

**KILTEALY NATIONAL SCHOOL**  
**Kiltealy, Enniscorthy**  
**Co. Wexford**



Tel: 053 9255446  
Email: [kiltealyns@gmail.com](mailto:kiltealyns@gmail.com)

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**(Appendix 1)**

**Administration of Medication to Students Request to Board of Management of Kiltealy National School**

I / We, the parents / guardians of \_\_\_\_\_ request the Board of Management of Kiltealy National School to

(a) authorise the taking of prescription medicine during the school day as it is absolutely necessary for the continued wellbeing of my/our child

(b) allow a member of staff to give medication to my/our child as they cannot administer independently

Childs Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

School Year: \_\_\_\_\_ Class: \_\_\_\_\_ Teacher: \_\_\_\_\_

Medical Condition: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Storage Details: \_\_\_\_\_

Details of who will administer the medication if agreed

Class Teacher Name: \_\_\_\_\_

SNA as sanctioned by DES to meet care needs of child, namely:

\_\_\_\_\_

Emergency Numbers: Mother \_\_\_\_\_ Father \_\_\_\_\_

I enclose a letter from Dr. \_\_\_\_\_ stating:

(a) Why the medication is needed

(b) Name of medication

(c) Time the medication should be administered

(d) Dosage to be administered

I/we understand that the school has no facilities for the safe storage of prescription medicines and that the prescribed amount must be brought in daily. Medicine that is to be used in an emergency will be stored in the school.



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**(Appendix 2)**

**Administration of Medication to Students**

Dear Doctor,

The Board of Management of Kiltealy NS requests that the information requested below be provided relating to medication which is administered to students during school hours.

The parents /guardians of \_\_\_\_\_ have been asked to return the information to the school and to advise of any changes to this regime in the future.

Many thanks for your co-operation in this matter.

Yours Sincerely,

\_\_\_\_\_  
Principal

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Name of Student: \_\_\_\_\_

Name of Medication:  
\_\_\_\_\_

Why is this medication required:  
\_\_\_\_\_  
\_\_\_\_\_

Time medication should be administered:  
\_\_\_\_\_

Dosage to be administered:  
\_\_\_\_\_

Additional Information (e.g. to be taken after meals, etc)  
\_\_\_\_\_  
\_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

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(Appendix 3)

Dear Parents,

Re: your request for the Administration of Medicine to your child \_\_\_\_\_.

The SNA \_\_\_\_\_ and teacher  
\_\_\_\_\_ in their absence, has agreed to do so and the Board of  
Management hereby grant him/her permission to administer said medication.

School personnel have no medical training and in order to indemnify school personnel and the Board from any liability that may arise from the administration of medicine, we ask you to please sign the attached Indemnity form and return same to school.

Regards,

Maeve Duff  
Principal

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**(Appendix 4)**

**Letter of Indemnity**

We request that the Board of Management of Kiltealy NS authorise the taking of prescription medicine during the school day as it is absolutely necessary for the continued wellbeing of our child \_\_\_\_\_ (child's name).

We understand that the school has limited facilities for the safe storage of prescription medicines and that the prescribed amounts be brought in as required. In the event of certain specific medicines being stored the expiry date is the responsibility of the parents.

We understand that we must inform the school Principal of any changes of medicines/dose in writing and that we must inform the Principal each year of the prescription/medical condition.

We acknowledge that the above facility provided by the school is on a purely voluntary basis and without obligation whatsoever on the part of the school.

In consideration of the school facilitating us as stipulated in paragraph one above, we hereby indemnify the Board of Management of Kiltealy National School in respect of all losses, claims, demands, actions or proceedings whatsoever arising under any statute or common law in respect of personal injury or injury of any nature whatsoever arising out of or in the course of, or caused directly or indirectly by the storage of the said medicine by or at school and/or the administration or failure to administer the said medication to my/our child.

We understand that no school personnel have any medical training and we indemnify the School Board of Management from any liability that may arise from the administration of the medication.

Signed: \_\_\_\_\_

Parent/Guardian

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Parent/Guardian

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_