SULLIVAN UPPER SCHOOL – ADMINISTRATION OF MEDICINES – ACTION PLAN

DETAILS OF PUPIL

Surname _____ Forename(s) _____

Date of Birth _____ Form _____

MEDICAL CONDITION eg ADHD, Asthma etc _____

CONTACT DETAILS	FAMILY CONTACT 1	FAMILY CONTACT 2
Mobile Number:	_____	_____
Work Number:	_____	_____
Relationship to Pupil:	_____	_____

MEDICATION – DIRECTIONS FOR USE, if applicable

Dosage of a prescribed medication can be changed on a Doctor's instructions.

Name of Medication _____

Type (ie liquid) _____

Self Administration Yes/No

(delete as appropriate)

Dose _____

Route (please tick as appropriate)

- Orally
- Injected
- Inhaled
- Other _____

Time (please tick as appropriate)

- Break-time
- Lunch-time
- Other (specify) _____