Appendix 1: Administration of Medication to Students

Request to Board of Management of Scoil an Athar Tadhg

I / We, the parent(s) / guardian(s) of (Child's Name) ……..... request the Board of Management of Scoil an Athar Tadhg to allow authorised members of staff to administer and/or supervise the administration of medication to my child (named above). I enclose a letter from Dr. ……stating:

(a) Why the medication is needed (b) Dosage to be administered

(c) Name of medication (d) Time the medication should be administered.

Should there be any change in medication, I/we will write to the Board of Management before this change takes place to notify them of same.

I /We understand that the school's insurers shall be notified of this arrangement.

I /We understand that no school personnel have any medical training and I/We indemnify the Board of Management in respect of any liability that may arise regarding the administration or non-administration of the medication.

Emergency Contact Details:

Please supply the following details in the event that you need to be contacted. Please list these in order of preference, i.e. 1. First person to be contacted; 2. Second person to be contacted. etc.

Name	Relationship to the child, e.g. Mother, father, aunt, childminder	Telephone number/s
1.		
2.		
3.		

Signed: Signed:

…… ……

Parent / Guardian Parent / Guardian

Office Use Only: **Please note: Medication will NOT be administered without the signature below**
Signed: _____ Representative of the Board of Management

Administration of Medication to Pupils
<u>To be completed by the Doctor who prescribed the medication</u>

Dear Dr. _____

In accordance with the policy on administration of medication of Scoil an Athar Tadhg please complete the form below providing information regarding medication which is to be administered to the pupil/s named below **<u>during school hours</u>**.

The parents /guardians of …… have been asked to return the information to the school and to advise of any changes to this regime in the future.

Many thanks for your co-operation in this matter.

Yours Sincerely

Marc Ó Siocháin

_____

Marc Ó Siocháin, Principal

To be completed by Doctor Prescribing Medication

Name of Patient: ……

Name of Medication: ……

Why is this medication required: ……

Time medication should be administered: ….……

Dosage to be administered: ……

Additional Information (e.g. to be taken after meals)

……..

This medication is to be administered until further notice Yes ☐ No ☐

Signed: Dr. …… **Date: ……**