St. Patrick's BNS, Drumcondra, Dublin 9. Phone: 01-8372714
Email: saintpatricksbns@gmail.com

Administration of Medicines Form

Medical Condition and Administration of Medicines

Child's Name: _____

Address: _____

Date of Birth: _____

Emergency Contacts

1) Name: _____ Phone: _____

2) Name: _____ Phone: _____

Child's Doctor: _____ Phone: _____

Medical Condition:

_____

Prescription Details:

_____

Storage details:

_____

Dosage required:

_____

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

_____

What Action is required

_____

I/We request that the Principal on behalf of 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 no facilities for the safe storage of prescription medicines and that the prescribed amounts be brought in daily. 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 _____

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Allergy Details (If Relevant)

Type of Allergy: _____

Reaction Level: _____

Medication: _____

Storage details: _____

Dosage required: _____

Administration Procedure (When, Why, How)

_____

_____

_____

_____

_____

_____

Signed: _____

Date: _____

Emergency Procedures

In the event of _____ displaying any symptoms of his medical difficulty, the following procedures should be followed.

Symptoms: _____
_____
_____
_____
_____

Procedure:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

To include: ***Dial 999 and call emergency services.***
Contact Parents

Signed: _____ Date: _____