Scoil Mhuire
Clontibret

Administration of Medicines/Monitoring of Medical Condition

Child's Name: ____
Address: ____
Date of Birth: ____

Emergency Contacts

1) Name: ______________________________ Phone: _________________________
2) Name: ______________________________ Phone: _________________________
3) Name: ______________________________ Phone: ___________________________

Child's Doctor: ______________________________ Phone: _________________

Diagnosed Condition: ____

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Prescription Details:

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Is the child to be responsible for taking the prescription him/herself?

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Description of Medical Condition:

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What Action is required

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I/We request that the Board of Management authorise the taking of Prescription Medicine during the school day as it is absolutely necessary for the continued well being of my/our child. I/We understand that we must inform the school/Teacher of any changes of medicine/dose in writing and that we must inform the Teacher each year of the prescription/medical condition. I/We understand that no school personnel have any medical training and we indemnify the Board from any liability that may arise from the administration of the medication.

Signed _________________________ Parent/Guardian
_________________________ Parent/Guardian

Date _________________________