



12 Courtenay Hill, Newry, Co Down, BT34 2EA
Phone: (028) 3026 2175

PERMISSION FORM FOR THE ADMINISTRATION OF PRESCRIBED MEDICATION

Name of Pupil: _____

Class and Teacher: _____

Name and Type of Medication: _____

Dosage to be given: _____ Times: _____

Date Medication to be given from: _____

Date Medication to cease: _____

I give permission to an Education Authority trained first aide to administer medication to my child.

Signed (Parent/Guardian) _____

Date: _____

Signed (Principal/Vice Principal): _____

Date: _____

