DROMARA PRIMARY SCHOOL

Request by Parent for school to supervise/administer medication

The school will not supervise/administer your child taking medicine unless you complete and sign this form.

DETAILS OF PUPIL

Surname: _____

Forename(s): _____

Address: _____

_____ M/F: _____

Date of Birth: _____ Class/Form: _____

Condition or illness: _____

MEDICATION

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

_____

For how long will your child take this medication: _____

Date dispensed: _____

Dosage, method and timing_____

Procedures to take in an Emergency: _____

_____

Contact Details

Print Name: _____Daytime Telephone No._____

Address:(If different from above) _____

I understand that I must deliver the medicine personally to the CLASS TEACHER and accept that this is a service which the school is not obliged to undertake.

Date: _____Signature(s): _____

Relationship to pupil: _____