



DIOCESE OF OAKLAND

2121 HARRISON STREET, SUITE 100 • OAKLAND, CA 94612-3788
510.628.2154 • FAX: 510.451.5331 • www.csdo.org

DEPARTMENT OF CATHOLIC SCHOOLS

PERMISSION TO CARRY AND SELF MEDICATE

Date: _____

_____ has been instructed in the proper use of
(*inhaler/medication/epi-pen*) _____ (name here). The
child's well-being is in jeopardy unless the *inhaler/medication/epi-pen* (circle appropriate item)
is carried on his/her person; therefore, we request that he/she be permitted to carry the
inhaler/medication/epi-pen (circle appropriate item). The student has been instructed in the
indications, appropriate method and frequency for administration, side effects, responsibility not
to share, and the responsibility to notify the teacher immediately after use.

Physician's signature: _____ Date: _____

Physician's name: _____ Phone: _____

Hospital/Clinic: _____

Address: _____

Please initial indicating you have read and agreed to each statement:

_____ I permit my child to carry the above listed *inhaler/medication/epi-pen* (circle one) as
ordered by his/her physician.

_____ It is my responsibility to check the expiration date of the *inhaler/medication/epi-pen*
(circle one) for my child.

_____ I understand that sharing this *inhaler/medication/epi-pen* (circle one) with other students
will result in disciplinary action.

_____ I will provide the *inhaler/medication/epi-pen* (circle one) at my own expense.

_____ I understand that use of an epi-pen necessitates a 911 call.

Parent's/Guardian's signature: _____ Date: _____

**THIS FORM MUST BE COMPLETED IN ADDITION TO THE
AUTHORIZATION FOR MEDICATION FORM.**