MEDICAL CONDITION ALERT

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 condition)

1.) _____

2.) _____

A separate MEDICATION PERMISSION FORM signed by a parent/guardian is REQUIRED for all medications given at school

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

PARENT/GUARDIAN'S HOME/CELL: _____

CALL 2nd: NAME: _____ **CELL:** _____

PHYSICIAN'S PHONE 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.

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