# **SECTION 6: MEDICAL FORMS**

# **Med form 1**

Request for School to Administer Medication

This form is for parents to complete if they wish the school to administer medication. The school will not give your child medicine unless you complete and sign this form, and the Head teacher has agreed that school staff can administer the medication.

DETAILS OF PUPIL

Surname:

Forename(s):

Address:

 Post Code:

Male/Female: Date of Birth: Class / Form:

Condition or Illness:

MEDICATION

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

For how long will your child take this medication?

Date dispensed:

***FULL DIRECTIONS FOR USE***

Dosage and method:

Timing:

Special Precautions:

Side Effects:

Self-administration: YES / NO

Procedures to take in an Emergency:

Pupil name:

Class:

CONTACT DETAILS for

Name:

Daytime Telephone No:

Work Telephone No. ………………………………..

Mobile Telephone No. ……………………………….

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.

Date: Signature(s):

Relationship to pupil:

# **Med form 2**

CONFIRMATION OF THE HEAD TEACHER’S AGREEMENT TO ADMINISTER MEDICATION

This form is for schools to complete and send to parent if they agree to administer medication to a named child.

I agree that ***(name of child)*** will receive ***(quantity and name of medicine)*** every day at ***(time medicine to be administered e.g. lunchtime or afternoon break)***.

**(Name of child)** will be ***given / supervised*** whilst he / she takes their medication by ***(names of members of staff)***.

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

Date:

Signed ………….......................................

(Head teacher or DHT pupil support):

# **Med form 3**

**Class/year group**

**Pupil Name**

RECORD OF MEDICATION ADMINISTERED IN SCHOOL

Date medicine supplied to school: Storage Point: Date medicine finished/sent home:

This form is for schools to record details of medication given to pupils.

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| **Date** | **Time** | **Name of Medication** | **Quantity at start** | **Dose given** | **Quantity that remains** | **Any Reactions** | **Other recording (e.g. blood sugar level)** | **Signature of Staff** | **Print Name** |
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# **Med form 3a**

**Class/year group**

**Pupil Name**

RECORD OF MEDICATION ADMINISTERED IN SCHOOL to pre-school children, or administration of controlled drugs

Date medicine supplied to school: Storage Point: Date medicine finished/sent home:

This form is for schools to record details of medication given to pupils. **NB! Two staff to sign for administration of controlled drugs**

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| **Date** | **Time** | **Name of Medication** | **Quantity at start** | **Dose given** | **Quantity that remains** | **Any Reactions** | **Other recording (e.g. blood sugar level)** | **Signature of Staff** | **Print Name** | **Signature of Staff** | **Print Name** |
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# **Med form 3b**

ADMINISTRATION OF BUCCAL MIDAZOLAM OR RECTAL DIAZEPAM (EMERGENCY MEDICATION) IN EPILEPSY AND FEBRILE CONVULSIONS FOR NON-MEDICAL STAFF

Joint Epilepsy Council

Individual care plan to be completed by or in consultation with the medical practitioner

(Please use language appropriate to the lay person)

Name of pupil or student: Age:

Seizure classification and / or description of seizures which may require rectal diazepam (Record all details of seizures e.g. goes stiff, falls, convulses down both sides of body, convulsions last 3 minutes etc. Include information re triggers, recovery time etc. If status epilepticus, note whether it is convulsive, partial or absence).

(i)

 Usual duration of seizure?

(ii)

 Other useful information:

EMERGENCY TREATMENT PLAN

1. When should emergency medication be administered? (Note here should include whether it is after a certain length of time or number of seizures).

2. Initial dosage; how much emergency medication is given initially? (Note recommended number of millilitre/milligrams for this person)

3. What is the usual reaction(s) to emergency medication?

4. If there are difficulties in the administration of emergency medication, what action should be taken?

5. Can a second dose of emergency medication be given? YES / NO

 After how long can a second dose of emergency medication be given? (State the time to have elapsed before re-administration takes place).

 How much emergency medication is given as a second dose? (State the exact dose to be given and how many times this can be done after how long).

 …………………………………………………………………………………………………...

6. When should the person’s usual doctor be consulted?

7. When should 999 be dialled for emergency help?

 e.g. (i) if the full prescribed dose of emergency medication fails to control the seizure

 (ii) Other (please give details)

8. Who should (a) administer the emergency medication

 (b) witness the administration of emergency medication

 (E.g. another member of staff of same sex as child, if rectal diazepam is the emergency medication)

9. Who / where needs to be informed?

 Parents / Guardian

 (a) Tel:

 Prescribing Doctor

 (b) Tel:

 Other

 (c) Tel:

10. Insurance cover in place? YES / NO

11. Precautions: under what circumstances should emergency medication not be used e.g. alternative medication such as Oral Diazepam already administered within the last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ minutes.

**All occasions when emergency medication is administered must be recorded.**

This plan has been agreed by the following:

Prescribing Doctor
(BLOCK CAPITALS)

Signature: Date:

AUTHORISED PERSON(S) TRAINED TO ADMINISTER EMERGENCY MEDICATION

Name: Signature: Date:

(BLOCK CAPITALS)

Name: Signature: Date:

(BLOCK CAPITALS)

Name: Signature: Date:

(BLOCK CAPITALS)

Pupil: Signature: Date:

(If sufficiently mature) (BLOCK CAPITALS)

Parent/Guardian: Signature: Date:

(BLOCK CAPITALS)

EMPLOYER OF THE PERSON(S) AUTHORISED TO ADMINISTER EMERGENCY MEDICATION

(BLOCK CAPITALS) Signature: Date:

HEAD OF UNIT / SCHOOL

(BLOCK CAPITALS) Signature: Date:

This form should be available at every medical review of the child / young person

Copies held by:

Expiry date of this form:

Copy holders to be notified of any changes by:

PUPIL

I have read the information detailed above and agree to the treatment as prescribed.

*BLOCK CAPITALS*

Name: Signature: Date:

# **Med form 4**

REQUEST FOR PUPIL TO CARRY HIS / HER MEDICATION

This form is for parents/carers to complete if they wish their child to carry his / her own medication.

This form must be completed by parents / carers.

Pupil’s Name: Class / Form:

Address:

Condition or illness:

Name of Medicine:

Procedures to be taken in Emergency:

CONTACT INFORMATION

Name:

Daytime Phone No.:

Work Phone No. …………………………………………………………………………………..

Mobile Phone No. …………………………………………………………………………………...

Relationship to child:

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

Signed: Date:

Relationship to Child:

# **Med form 5**

STAFF TRAINING RECORD - ADMINISTRATION OF MEDICAL TREATMENT

This form is for recording medical training for staff

Name:

Type of Training Received:

Date Training Completed:

Training Provided By:

I confirm that ........................................ has received the training detailed above and is competent to carry out any necessary treatment.

Trainer’s signature: Date:

I confirm that I have received the training detailed above.

Staff signature: Date:

Suggested Review Date:

# **Med form 6**

**This should be completed and displayed in prominent areas of the school**

 EMERGENCY PLANNING

1. Dial **999**
2. Ask for an **ambulance** and be ready with the following information:
3. Give your **name**
4. The school **telephone number**
5. Give brief description of **pupil’s symptoms**
6. Give your **location** as follows; (insert school address and postcode)
7. Give exact **location in the school** (insert brief description)

1. 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**

# **Med form 7**: Individual Pupil Protocol for a Child/young person with health care needs

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|  |

**Name of Pupil** Date of Birth / /

Condition

|  |
| --- |
|  |

Class/ Form

**Contact Information**

Family contact 1

|  |
| --- |
| NamePhone No: (home) (work)Relationship |

Family contact 2

|  |
| --- |
| NamePhone No: (home) (work)Relationship |

General Practitioner

|  |
| --- |
| NamePhone No |

Clinic/Hospital Contact

|  |
| --- |
| NamePhone No |

Protocol prepared by:

|  |
| --- |
| NameDesignation Date / / |

Agreed with:

* Parents / carer
* Community paediatrician / GP
* School nurse

**To be reviewed by date: / /**

**Describe condition and give details of pupil’s individual symptoms:**

|  |
| --- |
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**Medication and where it is stored in school**

|  |
| --- |
|  |

**Details of dose**

|  |
| --- |
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**Method and time of administration**

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

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| --- |
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**Action to be taken in an emergency**

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| --- |
|  |

**Follow up care / other support to be offered by school**

|  |
| --- |
|  |

**Members of staff trained to administer medication for this child**

*(State if different for off-site activities)*

|  |
| --- |
|  |

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

|  |
| --- |
|  |

**Signed**

 **Date / /**

*Parent or Guardian (or pupil if above age of legal capacity)*

# **Med form 8:** Risk assessment for the administration of medicines

|  |  |
| --- | --- |
| **Pupils Name:** |  |
| **Year Group/ Class:** |  |
| **Risk Assessment Undertaken By** (list all contributors)**:** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Hazard / Risk** | **Medication / Procedure / Objective** | **Person/s Affected** | **Risk level before controls are in place** | **Initial control measures** | **New / further control measures required** | **Risk level with controls in place** |
|  |  |  | **L** | **M** | **H** |  |  | **L** | **M** | **H** |
|  |  |  |  |  |  |  |  |  |  |  |
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| **List any activities which cannot be safely managed, as far as it is possible to foresee:** |
| **Risk Assessment Undertaken By:** |  | **Signed:** |  |
| **Date risk assessment completed:** |  | **Review date:** |  |

# **Exemplar Risk Assessment**

|  |  |
| --- | --- |
| **Pupils Name:** | Joe Bloggs |
| **Year Group/ Class:** | Secondary 2 |
| **Risk Assessment Undertaken By** (list all contributors)**:** | DHT pupil support, School nurse, Parents, Stoma nurse, GP, Community paediatrician |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Hazard / Risk** | **Medication / Procedure / Objective** | **Person/s Affected** | **Risk level before controls are in place** | **Initial control measures** | **New / further control measures required** | **Risk level with controls in place** |
|  |  |  | **L** | **M** | **H** |  |  | **L** | **M** | **H** |
| Epileptic seizure  | Medication administered via gastrostomy | Pupil |  | √ |  | Medication prescribed by GP. Protocol provided by parent and doctor. Parent has demonstrated procedure. Staff trained by Gastrostomy nurse. Only carried out by identified members of class team (trained staff). Accurate records kept.  | Parent / GP contacted for advice/support in the event of incomplete administration of the dose of medicine. | √ |  |  |
| Severe pain and inflammation / stick injury  | Steroid replacement injection | Pupil and staff |  |  | √ | Injection only to be administered by staff who have been trained by nurse to carry out procedure. Protocol provided by specialist nurse. Accurate records kept. Sharps’ bin to be used for disposal of syringe needles as per protocol | Parent to provide and remove sharps’ bins at agreed intervals |  | **√** |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **List any activities which cannot be safely managed, as far as it is possible to foresee:**  |
| **Risk Assessment Undertaken By:** | Mrs Jade Green | **Signed:** | Jade Green |
| **Date risk assessment completed:** | 14.05.2014 | **Review date:** | 14.05.2016 (or earlier if changes made to medication)  |

# Example Risk Assessment for an Objective of This Policy – Storage of Medication

|  |  |
| --- | --- |
| **Pupils Name:** | Heatherhill Primary School  |
| **Year Group/ Class:** | n/a |
| **Risk Assessment Undertaken By** (list all contributors)**:** | Mrs Green (Head teacher), Mr McCann (Depute head teacher), Mrs White (PSA) Mrs Young (PSA) |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Hazard / Risk** | **Medication / Procedure / Objective** | **Person/s Affected** | **Risk level before controls are in place** | **Initial control measures** | **New / further control measures required** | **Risk level with controls in place** |
|  |  |  | **L** | **M** | **H** |  |  | **L** | **M** | **H** |
| Inappropriate storage resulting in medicines being misplaced, unavailable or unusable resulting in possible harm to children | Ensure medication is stored appropriately and is accountable and available for children’s needs at all times during term time | Children  |  |  | √ | Procedures in place (Med forms 1-3) whereby all medicines incoming, administered and disposed of are recorded and signed for.Staff have received appropriate training (med form 5) including importance of appropriate storage conditions (depending on child’s need and storage requirement of medication), and record keepingTermly inspections of records and storage areas are conducted by the head teacherStaff to dial 999 if medical emergency arises and child is at risk of harmContact numbers of child’s parents / carers / GP | Ensure emergency response procedures are completed and prominently displayed around the school building (med form 6)**Proactive indicator:**Termly checks by head teacher to ensure that medication quantities are as recorded.**Reactive indicator:**Number of occasions that medicines have been reported as missing and did not have an impact on the childNumber of occasions that medicines have been reported as missing and did have an impact on the child | √ |  |  |
| **List any activities which cannot be safely managed, as far as it is possible to foresee:** n/a |
| **Risk Assessment Undertaken By:** | Mrs Jade Green | **Signed:** | Jade Green |
| **Date risk assessment completed:** | 18.08.2015 | **Review date:** | 18.08.2016 |