

Appendix 1

St Clare's Catholic Primary School

SUPPORTING CHILDREN WITH MEDICAL NEEDS IN SCHOOL

The Administration of Medicines in School

The school will not give your child any medication unless you complete and sign this request form and the headteacher has confirmed that school staff have agreed to administer the medication and, where necessary have received appropriate training.

DETAILS OF PUPIL

Surname	
Forenames(s)	
Address	M/F
	DATE OF BIRTH
	CLASS/FORM
Condition or illness	
Medication	
Name/type of medication (as described on container)	
For how long will your child take this medication?	
Date dispensed	
Full directions for use	
Dosage and amount (as per instructions on container)	
Method	
Timing	
Special storage instructions (explain if medicine should remain in school or return home daily)	
Special precautions	
Side effects	
Self administration	

Actions to be taken if pupil refuses to take the medication		
Procedures to take in an emergency		
CONTACT DETAILS		
Name		
Daytime Telephone No		
Relationship to pupil		
Address		
<p>I understand that I must deliver the medication personally to the school office and I request that authorised staff administer the above medication to my child. I accept that this is a service which the school is not obliged to undertake.</p> <p>I consent to medical information concerning my child's health to be shared with other school staff and/or health professionals to the extent necessary to safeguard his/her health and welfare.</p> <p>I confirm that the medication has been prescribed by a doctor/consultant and that this information has been provided in consultation with my child's doctor/consultant.</p>		
Signature		Date
FULL NAME OF PARENT/CARER (IN CAPITALS)		
Signature		Date
FULL NAME OF PARENT/CARER (IN CAPITALS)		

Each item of medication must be delivered in its original container and must be clearly labelled with the following information: pupil's name, name of medication, dosage, frequency of dosage, date of dispensing, storage requirements (if necessary) and expiry date.

APPENDIX 2

Record of Medicine

For parents/carers to complete for pupils who require several medications

Pupil's name: Pupil's date of Birth: Class:

I confirm that the combined medications listed below have been administered to my child without any adverse effect and that approval has been obtained from a medical practitioner for their combined administration.

Signed: Relationship to child: Date:

Date Information Supplied	Name of Medication	Type	Dose	When Given	Method of Administration	Start Date (as applicable)	End Date (as applicable)	Special Precautions	Side Effects	Emergency Procedures

Please add any other relevant information below (continue overleaf if necessary):

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APPENDIX 3

St Clare's Catholic Primary School

Staff Training on how to Administer Medicines to Children

Make sure the child's teacher is made aware that medicine needs to be administered and either send the child to the office or escort the child to the office at the allotted time.

Check the name of the child against the Details of Pupil Form which should be fully completed and signed by the parent. Ask the child to identify themselves by asking their name, birthday and class.

Check the medicine name and directions against the details on the above form.

Administer the medicine as per the directions on the form.

Use the proper measuring devices like a medicine cup, oral dropper, cylindrical dosing spoon or oral syringe to administer the drug. This should be provided by the parent with the medicine.

Do not leave a medicine unattended within the child's reach. When you prepare the medicine, never leave the bottle unattended.

Put the medicine back in the allotted cabinet.

Record the administration of the medicine in the correct record book, recording the date, name of child, time, name of medicine and the name of the person administering the medicine.

Make sure the child is sent back to class or escorted back if required.

Training given by the School Nurse and for children with specific medical requirements training given by specialist medical practitioners.

Names of staff who attended

NAME SIGNED DATE

NAME SIGNED DATE

NAME SIGNED DATE

NAME SIGNED DATE

NAME SIGNED DATE

APPENDIX 4

St Clare's Catholic Primary School

Supporting Children with Medical Needs in School

THIS FORM HAS TO BE COMPLETED FOR EVERY CHILD

PART 1 Everyone to fill in

Child's Name **Year**

My child has ASTHMA/MEDICAL NEEDS/ALLERGIES YES / NO

(PLEASE CIRCLE AS REQUIRED)

If **NO** please **sign** and **return this form to school as soon as possible.**

Parent/Carer's Name..... **Date**

Relationship to Child..... **Signature**

If **YES** to **Asthma** please complete **PART 2** below. If **YES** to **Allergies** please complete **PART 3.**

If **YES** to **Medical Needs** please complete **PART 4.**

PART 2 ASTHMA

1. Triggers can be.....

2. I confirm that either (please circle correct option a, b or c)

- a. The asthma medication which has been prescribed by my child's doctor will be administered by me before and after the school day and the medication is not required to be given to my child during the day.
- b. My child is able to take responsibility for the self-administration of his/her asthma medication.
- c. My child is not able to self-administer the contents of the reliever inhaler whilst in school which has been prescribed by his/her doctor. I am writing to ask if staff of the school will assist my child when he/she requires to use the inhaler and medication. Details of the inhaler and medication are as follows:-

Name of inhaler/medication

Dosage..... Times

3. The medication will be delivered by me to the school and I will ensure that a spare asthma inhaler/spacer with my child's name and class is supplied to the school for use by my child. I understand that if my child does not have an inhaler in school on his/her designated swimming day that he/she will not be able to take part in the swimming lesson.

I consent to medical information concerning my child's health to be shared with other school staff and/or health professionals to the extent necessary to safeguard his/her health.

Signed Name of Parent/Carer.....

Date

PART 3 ALLERGIES

It is very important that school is aware of any allergies. Please list any allergies and action/treatment that your child may require. If your child requires medication in school please fill in **PART 5**

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PART 4 MEDICAL NEEDS (eg eczema)

Describe and give details of child's condition, symptoms, triggers, signs, treatments, equipment or devices, environmental issues etc.

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PART 5 If your child requires medication to be taken during school hours then please state:

Name of medication:	
Method of administration:	
Dose:	Time to be taken:
Side effects/contra-indications:	
Can medication be administered by self: Yes/No	
Action to be taken if child refuses medication:	
Procedures in an emergency:	
Storage of medication: Fridge/locked cupboard	

I

understand that I must deliver the medication personally to the school office and I request that authorised staff administer the above medication to my child. I accept that his is a service which the school is not obliged to undertake.

I consent to medical information concerning my child's health to be shared with other school staff and/or health professionals to the extent necessary to safeguard his/her health.

I confirm the medication has been prescribed by a doctor/consultant and that this information has been provided in consultation with my child's doctor/consultant.

Each item of medication must be delivered in its original container and must be clearly labelled with the

following information: pupil's name, name of medication, dosage, frequency of dosage, date of dispensing, storage requirements (if necessary) and expiry date.

Name of Parent/Carer (in Capitals).....

Signature Date