



*Holy  
Trinity  
School*

108 South Linden, Westmont, IL 60559  
(630) 971 - 0184

**SCHOOL MEDICATION PERMISSION**

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

\_\_\_\_\_ Cell # \_\_\_\_\_

\_\_\_\_\_ Grade \_\_\_\_\_

I hereby grant permission for Holy Trinity School to issue the medication routine described below for the above named child.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

**TO BE COMPLETED BY THE PHYSICIAN**

Name of Medication \_\_\_\_\_

Dosage: \_\_\_\_\_ Time: \_\_\_\_\_

Type of illness: \_\_\_\_\_

Is this medication necessary in order to maintain the child at school? \_\_\_\_\_

Side Effects to be alert to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Phone Number

\_\_\_\_\_  
Date

Further Instructions or Remarks: \_\_\_\_\_