



WFISD Health Services Department

3106 Borton St, Wichita Falls, TX 76306 | 940-235-1033

Student Picture

Notice of Medical Disclosure & Documentation of Severe Allergy

Student Full Name _____ DOB _____

Campus Name _____ Grade _____

Severe Allergen(s): _____

Legal Acknowledgements and Information Sharing

(Parent/Guardian initial each box to confirm your understanding and agreement)

[☐] **INFORMATION DISSEMINATION TO STAFF:** I understand and agree that a copy of this Notice of Disclosure and the attached Emergency Action Plan will be distributed to campus personnel with a direct "need-to-know." This includes, but is not limited to classroom teachers, substitute teachers, cafeteria managers, physical education coaches, and bus drivers.

[☐] **SELF-CARRY AUTHORIZATION (TEC § 38.0151):** *(Check if applicable)*

[☐] My child is authorized to self-carry and self-administer their rescue medication. I confirm that a Physician's Self-Carry Authorization form is on file in the school clinic.

If self-carry authorization form checked nurse to verify and initial _____

Classroom Teacher Verification

(Campus Nurse to fill out)

△ **NOTICE TO STAFF / SUBSTITUTES:** The Emergency Action Plan for this student is securely attached to this disclosure sheet. You must review the specific triggers, medical history, and protocol immediately upon receiving this file.

Primary Location of Student Medication:

[☐] School Clinic

[☐] On Student's Person (Self-Carry Backpack/Pocket)

[☐] Specified Location: _____

Mandatory Signatures

Parent/Guardian Date

Nurse Date