Knockloughrim Primary School FORM AM2

REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Principal has agreed that school staff can administer the medicine

Details of Pupil

Surname_____ Forename(s) _____

Address

_____
_____
_____

Date of Birth _____

Class _____

Condition or illness

_____
_____
_____

Medication

Parents must ensure that in date properly labelled medication is supplied.

Name/ Type of Medication (as described on the container)

_____

Date dispensed _____

Expiry Date_____

Full Directions for use:

Dosage and method

_____
_____
_____

NB Dosage can only be changed on a Doctor's instructions

Timing _____

Special precautions _____

Are there any side effects that the School need to know about?

_____

_____

Self-Administration Yes/No (delete as appropriate)

Procedure to take in an Emergency

_____

_____

_____

Contact Details

Name _____

Phone No: (home/mobile) _____

(work) _____

Relationship to Pupil _____

Address

_____

_____

_____

I understand that I must deliver the medicine personally to _____ (agreed member of staff) and accept that this is a service, which the school is not obliged to undertake. I understand that I must notify the school of any changes in writing.

Signature _____ Date _____

Agreement of Principal

I agree that_____ (name of child) will receive _____ (quantity and name of medicine) every day at_____ (time(s) medicine to be administered eg lunchtime or afternoon break).
This child will be given/supervised whilst he/she takes their medication by _____(name of staff member)
This arrangement will continue until_____ (either end date of course of medicine or until instructed by parents)
Signed_____ Date _____
(Principal/authorised member of staff)

(The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to administer medication to the named pupil.)