|  |  |
| --- | --- |
| **KILLYLEA PRIMARY SCHOOL**  **ADMINISTRATION OF MEDICATION PERMISSION FORM**  ***[TO BE COMPLETED BY PARENTS/CARERS]*** | |
| Name of Pupil: |  |
| Class: |  |
| Teacher: |  |
| **I request permission for my child to be given the following medication during school hours by the class teacher or a designated member of staff.** | |
| Medication |  |
| Dosage |  |
| When taken |  |
| Doctor’s Name: |  |
| Doctor’s telephone no: |  |
| **I understand that whilst all best efforts will be made, staff of Killylea Primary School accept no responsibility whatsoever for omitting to administer this medicine or administering the medicine at a time different from that specified above.** | |
| Parent/Carer Signature: |  |
| Date: |  |
| **Please note that this form relates to temporary administration of medication. Any child requiring on-going medication requires a personal medical care plan which will be discussed and agreed with the Principal and signed by both parties.** | |