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

AUTHORIZATION FOR MEDICATION ADMINISTRATION  
(EDUCATION CODE SECTION 49423)

I, the undersigned, as legal parent/guardian of ___________________________________________  
Student Name

________________________________________  
School

Request that the following medication(s) _____________________________________________  
be made available to my child at the time(s) prescribed__________________________________________

I understand that only personnel meeting the requirements of the California Education and Administration Codes  
will be performing the above mentioned health care service and will be using only the standardized procedure  
approved by our physician.

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(s) 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 district assist the student as set forth in the physician’s statement.

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.

➢ I have read and accept the conditions set forth by Poway Unified School District for Medication  
Administration pursuant to Education Code Section 49423.

Parent/Guardian_________________________________________Date:_________Phone:____________________

Signature

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

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Method of Administration</th>
<th>Dosage</th>
<th>Approx. Time of Day/Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Puffs</td>
<td>mg.</td>
</tr>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
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</tbody>
</table>

Print Name of Physician_________________________Physician Signature_________________________Date_________________________

CA Medical License_________________________Phone_________________________Fax_________________________

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