



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 _____
 _____ attending _____ request that the following
 Date of birth _____ school _____ Child's Name

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