SAINT BEDE'S CATHOLIC HIGH SCHOOL
LYTHAM

Administration of Medication Policy (Appendices)

FORM 1 - Contacting Emergency Services

Request for an Ambulance

Dial 999, ask for ambulance and be ready with the following information

1. Your telephone number: _____

2. Give your location as follows: (insert setting address):

   _____

   _____

3. State that the postcode is: _____

4. Give exact location in the setting (insert brief description):

   _____

5. Give your name: _____

6. Give name of child and a brief description of child's symptoms:

   _____

7. Inform Ambulance Control of the best entrance and state that the crew will be met and taken to:

   _____

Speak clearly and slowly and be ready to repeat information if asked

Put a completed copy of this form by the telephone so that it is easily accessible in case of an emergency.

FORM 2 - Healthcare Plan

Name of Setting: _____

Child's name: _____

Group/Class/Form: _____

Date of Birth: _____

Child's Address: _____

Medical Diagnosis or Condition: _____

_____

Date: _____ Review date: _____

CONTACT INFORMATION

Family contact 1

Name: _____

Phone No: (work) _____

(home) _____

(mobile) _____

Family contact 2

Name: _____

Phone No:(work) _____

(home) _____

(mobile) _____

Clinic/Hospital contact:

Name: _____

_____

Phone No: _____

GP:

Name: _____

_____

Phone No: _____

Describe medical needs and give details of symptoms:

_____

_____

Daily care requirements: (eg before sport/at lunchtime)

_____

_____

_____

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

_____

_____

_____

Follow up care:

_____

_____

Who is responsible in an Emergency: (state if different for off-site activities)

_____

_____

Form copied to:

_____

_____

FORM 3

Parental agreement for setting to administer prescribed medicine

The setting will not give your child medicine unless you complete and sign this form, and the setting has a policy that staff can administer medicine

Name of Setting: _____

Name of Child: _____

Date of Birth: _____

Group/Class/Form: _____

Medical condition/illness: _____

Medicine

Name the medicine is prescribed to on the container: _____

_____

Name /Type of Medicine (as described on the container): _____

_____

Date to commence medication: _____

Date medication to cease: _____

Date dispensed: _____

Expiry date of medication: _____

Agreed review date to be initiated by: *[name of member of staff]*: _____

Dosage and method eg Oral, inhaled: _____

Timing of dosage: _____

Special Precautions: _____

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

Self Administration (self administration form to be completed if yes): YES/NO ***(delete as appropriate)***

Procedures to take in an Emergency: _____

_____

_____

Contact Details

Name: _____

Daytime Telephone No: _____

Relationship to Child: _____

Address: _____

_____

_____

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the setting staff administering medicine in accordance with the setting policy. I will inform the setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

I understand that I must deliver the medicine personally to [agreed member of staff] and accept that this is a service that the setting is not obliged to undertake.

Signature(s): _____

_____

Date: _____

Relationship to child: _____

If more than one medicine is to be given a separate form should be completed for each one

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FORM 4

Confirmation of the Adult with a Duty of Care's agreement to administer medicine

Name of Setting: _____

It is agreed that _____ *[name of child]* will receive _____ *[quantity and name of medicine]* every day at _____ *[time medicine to be administered eg Lunchtime or afternoon break]*.

_____ *[name of child]*
will be given/supervised whilst he/she takes their medication by _____ *[name of member of staff]*.

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

Signed: _____

Date: _____

[*The Head of Setting/Named Member of Staff*]

FORM 5

Record of medicine administered to an individual child

Name of Setting: _____

Name of Child: _____

Date medicine provided by parent: _____

Group/class/form: _____

Quantity received: _____

Name and strength of medicine: _____

Expiry date: _____

Quantity returned: _____

Dose and frequency of medicine: _____

Staff signature: _____

Parent signature: _____

Date:	_____	_____	_____
Time Given:	_____	_____	_____
Dose Given:	_____	_____	_____
Name of member of staff:	_____	_____	_____
Staff initials:	_____	_____	_____

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			

FORM 6

Record of medicines administered in school/setting to all children

Name of Setting: _____

Child's Name:					
Date:					
Name of Medicine:					
Dose given:					
Time:					
Any Reactions:					
Other comments: (eg refusal of medicine)					
Print Name:					
Signature of Staff:					

Child's Name:					
Date:					
Name of Medicine:					
Dose given:					
Time:					
Any Reactions:					
Other comments: (eg refusal of medicine)					
Print Name:					
Signature of Staff:					

FORM 7

Request for child to carry his/her medicine

THIS FORM MUST BE COMPLETED BY PARENTS

If staff have any concerns discuss request with the appropriate healthcare professionals

Name of Setting: _____

Child's Name: _____

Group/Class/Form: _____

Address: _____

_____

Name of Medicine: _____

Procedures to be taken in an emergency: _____

_____

_____

Contact Information

Name: _____

Daytime Phone No: _____

Relationship to child: _____

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

Signed: _____ Date: _____

If more than one medicine is to be given a separate form should be completed for each one

FORM 8

Staff training record - administration of medicines

Name of Setting: _____

Name: _____

Type of training received: _____

Date of training completed: _____

Training provided by: _____

Profession and title: _____

_____

I confirm that _____ *[name of member of staff]* has received the training detailed above and is competent within the area of training given on this occasion. I recommend that the training is updated (please state how often).

Trainer's signature: _____

Date: _____

I confirm that I have received the training detailed above.

Staff signature: _____

Date: _____

Suggested Review Date: _____

FORM 9

Authorisation for the administration of rectal diazepam

Name of Setting: _____

Child's name: _____

Date of birth: _____

Home address: _____

_____

GP: _____

Hospital consultant: _____

_____ *[name of child]* should be given Rectal Diazepam _____ mg if he/she has a *prolonged epileptic seizure lasting over _____ minutes.

OR

*serial seizures lasting over _____ minutes.

An Ambulance should be called for *at the beginning of the seizure

OR

If the seizure has not resolved *after _____ minutes.

(*please delete as appropriate)

Doctor's signature: _____

Parent's signature: _____

Print Name: _____

Date: _____