Valid for School Year
7/2017 to 7/2018

Medication Expiration Date
_____

PHSMB FORM B

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

AUTHORIZATION TO CARRY MEDICATION WHILE AT SCHOOL
(EDUCATION CODE SECTION 49423)

Place Student Picture Here

STUDENT _____ **SITE** Poway HS **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):

Name of Medication	Method of Administration	Dosage			Approx. Time of Day
		Puffs	mg.	ml.	
1.					
2.					
3.					

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** **Fax**