FORM AM2 (a)

NAME OF SCHOOL: DRUMAHOE P.S.

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 has agreed that school staff can administer the medicine

Details of Pupil

Surname _____ Forename(s) _____

Address _____

Date of Birth ___ /___ /___ Gender M / F

Class _____

Condition or illness _____

Medication

Parents must ensure that in date properly labelled medication is supplied.

Name/Type of Medication (as described on the container)

_____

Date dispensed _____

Expiry Date _____

Full Directions for use: Dosage and method

_____

_____

NB Dosage can only be changed on a Doctor's instructions

Timing _____

Special precaution _____

Are there any side effects that the School needs to know about?

_____

_____

Self-Administration Yes/No (delete as appropriate) **P.T.O.**

Procedures to take in an Emergency

_____

_____

Contact Details

Name _____

Phone No: (home/mobile) _____

(work) _____

Relationship to Pupil _____

Address _____

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.

Signature(s) _____ Date _____