Authorization For Medication Administration/Carry Medication Confidential

(Adapted from PUSD H-26 for Purposes of Co-Curricular Activities Only)

I, the undersigned, as legal	parent/guardian of:					
(student's name)		Birthdate: _		_ Grade:		
attending Poway High School	ol, request that the following	; medication(s)	be made availa	ble to my child at t	he time(s) prescribed.	
Parent/Guardian:						
I understand that staff/chap	perones may assist my stude	nt in taking the	e medicine(s) as	directed by our ph	ysician.	
physician's name, and time	n(s) in the prescription conta and dosage of medication pop parent/guardian and the ph	escribed. If an				
	rescription medications requ t the staff/chaperones assist					
I will notify the Poway High there is a change in or cance	School Music Boosters immeellation of the procedure.	ediately if the h	nealth status of	my child changes, v	ve change physicians, or	
	this form, I agree to release /Chaperones from, any and a dication assistance.					
Parent/Guardian Signature		Date		Phone	Phone	
This portion to be complete	d by a physician licensed in t	he State of Cal	ifornia.			
Name of Medication	Method of Administration	on	Dosa	ze	Approx. Time of	
		Pu			Day/Reason	
1.						
2.						
3.						
Print Name of Physician		Physician Signature		Date	Date	
CA Medical License		Phone			Fax	