Supporting Children with Medication Needs Policy

SAINT COLUMBAN'S P.S. BELCOO

Signed:

Gerry McAloon	***10/11/2015***
Chair of Board of Governors	Date
Liam Magee	***10/11/2015***
Principal	Date

Reviewed November 2015

POLICY FOR THE ADMINISTRATION OF ESSENTIAL MEDICATION IN SCHOOL

1.5.1 The Board of Governors and staff of St Columban's wishes to ensure that pupils with **essential** medication needs receive appropriate care and support at school. The Principal will accept responsibility in principle for members of the school staff giving or supervising pupils taking prescribed medication during the school day **where those members of staff have volunteered to do so.**

Please note that parents should keep their children at home if acutely unwell or infectious.
Non essential medication may not be sent to school this may include painkillers, Calpol, antibiotics etc.

1.5.2 Parents are responsible for providing the Principal with comprehensive information regarding the pupil's condition and medication.

1.5.3 Prescribed medication will not be accepted in school without complete written and signed instructions from the parent.

1.5.4 **Staff will not give a non-prescribed medicine to a child.**

1.5.5 Only reasonable quantities of prescribed medication should be supplied to the school (for example, a maximum of four weeks supply at any one time).

1.5.6 It is the parent's responsibility to ensure that their child's medication needs are catered for while travelling to and from school.

1.5.7 Each item of medication must be delivered to the Principal or Authorised Person, in normal circumstances by the parent, **in a secure and labelled container as originally dispensed**. Each item of medication must be clearly labelled with the following information:

. Pupil's Name.

. Name of medication.

. Dosage.

. Frequency of administration.

. Date of dispensing.

. Storage requirements (if important).

. Expiry date.

The school will not accept items of medication in unlabelled containers.

1.5.8 Medication will be kept in a secure place, out of the reach of pupils. Unless otherwise indicated all medication to be administered in school will be kept in a safe place.

1.5.9 The school will keep records, which they will have available for parents.

1.5.10 If children refuse to take medicines, staff will not force them to do so, and will inform the parents of the refusal, as a matter of urgency, on the same day. If a refusal to take medicines results in an emergency, the school's emergency procedures will be followed.

1.5.11 It is the responsibility of parents to notify the school in writing if the pupil's need for medication has ceased.

1.5.12 It is the parents' responsibility to renew the medication when supplies are running low and to ensure that the medication supplied is within its expiry date.

1.5.12 The school will not make changes to dosages on parental instructions.

1.5.13 School staff will not dispose of medicines. Medicines, which are in use and in date, should be collected by the parent at the end of each term. Date expired medicines or those no longer required for treatment will be returned immediately to the parent for transfer to a community pharmacist for safe disposal.

1.5.14 For each pupil with long-term or complex medication needs, the Principal, will ensure that a Medication Plan and Protocol is drawn up, in conjunction with the appropriate health professionals.

1.5.15 Where it is appropriate to do so, pupils will be encouraged to administer their own medication, if necessary under staff supervision. Parents will be asked to confirm in writing if they wish their child to carry their medication with them in school.

1.5.16 Staff who volunteer to assist in the administration of medication will receive appropriate training/guidance through arrangements made with the School Health Service.

1.5.17 The school will make every effort to continue the administration of medication to a pupil whilst on trips away from the school premises, even if additional arrangements might be required. However, there may be occasions when it may not be possible to include a pupil on a school trip if appropriate supervision cannot be guaranteed.

1.5.18 All staff will be made aware of the procedures to be followed in the event of an emergency.

NAME OF SCHOOL _____ **FORM AM1**

MEDICATION PLAN FOR A PUPIL WITH MEDICAL NEEDS

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

Name _____

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

_____

_____

_____

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

Signed _____ **Date** _____

Parent/carer

Distribution

School Doctor _____ School Nurse _____

Parent _____ Other _____

NAME OF SCHOOL _____ **FORM AM2**

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

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 theSchool 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 eg 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.

NAME OF SCHOOL _____ **FORM AM3**

TEMPLATE FOR A REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION

This form must be completed by parents/carers

Details of Pupil

Surname _____ Forenames(s) _____

Address _____

_____

Date of Birth ____ / ____/_____

Class _____

Condition or illness _____

_____

Medication

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

Name of Medicine

_____

Procedures to be taken in an emergency

_____

_____

Contact Details

Name _____

Phone No: (home/mobile)_____
(work) _____

Relationship to child _____

I would like my child to keep his/her medication on him/her for use as necessary

Signed _____ **Date** _____

Relationship to child _____

Agreement of Principal

I agree that _____ (name of child) will be allowed to carry and self-administer his/her medication whilst in school and that this arrangement will continue until _____ (either end date of course of medication 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 the named pupil carrying his/her own medication

NAME OF SCHOOL **FORM**
AM4

Record of medicine administered to an individual child

Surname	
Forename (s)	
Date of Birth	___ /____ / ___ M ☐ F ☐
Class	
Condition or illness	
Date medicine provided by parent	
Name and strength of medicine	
Quantity received	
Expiry date	____ / ____ / ____
Quantity returned	
Dose and frequency of medicine	

Checked by:

Staff signature _____ **Signature of parent** _____

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

FORM

AM4(Continued)

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

NAME OF SCHOOL _____ **FORM AM5**

RECORD OF MEDICINES ADMINISTERED TO ALL CHILDREN

DATE	Child'sName	Time	Name of Medicine	Dose Given	Any Reactions	Signature of Staff	Print Name

St Columban's PS Belcoo

NAME OF SCHOOL _____ **FORM AM6**

TEMPLATE FOR A 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 _____

SAMPLE CONTACT FORM

SUPPORTING PUPILS WITH MEDICAL AND ASSOCIATED NEEDS

LOCAL CONTACT NUMBERS

(Please complete as appropriate for your school)

_____ **School**

Principal _____

Authorised person _____

SENCO _____

School Nurse _____

_____**Education and Library Board**

SEN Section _____

Educational Psychology _____

Health and Safety _____

_____ **Health Board/Trust**

School Doctor _____

School Nurse _____

Local Hospital _____

Local GP Surgeries _____

Community Paediatrician _____

School Health Service _____