness: \_\_\_\_\_

Current medication (send with MISD medical form): \_\_\_\_\_

Any specific activities to be limited by physician advice: \_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions: \_\_\_\_\_

Any known allergies (food, drugs, plants, insects, etc.): \_\_\_\_\_

Dates of operations, serious injuries, psychiatric counseling or hospitalization: \_\_\_\_\_

Additional health information: \_\_\_\_\_

Student Name: \_\_\_\_\_ ID# \_\_\_\_\_ Grade: \_\_\_\_\_

**Oral/Topical Medication Release**

	No	Yes
I. Anti-inflammatory / anti-pyretic		
1. Ibuprofen (Advil, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Acetaminophen (Tylenol, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
II. Antacids / Anti-nausea & Diarrhea		
1. TUMS	<input type="checkbox"/>	<input type="checkbox"/>
2. Imodium AD	<input type="checkbox"/>	<input type="checkbox"/>
III. Allergy		
1. Benadryl	<input type="checkbox"/>	<input type="checkbox"/>
IV. Topicals		
1. Bacitracin	<input type="checkbox"/>	<input type="checkbox"/>
2. Caladryl	<input type="checkbox"/>	<input type="checkbox"/>
3. Sunscreen	<input type="checkbox"/>	<input type="checkbox"/>
4. Aloe	<input type="checkbox"/>	<input type="checkbox"/>
V. Cough drops	<input type="checkbox"/>	<input type="checkbox"/>

**I authorize the supervising McKinney ISD employee to administer the above medication per package instructions.**

**Any other medication (OTC or prescription) must be provided by the parent in the original container or package with a signed MISD medication form and adhered to MISD medication policy.**

**PLEASE NOTE: If any medications are found on the student's person or in his/her possession he/she may be subject to disciplinary action.**

**Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_**

*If parents cannot be reached in case of emergency, please contact:*

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

This health form is correct so far as I know, and the person listed above has permission to engage in all prescribed activities except as noted.

*In case of injury or serious illness during any trip, I hereby grant permission for school employees to secure medical services for the student named on this sheet. Such treatment will be administered only by licensed medical personnel. I agree to accept responsibility for all authorized doctor, hospital and medical expenses.*

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_