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

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.
I will check the expiration date of the medication(s) and replace as needed.
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):

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

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

Medication Expiration Date

Valid for School Year

________ to ________