Appendix 1

Administration of Medicine in School Form

1. Name of child: ____

2. Address: ____

3. Date of Birth____________________ **4. Contact numbers**__________________

5. Class: ________________________ **6.Teacher:**________________________

7. Condition, (which necessitates the administration of medication):

____

8. Family Doctor: ______________________________ **9. Phone No:** ____________________

10. Will this medication be self-administered by pupil? **YES** **NO**

If the medication needs to be administered by school personnel, is any training needed in the administration of this medicine/treatment? **YES** **NO**

Please provide all necessary details on the administration of medications including dosage and storage:

Request granted by Board of Management? YES NO

I/We request that the Board of Management authorise the taking of Prescription Medicine/ emergency medicine during the school day as it is absolutely necessary for the continued wellbeing of my/our child.
I/We understand that it is my/our responsibility to supply this medication to the school.
I/We understand that we must inform the school/class teacher of anychanges of medicine/dose in writing and that we must inform the class teacher each year of theprescription/medical condition.
I/We understand that it is my/our responsibility to ensure that the medication is within date and to replace it following expiry.
I/We understand that school personnel have no medical training and we indemnify the Board and the school staff from any liability that may arise from the administration of the medication.

Parent/Guardian **On behalf of the Board of Management**

Signed ____________________ ____________________

Date ______________ ______________