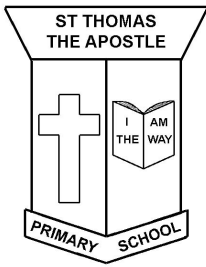


APPENDIX ONE



**St Thomas the Apostle
Primary School**
Boddington Crescent
Kambah, ACT 2902
Phone: (02) 6231 4144
Fax: (02) 6296 2621
www.sttap.cg.catholic.edu.au

Request to Dispense Medicine

To be completed by Parent or Guardian

I request that my child:

_____ (*Full Name of Student*)

in _____ (*Roll Class*) **be given**

_____ (*Name of Medication*)

at _____ **in dosages of** _____
(*times*) (*ml or tablets*)

For the Medical Condition:

Any other relevant comments:

Signed:

Parent/Guardian _____ *Date* _____