GEORGE WEST PRIMARY
SINCE 2003, THE ONLY TWO-TIME WINNER IN THE STATE OF TEXAS

2005 / 2012
NATIONAL BLUE RIBBON SCHOOL

PARENT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____ to release all health records and any other information which may be of value in formulating the best plans for the education and development of my child.

Requested from:

Doctor: _____

Address: _____

_____

Phone: _____

Release to:

George West ISD
Attn: School Nurse
405 Travis St.
George West, TX 78022
361-449-1914 ext. 1062
361-449-8921 fax
rclayton@gwisd.esc2.net

STUDENT: _____ DOB: _____

Please release my child's medical records to the address listed below concerning the following:

- ☐ Asthma Action Plan
- ☐ Epi Pen/ Allergy Action Plan
- ☐ Prescribed Medications at School Permission Form
- ☐ Vision/Hearing Report
- ☐ Seizure Action Plan
- ☐ Diabetic Management Plan
- ☐ Permission to verbally communicate about care with physician
- ☐ Other: _____

_____ _____

Name of Parent/Guardian Requesting Records Date