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 ASSISTED IN TAKING THE MEDICATION DESCRIBED BELOW AT SCHOOL BY AUTHORIZED PERSONS AS ALSO AUTHORIZED BY MYSELF AND MY 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.

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Physician Signature and Date

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Printed Name

____

Phone Number

____

Fax Number

____

Parent Signature and Date