Appendix to the Supporting Pupils with Medical Conditions Policy

Administering Medicines Consent Form and Administration Record Templates

Template A – Pupil Health Information	To be completed on admission
Template B – Parent/guardian consent to administer short-term non-prescribed 'adhoc' paracetamol medicine	To be completed on admission
Template C – Parental consent to administer medicine (where an Individual Healthcare Plan or Education Healthcare Plan is not required)	MUST BE COMPLETED AND SIGNED BY PARENT OR GUARDIAN FOLLOWING A REQUEST
Template D – Record of medicine administered to an individual child	Staff member MUST complete and sign this Pupil Log every time they administer the medication
Template E – Record of medicine administered to all children	Staff member MUST complete and sign this overview log every time they administer medication
Template F – Contacting the emergency services	
Template G - Consent to administer non-prescribed medication on a school trip	
Template H – HSF 36 Medication Incident Report Form	MUST be completed if an error is made
Template I – HSF 31 Self Medication Assessment	
Template J – HSF 32 GP Consent Form self medication	
Template K- HSF 33 GP Consent Form over counter/homely remedy	

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Template A Pupil Health Information Form

This information will be kept securely with your child's other records. If further information is needed we will contact you. Please do not hesitate to contact the school if there are any issues you wish to discuss.

Childs Name	**D.O.B**
Gender	**Year/Class**

Please complete if applicable
Has your child been diagnosed with or are you concerned about any of the following:

Condition	**Yes**	**No**	**Medication**
Asthma			
Allergies/Anaphylaxis			

Epilepsy			
Diabetes			

Is your child taking regular medication for any condition other than those listed on the previous page – continue on a separate sheet if necessary.

Condition	**Medication, emergency requirements**

Please use the space below to tell us about any other concerns you have regarding your child's health, continue on a separate sheet if necessary:

I give permission for the school to contact my child's medical practitioner as necessary and/or any other medical professional (school nurse etc)

Signed ……..…

Relationship to child ……. Date ……..

Template B Parent/guardian consent to administer short-term nonprescribed 'ad-hoc' medicines

The school will not administer medication unless this form is completed and signed. This information will be kept securely with your child's other records. If further information is needed we will contact you. Please do not hesitate to contact the school if there are any issues you wish to discuss.

Pupils Name	**D.O.B**
Gender	**Year/Class**

The Medicines Policy permits the school to administer the following non-prescription medication if your child develops the relevant symptoms during the school day. Pupils will be given a standard dose suitable to their age and weight. You will be informed when the school has administered medication by phone.

☐ **Paracetamol**

☐

Tick the non-prescription medications above that you give your consent for the school to administer during the school day and confirm that you have administered these medications in the past without adverse effect. Please keep the school informed of any changes to this consent.

_____ _____

Signature(s) Parent/Guardian Date

_____

Print name

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Template C Parental consent to administer medication

(where an Individual Healthcare Plan or Education Healthcare Plan is not required)

This school/staff will NOT give your child medicine unless you complete and sign this form, and the school has a policy that the staff can administer medicine.

Date for review to be initiated by	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy and the manufacturer's instructions and/or Patient Information Leaflet (PIL) must be included

Contact Details	
Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[agreed member of staff/school location]

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I confirm that this medication has been administered to my child in the past without adverse effect. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) Date

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If this consent is required for a non-prescribed medication please also complete the following :

This form should be completed in conjunction with parental consent form above

Under exceptional circumstances where it is deemed that their administration is required to allow the pupil to remain in school the school will administer non-prescription medicines for a maximum of 48 hours.

Date (requirement reviewed daily)	Time last dose administered at home as informed by parent/guardian	Dosage given in school	Time	Comments
Day 1				
Day 2				

3 main side effects of medication as detailed on manufacturer's instructions		
1.	**2.**	**3.**

Emergency procedures – if the pupil develops any of the signs or symptoms mentioned above or any other signs of reaction as detailed on the manufacturer's instructions this might be a sign of a negative reaction or if it is suspected that the child has taken too much medication in a 24 hour period staff will call 999 and then contact the parent/guardian(s).

I agree that the medical information contained in this document may be shared with individuals involved with my child's care and education.
I am aware that each day I must inform the school when I last administered the medication and that I will be informed by the school when medication has been administered.

Agreed by:
Parent/guardian……..…..Date…….

Signature of parent _____

Bailey Street Alternative Provision Academy Record of medicine administered to an individual child

Name of school/setting	Bailey Street Alternative Provision Academy
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

_____

Date	DATE		
Time given	TIME		
Dose given	DOSE		
Name of member of staff	STAFF MEMBER COMPLETE NAME AND SIGNATURE		
Staff initials	INITIALS		
Witnessed by	COMPLETE NAME AND SIGNATURE		

_____

Date	DATE		
Time given	TIME		
Dose given	DOSE		
Name of member of staff	STAFF MEMBER COMPLETE NAME AND SIGNATURE		
Staff initials	INITIALS		
Witnessed by	COMPLETE NAME AND SIGNATURE		

Date	DATE		
Time given	TIME		
Dose given	DOSE		
Name of member of staff	STAFF MEMBER COMPLETE NAME AND SIGNATURE		
Staff initials	INITIALS		
Witnessed by	COMPLETE NAME AND SIGNATURE		

Record of medicine administered to an individual child (Continued)

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			
Witnessed by			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			
Witnessed by			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			
Witnessed by			

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Record of medicine administered to all pupils

Name of school/setting | Bailey Street Alternative Provision Academy

Date	Pupil's name	Time	Name of	Dose given	Any reactions	Signature	Print name	Comments

Contacting Emergency Services

Request an ambulance - dial 999, ask for an ambulance and be ready with the information below.
Speak clearly and slowly and be ready to repeat information if asked.

1. **Telephone number**

01785 556439

2. **Your location as follows**

Bailey Street Alternative Provision Academy **Bailey Street** **Stafford** **ST17 4BG**

2. **State what the postcode is – please note that postcodes for satellite navigation systems may differ from the postal code**

ST17 4BG

3. **Inform Ambulance Control of the best entrance to use and state that the crew will be met and taken to the patient**

Main Reception Entrance

4. **Your name**

5. **Provide the exact location of the patient within the school setting**

6. **Provide the name of the child and a brief description of their symptoms**

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Consent to administer non-prescribed medication on a Residential Visit

The school will not administer medication unless this form is completed and signed. This information will be kept securely with your child's other records. Whilst away if your child feels unwell the school staff may wish to administer the appropriate non-prescription. Please do not hesitate to contact the school if there are any issues you wish to discuss.

Pupils Name	**D.O.B**
Gender	**Year/Class**

If your child develops the relevant symptoms during the residential visit, they will be given a standard dose suitable to their age and weight of the appropriate non-prescribed medication. If symptoms persist medical advice will be sought and if necessary the emergency services called. You will be informed when the school has administered medication on our return by notification form. The school will hold a small stock of the following medicines:

☐ **Paracetamol**

☐ **Antihistamnine**

☐ **Travel Sickness**

☐

☐

☐

☐

Tick the non-prescription medications above that you give your consent for the school to administer during the residential visit and confirm that you have administered these medications in the past without adverse effect. Please keep the school informed of any changes to this consent.

_____ _____

Signature(s) Parent/Guardian Date

_____

Print name

Medication Incident Report Form

Service User/Pupil	Date of Birth
Address	

Details of Incident	
Date of Incident –	**Time of Incident-**
Member of Staff Reporting Incident-	
Detail of Incident-	
Reason for Incident (Pharmacy Error, Wrong Medication Administered, Overdose, Missed Medication, etc) -	
Detail of any injuries/ill health effects-	
Detail of any Treatment Given-	
Admission to Hospital **Yes/No** If yes what was the outcome-	

Who has been informed of the incident (Carers, Pharmacist, GP, NHS Direct, CSCI) –
Any Additional Information
Statement Taken from relevant Parties – Detail whom and attach a copy.
Corrective/Remedial Action Taken-

This incident must be reported to the Headteacher/Service Manager/Group Manager immediately, and a copy of the report forwarded.

Signature Reporting Officer_____

Date _____

Service User Self Medication Assessment

Service User	Date of Birth
Address	

	Assessment Criteria	Yes	No	Comments State if risk assessment/ protocols are required.
1	**Is the individual self-medicating at present?**			
2	Does the individual show symptoms of confusion or suffer any memory impairment?			
3	Has the individual got the dexterity to open medication packaging and containers required to self medicate?			
4	Can the individual read the label and interpret the instructions?			
5	Can the individual take their medication without difficulties (i.e. swallow medicines, apply creams properly, use inhaler effectively, put in eye drops etc)?			
6	Do you consider that the individual understands the need to take their medication as prescribed? If the service user had a language or communication needs, have these been sufficiently addressed?			
7	Does the individual understand the consequences of not taking their medication correctly?			
8	Is there a suitable storage facility for medication?			
9	Have you explained the process of self-medication to the individual?			
10	Has the procedure been explained to close family/carer with the consent of the individual?			

Service User _____ is / is not* capable of self-medicating.
(delete as applicable)

Form Completed by _____Signature _____

Date Completed _____ **Review Date**_____

Service Users Statement

I wish to retain responsibility for taking my own medication. I understand that I must keep the medication safe (detail how medication is to be kept)_____

I understand that if I have any concerns about my medication, or forget to take my medication I will inform a member of care staff at the earliest opportunity.

Signature of Service User _____ Date_____

GP Consent Form - Self Medication

Service User/Pupil	Date of Birth
Address	
GP Name	GP Telephone Number

I consider that the above named person is capable of self-medicating.

Signature of GP_____

Date _____

GP Consent Form -Over the Counter Medication (Homely Remedies)

Service User/Pupil	Date of Birth
Address	
GP Name	GP Telephone Number

I consider that the above named person is able to use the following homely remedies.

Description of OTC Medication	Please Tick		**Special Instruction**	Comments
	Yes	No		

Signature of GP__________________________________

Date ____