Appendix 1
Medical Condition and Administration of Medicines

Child's Name: ____

Address: ____

Date of Birth: ___________

Emergency Contacts

1) Name: ___________________________ Phone: __________________

2) Name: ___________________________ Phone: __________________

3) Name: ___________________________ Phone: __________________

4) Name: ___________________________ Phone: __________________

Child's Doctor: ___________________________ Phone: _______________

Medical Condition: ____

Prescription Details:

____

Storage details: ____

Dosage required:

____

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

____

What Action is required

____

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 the school has no facilities for the safe storage of prescription medicines and that the prescribed amounts be brought in daily. 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 _______________________

Appendix 2
Allergy Details

Type of Allergy: ____

Reaction Level: ____

Medication: ____

Storage details: ____

Dosage required: ____

Emergency Procedures

In the event of _______________ displaying any symptoms of his/her medical difficulty, the following procedures should be followed.

Symptoms: ________________________________

____

____

____

____

Procedure:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

To include: ***Dial 999 and call emergency services.***
Contact Parents

Permission for emergency medication
In the event of an emergency, I agree with my child receiving emergency medication administered by a staff member or providing treatment set out above.

Signed by Parent: _________________________ ***Print Name:*** ________________________
Date: _________________

I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education (this includes emergency services). I understand that I must notify the school of any changes in writing.

Signed by Parent: _________________________ ***Print Name:*** ________________________
Date: _________________

Emergency Medication Provision School Record

DATE	TIME	STUDENT'S NAME	MEDICATION	DOSE GIVEN	ANY REACTIONS	SIGNATURE OF STAFF MEMBER	PRINT NAME