



Administration of Medicines Permission Form

Name of Child: _____ School Class : _____

Condition requiring prescribed medication: _____

Name of Medication: _____

Dose of Medication (must concur with prescription label): _____

Doctors Instructions of how to take medication, how often it can be given and emergency procedures: _____

Expiry Date of Medication: _____

(Please note it is the parent's responsibility to take note of this date and arrange for a replacement to be brought into school – children's who's medication has expired will not be permitted to leave school premises on residential trips/excursions)

I give permission for the trained staff at St Bonaventure's Catholic Primary School to administer the above medication as stated on this sheet. I understand that it is my responsibility to inform the school office if my child has had medication in the morning before coming to school and therefore a possible overdose of medication possible. I accept that the School cannot be held liable for any overdose if additional medication has been given at home and the school not informed. I also confirm that my child has had this medication before whilst in my care and that they have not experienced an allergic reaction to this medication.

I understand that if my child requires their medication they will inform their classteacher/adult on duty who will send them to the medical room in order for that medication to be administered and accept that the school is not responsible if a child forgets a dosage of their medication.

Parents / carers should note that they will be contacted if their child shows any adverse reaction to medicines given in school. If their child vomits or spits out medicines then the dose will not be repeated, and parents / carers will be informed.

Signed: _____ parent/carer

Print Name: _____ Date: _____

