CISD

Dear Parent or Guardian:

To comply with Texas State Law, the following restrictions apply to the taking of medication by students while at school:

1. When possible, medications should be scheduled to be taken at home. If medications must be taken during school hours, all medication must be brought to and kept in the school nurse's office.

2. Prescription and non-prescription medication must be in the original container. Prescription medication must be in a container with the pharmacy label for that student. All prescription and nonprescription medication that needs to be taken at school for more than 15 days must be accompanied by a written request signed and dated by the prescribing health care provider.
   Medications that must be taken during the school day for less than 15 days must be accompanied by a note signed by a parent or guardian giving authorized school personnel directions for its administration (time and dosage) SEE ATTACHED FORM.

3. School personnel will not give any medication, including Tylenol, unless it is provided by you, in the appropriate manner as stated above.

4. The school nurse has the responsibility and authority to refuse to administer medications that, in his or her judgment, are not in the best interest of the student.

5. Any medications left in the school nurse's office from the last school year must have a new request signed and dated, as stated above before medication will be dispensed. All expired medications have been discarded.

These restrictions are necessary for protection of the health and safety of your child. We will appreciate your cooperation in this matter.

Sincerely,

Debbie Rosales, LVN
School Nurse

Please keep the attached form available for future use should your child need to take a medication during school hours.

Coleman Independent School District

STUDENT NAME______________________ STUDENT #__________ Grade ______

SCHOOL______________________ TEACHER______________________

NAME OF MEDICATION______________________

PHARMACY NAME & PRESCRIPTION NUMBER______________________

DOSAGE______________________

TIME TO BE GIVEN AT SCHOOL (DURING SCHOOL HOURS)______________________

DATE MEDICATION STARTS__________ DATE MEDICATION ENDS__________

NAME OF MEDICATION______________________

PHARMACY NAME & PRESCRIPTION NUMBER______________________

DOSAGE______________________

TIME TO BE GIVEN AT SCHOOL (DURING SCHOOL HOURS)______________________

DATE MEDICATION STARTS__________ DATE MEDICATION ENDS__________

NAME OF MEDICATION______________________

PHARMACY NAME & PRESCRIPTION NUMBER______________________

DOSAGE______________________

TIME TO BE GIVEN AT SCHOOL (DURING SCHOOL HOURS)______________________

DATE MEDICATION STARTS__________ DATE MEDICATION ENDS__________

SPECIAL INSTRUCTIONS, POSSIBLE REACTIONS, IF ANY______________________

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I authorize clinic personnel to contact my child's physician for information concerning my child when necessary.
Medications will be dispensed during school hours only.

Home Phone No. __________ ______________________
PARENT'S SIGNATURE/LEGAL GUARDIAN

Work Phone No.__________ ______________________
DATE

DATE MEDICATION RECEIVED__________ DATE FORM FILED__________

BY______________________ COMPUTER ENTRY______________________
Initial & date