Galena Park Independent School District

Medical Condition/Food Allergy Disclosure

To Whom It May Concern:

I have informed the District personnel that my child, _____

has a medical condition/food allergy that may require him/her to receive assistance during the school day.

Students Name:_____

Medical Condition:_____

_____

Food Allergy:_____

_____

Specific signs and symptoms to observe for:_____

_____

_____

I give my permission for the assistance during the school day. I give my permission for the School Nurse to instruct my child's teacher, and others in the care of my child, on his/her medical condition so they can observe for any complications that may occur.

_____ _____

Parent/Guardian Name Parent/Guardian Signature

_____ _____ _____

Date Phone Number Alternate Phone Number

_____ _____

North Shore Middle School Nurse North Shore Middle School Nurse Signature

_____

Date