Administration of Medicines Policy

St. Francis of Assisi Primary School

Date Approved	Oct 17
Review Date	Oct 19

It is school policy that staff will **not administer** medicines to pupils except in cases a where a request has been received from parents to help in the administration of medicines, when these are of an **essential** nature (e.g diabetes, epilepsy, diabetes, asthma, anaphylaxis.) . Parents are responsible for the administration of medicines to their children. If a child requires medicine during the school day the pupil should return home for this or parents should come to the school to administer the medicine.

It is school policy however, to allow the **self-administration** of medicines if written permission is obtained from the pupil's parent or guardian.

The following procedures must be followed if a pupil is to be permitted to self-administer medicines:

- written details from the parents must be obtained, giving the name of the child, name, dose and timing of medicine, and, in the case of any difficulties, where and when the parent can be contacted;

- written advice must also be provided on the storage of medicine, including pharmaceutical requirements (eg., refrigeration if necessary);

- the age and responsibility of the pupil must be considered regarding the storage of the medicine and their access to it;

- the smallest practical dose should be brought to school, preferably by the parent;

Appendix 1
e.g Anaphylactic Shock
(completion of AM1 also required)

Dear Principal

I request and authorise that _____ (Child's full name) be given the following medication:

_____

_____

_____

This medication has been prescribed to my child by _____ (name of doctor), whom you may contact for verification. The medication is clearly labelled indicating the contents, dosage and the child's full name.

I further authorise_____ (name/s of trained person/s) to administer the injection/medication as I am satisfied that he/she has been trained in the use of the injection and is competent in recognising the indications for its administration.

I confirm that I am the parent/person with parental responsibility in respect of the child and accordingly I am legally empowered to give authority for the administration of this medication.

Signed: _____

Date: _____

Name: _____

Address: _____

_____

_____

Witness: _____ Date: _____

Appendix 2

ASTHMA

Dear Principal

I request and authorise that _____ (Child's full name) be given permission to self administer the following medication:

_____

_____

_____

_____

This medication has been prescribed to my child by _____ (name of doctor), whom you may contact for verification. The medication is clearly labelled with the child's full name.

I confirm that I am the parent/person with parental responsibility in respect of the child named above.

Signed: _____

Date: _____

Name: _____

Address: _____

_____

_____

Witness: _____

Date: _____

Appendix 3

DIABETES(AM1 form also to be completed)

Dear Principal

I request and authorise that _____ (Child's full name) be given permission to **self administer** the following medication:

_____

_____

_____

This medication has been prescribed to my child by _____ (name of doctor), whom you may contact for verification. The medication is clearly labelled indicating the contents, dosage and the child's full name.

I confirm that I am the parent/person with parental responsibility in respect of the child named above.

Signed: _____

Date: _____

Name: _____

Address: _____

_____

_____

Witness: _____

Date: _____

Appendix 4

Attention Deficit Disorder (ADD or ADHD)

Dear Principal

I request and authorise that _____ (Child's full name) be given permission to **self administer** the following medication:

_____

_____

_____

This medication has been prescribed to my child by _____ (name of doctor), whom you may contact for verification. The medication is clearly labelled indicating the contents, dosage and the child's full name.

I confirm that I am the parent/person with parental responsibility in respect of the child named above.

Signed: _____

Date: _____

Name: _____

Address: _____

_____

_____

Witness: _____

Date: _____

Form AM1

Name of School St. Francis of Assisi Primary School

MEDICATION PLAN FOR A PUPIL WITH MEDICAL NEEDS (SELF ADMINISTRATION)

Date _____ Review Date_____

Name of Pupil _____

Date of Birth ____ / ____ / ____

Class _____

National Health Number _____

Medical Diagnosis _____

_____

Contact Information

1 Family Contact 1

Name
_____

Phone No (home/mobile) _____

(work) _____

Relationship
_____

2 Family Contact 2

Phone No (home/mobile) _____

(work) _____

Relationship
_____

3 GP

Name _____

Phone No _____

4 Clinic/Hospital Contact

Name _____

Phone No _____

Plan prepared by

Name _____

Designation _____ Date _____

Describe condition and give details of pupil's individual symptoms

_____

_____

Daily care requirements (e.g. before sport, dietary, therapy, nursing needs)

_____

_____

_____

_____

Members of staff trained to administer medication for this child (state if different for off-site activities)

_____

_____

_____

Describe what constitutes an emergency for the child, and the action to take if this occurs

_____

_____

Follow up care

_____

_____

_____

Medication

Parents must ensure that in date, properly labelled medication is supplied.

Name/Type of Medication (as described on the container)

_____

Date dispensed _____

Expiry Date _____

Full Directions for use

Dosage and method

_____

_____

_____

NB Dosage can only be changed on a Doctor's instructions
Timing _____

Special precautions

_____

Are there any side effects that the School needs to know about?

_____

Self Administration Yes/No *(delete as appropriate)*

Procedures to take in an Emergency

_____

_____

_____

I understand that I must deliver the medicine personally to

_____(*agreed member of staff*) and accept that this is a service, which the school is not obliged to undertake. I understand that I must notify the school of any changes in writing.

Signature(s) _____ *Date* _____

Agreement of Principal

I agree that _____ (*name of child*) will receive

_____ (*quantity and name of medicine*)

This child will be given/supervised whilst he/she takes their medication by

_____ (*name of staff member*).

(when)

This arrangement will continue until _____
(*either end date of course of medicine or until instructed by parents*).

A record of any medicines administered by staff must be completed and retained.

Signed _____ Date _____

(The Principal/authorised member of staff)

I agree that the medical information contained in this form may be shared with individuals involved with the care and education of my child.

Signed _____ Date _____

Parent/carer

The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to administer medication to the named pupil.

St. Francis of Assisi Primary School

RECORD OF MEDICINES ADMINISTERED

Date	Child's name	Time	Name of medicine	Dose given	Any reactions	Signature of staff	Print name

Form AM2

Name of School: St. Francis of Assisi Primary School

MEDICATION PLAN FOR A PUPIL WITH MEDICAL NEEDS

REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete and sign this form, and the Principal has agreed that school staff can administer the medicine. (long term condition)

Details of Pupil

Surname _____ Forename(s) _____

Address

_____

_____

Date of Birth ____ / ____ / ____ M ♉ F ♉

Class _____

Condition or illness _____

_____

Medication

Parents must ensure that in date properly labelled medication is supplied.

Name/Type of Medication (as described on the container)

_____

Date dispensed _____

Expiry Date _____

Full Directions for use

Dosage and method

_____

_____

NB Dosage can only be changed on a Doctor's instructions
Timing _____

Special precautions
_____

Are there any side effects that the School needs to know about?

_____

Self Administration Yes/No *(delete as appropriate)*

Procedures to take in an Emergency
_____

_____

_____

Contact Details

Name _____

Phone No (home/mobile) _____

(work) _____

Relationship to Pupil _____

Address
_____

_____

I understand that I must deliver the medicine personally to

_____(*agreed member of staff*) and accept that this is a service which the school is not obliged to undertake. I understand that I must notify the school of any changes in writing.

Signature(s) _____ *Date* _____

Agreement of Principal

I agree that _____ (*name of child*) will receive

_____ (*quantity and name of medicine*) every

day at _____ (*time(s) medicine to be administered e.g. lunchtime or afternoon break*).

This child will be given/supervised whilst he/she takes their medication by

_____ (*name of staff member*).

This arrangement will continue until _____
(*either end date of course of medicine or until instructed by parents*).

Signed _____ Date _____

(The Principal/authorised member of staff)

The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to administer medication to the named pupil.

Form AM6

Name of School St. Francis of Assisi Primary School

RECORD OF MEDICAL TRAINING FOR STAFF

Name _____

Type of training received _____

Name(s) of condition/
_____

Medication involved

_____

_____

Date training completed

_____

Training provided by

_____

I confirm that _____ has received the training detailed above and is competent to administer the medication described.

Trainer's signature _____ Date _____

I confirm that I have received the training detailed above

Trainee's signature _____ Date _____

Proposed Retraining Date _____

Refresher Training Completed -

Trainer _____ Date _____

Trainee _____ Date _____

Appendix 5

USEFUL ADDRESSES

National Asthma Campaign

Providence House
Providence Place
London
N1 0NT
Tel: 020 7226 2260 (general enquiries)
0845 70102 (helpline)
Web: www.asthma.org.uk

British Epilepsy Association

New Ansty House
Gate Way Drive
Yeadon
Leeds
LS19 7XY
Tel: 0113 210 8800 (general enquiries)
0808 800 5050 (helpline)
Web: www.epilepsy.org.uk

Diabetes UK

10 Queen Street
London
W1G 9LH
Tel: 020 7323 1531
Web: www.diabetes.org.uk