COLMESNEIL INDEPENDENT SCHOOL DISTRICT
610 W. Elder St.
P. O. Box 37
Colmesneil, TX 75938
Phone: 409.837.5757
Fax: 409.837.5759
www.colmesneilisd.net

MEDICATION AUTHORIZATION

Please have your child's doctor complete this form and return it to the nurse's office.

Student's Name:_____

Diagnosis: _____

Medication: _____

Dosage/Time: _____

Duration of Time: _____

Possible Side Effects: _____

_____ _____

Doctor's Signature Date

I authorize my child's school nurse or delegate to administer the above medication to my child during the school day, at time, dose, and intervals listed as above. I agree to hold the Colmesneil ISD, its employees, and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication(s) at school. Also, in the event this medication is changed or discontinued by prescribing doctor, I will immediately notify the school.

Parent's Signature: _____

Date : _____

Reviewed by school nurse: _____ Date: _____