FORM APD

LISNASHARRAGH PRIMARY SCHOOL

PROCEDURE FOR THE ADMINISTRATION OF PRESCRIBED DRUGS

NAME OF CHILD ________________________________

CLASS ______________________

I request that the Drugs detailed below be administered to my child during the school day according to the details below and agree to the conditions noted at the end of this form.***

PARENTS SIGNATURE ___________________________

DATE ___________________________

NAME OF DRUG ____

DETAILS OF DOSAGE ___________________________________
(Eg one spoonful)

FREQUENCY ____
(eg once a day)

TIMES ____
(eg 12 oclock)

HOW LONG IS THE DRUG TO BE ADMINISTERED FOR? (eg 1 week)

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ANY OTHER DETAILS ___________________________________

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***Please note that teaching staff will attempt to keep to the terms of the request but in the event of omission of the administering of the drug or inaccuracy in dosage the school and the teachers will accept no liability.