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 pharmicist.

______________________________ (Parent's Name)

______________________________ (Parent's Signature)

Office Use:	Amount:	Time:	Date:	Signature: