Poway Unified School District
15250 Avenue of Science, San Diego CA 92128

Health Services

Parent Authorization for Specialized Physical Health Care Services

I, the undersigned, as legal parent/guardian of _____
Child's Name
_____ attending _____ request that the following
Date of birth school

specialized physical health care _____
be administered to my child.

I understand that only personnel meeting the requirements of 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.

_____ _____ _____
Physician's Name Phone: Fax:

To facilitate the foregoing, I hereby grant permission for the exchange between our physician and the Poway Unified School District of that 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 and will ensure that the procedure is accomplished as needed at home immediately prior to departure for and returning from school.

_____ _____ _____
Signature Date Cell phone

_____ _____ _____
Home address Home phone Work phone

PHYSICIAN'S AUTHORIZATION

Name of Standardized Procedure:	Physical Condition for which the Procedure is to be preformed:

I have reviewed the attached Standardized Procedure and (check one): ☐ Approve it as written ☐ Approve it with modification as indicated thereon ☐ Disapprove it and hereby authorize the attached alternative procedure	Time schedule and/or indication for the procedure:
Precautions possible untoward reactions and interventions:	Date procedure is to be discontinued:
Physician's signature:	Date: