

Ballymacrickett Primary School and Nursery Unit
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: ____/____/____ Male/Female

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 Direction for Use

Dosage and method

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

Timing:

Special precautions:

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

Self Administration Yes / No (*delete as appropriate*)

Parent's Signature: _____ Date: _____