

## AUTHORIZATION FOR SELF ADMINISTRATION OF PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

STUDENT'S NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SCHOOL: POWAY HIGH SCHOOL

**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

The medical condition, \_\_\_\_\_, warrants that the student needs immediate access to the medication.

The student is responsible for handling own medication (i.e., no sharing with friends, safekeeping of medication, etc.) Failure to comply with school rules will result in immediate revocation of this privilege.

The medication will be with the student at all times (i.e., fanny pack, secure pocket, etc.)

Medication(s) will be provided in the prescription container(s) that is labeled with the name of my child, the prescribing physician name, and amount 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.

Prescription and nonprescription medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent.

I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, or whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

\_\_\_\_\_  
Physician's Signature & Date

\_\_\_\_\_  
Medical License #

\_\_\_\_\_  
Phone #

\_\_\_\_\_  
Parent / Guardian Signature & Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Phone #