Valid for School Year
_____to_____

Place Student's Picture Here

THE NATIVITY SCHOOL
Rancho Santa Fe

AUTHORIZATION FOR MEDICATION ADMINISTRATION
(EDUCATION CODE SECTION 49423)

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

_____attending _____
Birthdate School

Request that the following medication(s) _____for_____

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 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
		Puffs	mg.	ml.	
1.					
2.					
3.					

_____ _____ _____
Print Name of Physician **Physician Signature** **Date**

_____ _____ _____
CA Medical License **Phone** **Fax**