HOLY TRINITY
CATHOLIC SCHOOL
Teaching With Love, Learning With Spirit.

School Medication Permission

Student's Name________________________ Birthdate ____________________

Address ________________________ Telephone ____________________

________________________ Cell # ____________________

________________________ Grade ____________________

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

________________________ ____________________

Parent's Name 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: ____

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Physician's Signature

____

Physician's Phone Number

____

Date

Further Instructions or Remarks: ____