E 5141.21 (2)
CALAVERAS UNIFIED SCHOOL DISTRICT
3304-B Highway 12
P.O. Box 788
San Andreas, CA 95249
(209) 754-3504
www.calaveras.k12.ca.us

Self-Administered Medication Permission Slip

Date: ________________

__________________________________(student's name) has been instructed in the proper use of __________________________________ (inhaler/medication). The student's well-being is in jeopardy unless the inhaler/medication is carried on his/her person; therefore, we request that he/she be permitted to carry the inhaler/medication. He/she understands the purpose, appropriate method, and frequency of use of this inhaler/medication.

Physician's signature: _______________________________ Date: ______________

Physician's name (print): ____________________________ Phone: _____________

Address: ____

I permit my child to carry the above listed inhaler/medication as ordered by his/her physician. I understand that sharing medication with other students will result in disciplinary action.

Parent/Guardian signature: ____________________________ Date: _____________

THIS FORM MUST BE COMPLETED IN ADDITION TO THE ROUTINE DISTRICT MEDICATION AUTHORIZATION FORM.