Administration of Medicines/Monitoring of Medical Condition

CHILD'S NAME: _____
ADDRESS: _____
DATE OF BIRTH: _____

EMERGENCY CONTACTS:
1) NAME: _____ PHONE: _____
2) NAME: _____ PHONE: _____
3) NAME: _____ PHONE: _____
4) NAME: _____ PHONE: _____

CHILD'S DOCTOR: _____ PHONE: _____

DIAGNOSED CONDITION: _____

_____

PRESCRIPTION DETAILS:

_____

_____

Is the child to be responsible for taking the prescription him/herself?
_____

_____

DESCRIPTION OF MEDICAL CONDITION:

_____

_____

WHAT ACTION IS REQUIRED

_____

_____

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 the school has limited facilities for the safe storage of prescription medicines and that the prescribed amounts be brought in as required. In the event of certain specific medicines being stored the expiry date is the responsibility of the parents. 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 from any liability that may arise from the administration of the medication.

SIGNED: _____ Parent/Guardian
_____ Parent/Guardian
DATE: _____