

**ST. THERESA SCHOOL  
MEDICATION REQUEST FORM**

I request the below named student be given the medication at school and school activities by qualified staff, according to the prescription instructions and a record maintained. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand that the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment or it will be properly destroyed.

**MEDICATION FORM TO COMPLETE**

Student's Name \_\_\_\_\_

I hereby give my permission to the staff at St. Theresa School to administer medication

prescribed by Dr. \_\_\_\_\_ Dr's Phone No. \_\_\_\_\_

for my child, beginning \_\_\_\_\_; ending \_\_\_\_\_

Name of Medication \_\_\_\_\_

Special instruction for dispensing \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time: \_\_\_\_\_

If there are any side effects of this medication, please indicate: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent's signature \_\_\_\_\_ Date \_\_\_\_\_