St. Louise de Marillac Primary School, Drumfinn Rd., Ballyfermot, Dublin 10

Administration of Short-term Medication (Parental Request)

Date _______________

To the Board of Management,

I _________________________ request that:

a staff member/ teacher would administer this medication ☐

or

my child self-administers this medication ☐

I understand that the staff/school will not be responsible for any incident/issue that may arise due to the administration and/or non-administration of this medication. ☐

Child's Name & Address: ____

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Class Teacher's Name: ___________________________

Parent/Guardian Contact Phone Number: ______________________

Emergency Phone Number: _______________ Name/Relation to Child: __________________________

Name of medication to be administered: ____

Exact dosage and time(s): ____

Any other procedure to follow: ____

Suggested storage of medication: ____

Parent(s)/ Guardian(s) Signature: ____