Colmesneil Independent School District

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EVERY YEAR, IN ORDER FOR MEDICATIONS TO BE GIVEN BY THE SCHOOL NURSE TO YOUR CHILD, THE CISD SCHOOL MUST HAVE A SIGNED PARENT'S PERMISSION FORM ON FILE. BELOW ARE OVER-THE-COUNTER MEDICATIONS THAT MAY BE NEEDED BY YOUR CHILD.

PLEASE PUT YOUR INITIALS BY THE MEDS THAT YOU WILL ALLOW THE NURSE TO ADMINISTER TO YOUR CHILD. IN THE EVENT YOU DO NOT WANT ANY OVER-THE-COUNTER MEDS GIVEN TO YOUR CHILD, PLEASE MARK THE APPROPRIATE PLACE.

THIS FORM MUST BE SIGNED AND RETURNED BEFORE ANY OTC MEDS WILL BE ADMINISTERED.

ALL PRESCRIPTION MEDICATIONS SHOULD BE SENT IN THE ORIGINAL CONTAINER WITH THE STUDENT'S NAME ON IT, MED NAME, AND CORRECT DOSAGE ON CONTAINER. ALSO, A PERMISSION SLIP FROM PARENT OR LEGAL GUARDIAN IS REQUIRED FOR THE NURSE TO BE ABLE TO ADMINISTER THE MED DURING SCHOOL HOURS.

________ TYLENOL OR MOTRIN/ADVIL (AS NEEDED FOR HEADACHE, TOOTHACHE, PAIN OR FEVER)

________ TUMS OR ALAMAG (INDIGESTION, NAUSEA, OR STOMACH ACHE)

________ BENADRYL (SINUS PROBLEMS OR ALLERY-RELATED)

________ ROBITUSSIN SYRUP (FOR COUGH OR CONGESTION)

________ TYLENOL COUGH/COLD MEDS (NASAL CONGESTION/HEADACHE/COUGH)

________ OTHER (WRITE IN ANY PRESCRIBED MED THAT WILL NEED TO BE ADMINISTER AT SCHOOL ON A ROUTINE BASIS)

__________________________________(MED NAME)
__________________________________(DOSAGE GIVEN)
__________________________________(TIME TO BE ADMINISTERED)

*******________DO NOT GIVE ANY OVER THE COUNTER MEDS TO MY CHILD*******

NAME OF STUDENT _______________________________________ GRADE ________

PARENT'S NAME____

PARENT'S SIGNATURE ____________________________________ DATE________