

St Theresa's Primary School



***MEDICATION REQUEST FORM***

Date: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone: Work/Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

(Please list phone numbers you are able to be contacted on for the duration of your child requirement for this medication)

Dear Principal,

I request that my child, \_\_\_\_\_, from Grade \_\_\_\_\_ be

administered the following medication at school, as prescribed by the child's medical practitioner.

NAME OF MEDICATION: \_\_\_\_\_

DOSAGE (AMOUNT): \_\_\_\_\_

TIME: \_\_\_\_\_  
eg., am,pm, after eating, etc

I have sent the medication in the original container displaying the instructions provided by the pharmacist.

\_\_\_\_\_  
(Parent's Name)

\_\_\_\_\_  
(Parent's Signature)