

TULLYGALLY PRIMARY SCHOOL

"Soaring to excellence with children at the heart"



Request for school staff to administer medication

Name of pupil _____

Class _____

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, Mrs K Andrews, has agreed that school staff can administer the medicine.

Details of Pupil

Surname

Forenames

Address

Date of Birth

Male/Female

Class

Teacher

Condition or illness:

Medication: Parents must ensure that the medication is

- in date
- clearly labelled with the child's name
- clearly labelled with dosage and method of administration

Name/Type of medication

1.

Date dispensed:

Expiry date:

Name/Type of medication

2.

Date dispensed:

Expiry date:

Name/Type of medication

3.

Date dispensed:

Expiry date:

Name/Type of medication

4.

Date dispensed:

Expiry date:

Full Directions for use

1	Method Timing: Special Precautions
2	Method Timing: Special Precautions
3	Method Timing: Special Precautions

NB Dosage can only be changed on a doctors instructions

Side Effects Which the school needs to know about:

Self Administration: YES/NO

PROCEDURES TO TAKE IN AN EMERGENCY:

CONTACT DETAILS

Name		Relationship	
Phone Number	1. Mobile	2.Home	3.Work

Address			
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Phone Number	1. Mobile	2.Home	3.Work

Address			
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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.

Parents/Guardians Signatures:

Date:

Agreement of Principal

I agree that _____ (name of child) will receive _____ (quantity and name of medication) every day at _____ (times medicine is to be administered)

This child will be given/supervised whilst he/she takes their medication by _____ (names of staff members). This will continue until _____ (either end date of course of medicine or until instructed by parents).

Principal Signed:

Date:



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CONSENT FORM: USE OF EMERGENCY SALBUTAMOL INHALER

If my child is showing symptoms of asthma / having asthma attack

[Tick as appropriate].

1. I can confirm that my child _____

• has been diagnosed with asthma

• has been prescribed an inhaler.

2. My child has a working, in-date inhaler, clearly labelled with their name, which they will bring with them to school every day and the school also holds a spare inhaler prescribed for my child.

3. In the event of my child displaying symptoms of asthma, I consent for my child to receive salbutamol held by the school for such emergencies.

Signed: Date:

Name (print).....

Child's name:

Class:

Parent's address and contact details:

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.....
.....

Telephone:

E-mail:

