

Valid for School Year
_____ to _____

POWAY UNIFIED SCHOOL DISTRICT
15250 Avenue of Science, San Diego CA 92128

Place
Student
Picture
Here

**AUTHORIZATION TO CARRY
MEDICATION WHILE AT SCHOOL
(EDUCATION CODE SECTION 49423)**

STUDENT _____ **SITE** _____ **GRADE** _____

PARENT/GUARDIAN:

I will provide the medication(s) in the prescription container(s) which is labeled with the name of my child, the prescribing physician's name, and amount of medication prescribed.

If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian, student and the physician.

To facilitate the foregoing, I hereby grant permission for the exchange between our physician and the Poway Unified School District of the confidential medical information contained in my child's records necessary to accomplish this service.

I will notify the school immediately if the health status of my child changes, we change physicians, or there is a change in or cancellation of the procedure.

Parent/Guardian Signature

Date

STUDENT:

I understand the purpose, method, and frequency of use for my medication(s). I know that my medication(s) is not a toy, and that carrying my medication(s) with me requires that I act responsibly.

1. I will keep my medication(s) with me at all times
2. I will notify school staff if emergency medication(s) is used
3. I will not share my medication(s) with other students or friends
4. I will not play with my medication(s) in class or during school activities
5. I will not threaten others with my medication(s)

If I do not comply with the above behavioral expectations, I know that my parent/guardian will be notified and I will not be able to carry my medication(s) with me. If this happens other arrangements will be made for my emergency medication(s) while I am at school.

Student Signature

Date

This Portion to be completed by a physician licensed in the State of California.

1. The student's medical condition, _____, warrants that the student needs immediate access to the following medication(s):

Name of Medication	Method of Administration	Dosage			Approx. Time of Day
		Puffs	mg.	ml.	
1.					
2.					
3.					

2. The student is responsible for handling and administering his/her own medication(s) during the school day, on fieldtrips, and all school sponsored activities including overnight school activities.

Print Name of Physician

Physician Signature

Date

CA Medical License

Phone

Fax