Medication Administration in St. Pius Xth R.C.V.A. Primary: Consent And Record Form

Dear Head Teacher,

I request that, **Surname:.....**

Christian Name (in full) …….

Date of Birth……/……/..... Class……..

be given the following medication, which has been prescribed by a registered medical practitioner:

Name of medicine.....
Formula - (Please Tick): Liquid……., Tablet….., Ointment……, Eye Drops……, Other……
Dosages .....
Method of Administration e.g. frequency, time of day
……
.....

First Date of Administration……./……/20..
Projected Last Date of Administration…../…../20..
Expiry Date of Medicine……/…../20..
Medicines Returned to Parents/Guardians or Destroyed…../…../20..

I understand that the medicines must be delivered personally by me to the Head Teacher or nominated representative, and that this is a service which is subject to agreement with the school.

Signature of Authorisation.....…..... (Parent/Guardian)
Date ...../...../ 20..
Address .....….....
.....….....
........….....

Emergency Contacts: 1. Name:…… Tel. No. ……

2. Name …….. Tel. No……

General Practitioner Name…… Tel. No. ……

Signature of School Authorisation …… Dated …../…../20..

Notes: (1) Medication will not be administered by the establishment unless this written authorisation is completed and signed by the parents/guardians of the pupils. Oral messages received via pupils will not be accepted.

(2) The Governors and Head Teacher/Head of Establishment reserve the right to withdraw this service.

(3) This is kept on file and counts as the Medication Record