



ADMINISTRATION OF MEDICINES/MONITORING OF MEDICAL CONDITION

Child's Name: _____ **D.O.B.:** _____

Address: _____

Teacher: _____ **Class:** _____

EMERGENCY CONTACTS:

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

CHILD'S DOCTOR: _____ **Phone:** _____

MEDICAL CONDITION: _____

DESCRIPTION OF MEDICAL CONDITION: _____

WHAT ACTION IS REQUIRED: _____

NAME OF MEDICATION: _____

STORAGE DETAILS: _____

DOSAGE: _____

Is the child to be responsible for taking the prescription him/herself? Yes No

I/we request that the Board of Management authorise the taking of prescription medicine during the school day as it is absolutely necessary for the continued well-being of my/our child. I/We understand that we must inform the school/teacher of any changes of medicine/dose in writing and that we must inform the teacher each year of the prescription/medical condition. I/We understand that no school personnel have any medical training and we indemnify the Board, Staff and Special Needs Assistants from any liability that may arise from the administration of the medication.

Signed: _____ Parent/Guardian

_____ Parent/Guardian

Date: _____