Pearland Independent School District

PHYSICIAN'S MEDICATION AUTHORIZATION

P.I.S.D. AUTHORIZATION FOR MEDICATION TO BE TAKEN DURING SCHOOL HOURS

I REQUEST THAT MY CHILD BE GIVEN THE MEDICATION LISTED BELOW AT SCHOOL, AS AUTHORIZED BY MYSELF AND MY CHILD'D PHYSICIAN. THE MEDICATION IS TO BE SUPPLIED BY THE PARENT AS NEEDED.

STUDENT_____**GRADE**_____**TEACHER**_____

DATE OF BIRTH _____**DIAGNOSIS**_____

MEDICATION_____**DOSE** _____

ROUTE_____**TIME**_____

***MEDICATION IS TAKEN AT HOME AS FOLLOWS: DOSE**_____**TIME**_____

SIDE EFFECTS_____**SPECIAL INSTRUCTIONS**_____

MEDICATION_____**DOSE**_____

ROUTE _____**TIME**_____

***MEDICATION IS TAKEN AT HOME AS FOLLOWS: DOSE**_____**TIME**_____

SIDE EFFECTS_____**SPECIAL INSTRUCTIONS**_____

*****NOTE: In the event that a home dose of medication is not taken, the school has permission to administer an additional dose of medication at school per verbal (PHONE) request by parent or physician.**

_____

Physician Signature and Date

_____

Printed Name

_____

Phone Number

_____

Fax Number

_____

Parent Signature and Date

YOU MAY FAX THIS FORM TO THE SCHOOL