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

STUDENT'S NAME:_____SCHOOL YEAR:_____

GRADE:_____TEACHER:_____

ADDRESS:_____BUS#_____

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.) _____

- **PARENT OR GUARDIAN: Please complete this form and return it to the Nurse's office.**
  - A separate MEDICATION PERMISSION FORM signed by a parent or guardian is **REQUIRED** for all medications given **in school**.

SIGNED:_____DATE:_____

HOME #:_____WORK #:_____CELL #:_____

CALL 1ST: NAME:_____PHONE #:_____

CALL 2ND: NAME:_____PHONE #:_____

PHYSICIAN'S NAME AND 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 4/17**