Pearland Independent School District

10 Day Medication/Special Procedure Authorization

I request that my child be assisted in taking the medication, or with the special procedure described below. I understand that the nurse or another authorized employee will administer the medication or perform the special procedure. There must be a parent demonstration for all special procedures performed at school.

The medication will be provided by parent.
I understand that this medication will only be given for 10 school days and that if it needs to be given longer, I will provide written authorization from my child's physician.

Items required for the special procedure will be provided by the parent.
I understand that if the procedure is to be done for longer than 10 school days, I will provide written authorization from my child's physician.

Student_____________________________Grade_______Teacher_____________________
DOB____________________________Diagnosis____________________________________

Medication_____________________________________Dose__________________________
Route___________________________Time_______________________________________
*Medication is taken at home as follows: Dose__________Time___________________

Medication____________________________________Dose____________________________
Route___________________________Time_______________________________________
*Medication is taken at home as follows: Dose:_________Time___________________

Special Procedure to be performed:____
Precautions, possible reactions and interventions:________________________________

Parent Demonstration Date:____________________________
Parent Signature:_____________________________________
Date Signed:____

Beginning Date :____________________ End Date:____________________

School:_____________________________ Nurse's Signature:______________________