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, request that the following medication(s) be made available to my child at the time(s) prescribed.

Parent/Guardian:

I understand that staff/chaperones may assist my student in taking the medicine(s) as directed by our physician.

I will provide the medication(s) in the prescription container(s) which is labeled with the name of my student, the prescribing physician's name, and time and dosage of medication prescribed. If any of the conditions in the Physician's Statement change, a new form must be signed by the parent/guardian and the physician.

Both prescription and nonprescription medications require a written statement from the physician and a written statement from the parent indicating desire that the staff/chaperones assist the student as set forth in the physician's statement.

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

I understand that by signing this form, I agree to release the Poway Unified School District, its officers, employees, agents, or Poway High School Music Boosters/Chaperones from, any and all liability, loss, expense, or claim for illness, injury, or any damage any student may incur from medication assistance.

Parent/Guardian Signature	Date	Phone

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

Name of Medication	Method of Administration	Dosage			Approx. Time of Day/Reason
		Puff	Mg.	ml.	
1.					
2.					
3.					

Print Name of Physician	Physician Signature	Date
CA Medical License	Phone	Fax