CASTLE GARDENS PRIMARY SCHOOL

69 BOWTOWN ROAD, NEWTOWNARDS BT23 8SH

PRINCIPAL MR J GRAY BA Hons, PGCE, PQH NI

TEL: 028 91813827

REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Principal has agreed that school staff can administer the medicine.

Details of Pupil

Surname _____ Forename(s) _____

Address _____

_____

Date of Birth ___/ ___/ _____ M ☐ F ☐

Class _____

Condition or illness _____

_____

Medication

Parents must ensure that in date properly labelled medication is supplied. Should medication expiry dates lapse, parents must ensure a replacement is supplied without delay. In some situations if medication is not provided a pupil will not be permitted to attend school until applicable medication is received by the school.

Medication 1. Name/Type of Medication (as described on the container)

_____

Full Directions for use:

Dosage and method

_____

_____

Timing _____

Special precautions _____

Are there any side effects that the School needs to know about?

_____

_____

(please sign on the reverse of this page)

Medication 2. Name/Type of Medication (as described on the container)

_____

Full Directions for use:

Dosage and method

_____

_____

Timing _____

Special precautions _____

Are there any side effects that the School needs to know about?

_____

_____

Medication 3. Name/Type of Medication (as described on the container)

_____

Full Directions for use:

Dosage and method

_____

_____

Timing _____

Special precautions _____

Are there any side effects that the School needs to know about?

_____

_____

I agree that medication can be administered by the following members of staff (include role):

_____

_____

Name of parent/guardian (please print)_____

Signed (parent/guardian) _____

Date of signing _____/_____/_____