

**CHARLES A. BEARD MEMORIAL SCHOOL CORPORATION
MEDICAL CONDITION ALERT (other than Asthma)**

STUDENT'S NAME: _____ **SCHOOL YEAR:** _____

GRADE: _____ **TEACHER:** _____ **BUS#** _____

ADDRESS: _____

MEDICAL AND/OR ALLERGY CONDITION(S):

- 1.) _____
- 2.) _____
- 3.) _____
- 4.) _____

SYMPTOMS: *(what to look for regarding his/her condition)*

- 1.) _____
- 2.) _____

CURRENT MEDICATIONS (TAKEN AT HOME OR AT SCHOOL)

- 1.) _____ 2.) _____
- 3.) _____ 4.) _____

SPECIFIC INSTRUCTIONS: *(if problem occurs with his/her condition)*

- 1.) _____
- 2.) _____

****A separate MEDICATION PERMISSION FORM signed by a parent or guardian is REQUIRED for all medications given in school. ****

PARENT/GUARDIAN'S SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN'S HOME/CELL#: _____

CALL 1ST: NAME: _____ **PHONE #:** _____

CALL 2ND: NAME: _____ **PHONE #:** _____

PHYSICIAN'S NAME/NUMBER: _____

BY SIGNING THIS FORM, I AGREE TO ALLOW THIS INFORMATION TO BE SHARED WITH ANY AND ALL SCHOOL PERSONNEL WHO MAY BE IN CONTACT WITH MY CHILD. **UPDATED 7/25**

Staff Use Only: _____ Scanned to Staff _____ Entered in PowerSchool _____ CML