ST JAMES
THE APOSTLE
CATHOLIC PRIMARY SCHOOL
Learning with strength and in gentleness

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To the Principal,

RE: MEDICATION REQUEST FORM

DATE:	
PARENT'S NAME:	
ADDRESS:	
TELEPHONE:	

I request that my child,

NAME:	
HOME GROUP:	

be administered the following medication whilst at school, as prescribed by the child's medical practitioner:

NAME OF MEDICATION:	
DOSAGE (AMOUNT):	
TIME:	

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

Yours sincerely,

_____ (Parent Signature)

Parent name: _____ (Please Print)