



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

Galena Park Middle School Nurse

Galena Park Middle School Nurse Signature

Date