



TEMPORARY ADMINISTRATION OF MEDICATION



CONSENT FORM FOR ADMINISTERING MEDICATION IN SCHOOL

Name of Pupil: _____

Class: _____

Teacher: _____

I request permission for my son/daughter to be given the following medication during school hours by the class teacher or a designated member of staff.

Medication: _____

Dosage: _____

When taken: _____

Doctor's name: _____

Doctor's telephone number: _____

I understand that whilst all best efforts will be made, staff of Mullavilly Primary School accept no responsibility whatsoever for omitting to administer this medicine or administering the medicine at a time different from that specified above.

Signed (Parent/Guardian): _____

Date: _____

Please note that this form relates to temporary administration of medication. Any child requiring ongoing medication requires a personal medical care plan which will be discussed and agreed with the Principal and signed by both parties.