



Affiliated with Holy Trinity Hellenic
Orthodox Church of Chicago

Hellenic American Academy

Academic Achievement, Cultural Awareness and Pride, Spiritual Enrichment

2010-2011 MEDICATION PERMISSION FORM MUST BE UPDATED ANNUALLY!

STUDENT INFORMATION

NAME: _____

STUDENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____ BIRTHDATE: _____ AGE: _____ GENDER: _____

Is it necessary for this child to be given medication during the school day? Yes No

TO BE COMPLETED BY PHYSICIAN

Name of Drug	Reason for Medication	Side Effects	Dosage	Frequency (Daily/pm)	Time to be given at school	Start Date	End Date

**If student experiences any side effects, medication will be discontinued and parent and physician will be notified*

Yes This medication may be safely self-administered by the child under the supervision of the school designee.

No The school designee must administer medication.

FOR ASTHMA INHALERS ONLY

This student should carry his/her Asthma Inhaler on his/her person and use at his/her discretion Yes No

Physician's Name (Please Print)

Phone

Physician's Signature

Date

TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN

I give permission for my child to receive the above medication(s) as directed by the physician. The medication will be sent to school in a container appropriately labeled by pharmacy. If it is over the counter medication, it will be sent in the original package with my child's name on it. I will notify the school in writing if the medication is discontinued. Also, I will obtain a written doctor's order if the medication order is changed.

Parent/guardian's Signature

Phone Number

Date