Appendix 2 WSCC

Administering Medicines Templates

Supporting pupils with medical conditions

December 2021

Insert Name of School

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/Tutor Group**

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

Condition	**Yes**	**No**	**Medication**
Asthma NB:Parents of pupils with mild asthma must also sign an asthma protocol form (template 2 in Appendix 1) available from the school			
Allergies/Anaphylaxis NB:Parents of pupils prescribed an auto injector must also sign The relevant auto injector protocol form (template 3, 4, 5 in Appendix 1 or available from the school)			
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:

Thank you

Insert Name of School

Template B: Parent/guardian consent to administer short-term non-prescribed '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/Tutor Group**

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 (insert method of communication). The school holds a small stock of the following medicines:

Paracetamol

Ibuprofen (Pupils age 12 and over)

Anti-histamine

E45 Cream

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, otherwise if you are giving consent for the administration of the schools E45 cream it will be assumed that consent remains in place unless the schools is informed in writing.

_____ _____

Signature(s) Parent/Guardian Date

_____

Print name

Insert Name of School

Template C: parental consent to administer medication (where an Individual Healthcare Plan or Education Healthcare Plan is not required)

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting 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 or 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

If this is a request to administer non-prescribed medication, please work with the school to complete Template C1 on the reverse of this form

Template C1 - Individual Protocol for non-prescribed medication

This form should be completed in conjunction with Template C – parental consent

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 or PIL		
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 and/or PIL 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 plan 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 in writing when medication has been administered by (insert method of communication).

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

Template D: record of medicine administered to an individual child

Name of school/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

Signature of parent

Date / /	/ /	/ /	/ /
Time given			
Dose given			
Controlled drug stock			
Name of member of staff			
Staff initials			
Witnessed by			

Date / /	/ /	/ /	/ /
Time given			
Dose given			
Controlled drug stock			
Name of member of staff			
Staff initials			
Witnessed by			

D: Record of medicine administered to an individual child (Continued)

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

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

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

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

Template E: record of medicine administered to all children

Name of school/setting

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

Template F: staff training record – administration of medicines

Training can also be recorded on a matrix, in SIMS or similar database or using this form.

Name of school/setting	
Name	
Type of training received	
Date of training completed	
Training provided by – print name and signature	
Refresher/update training date	
Profession and title	
I confirm I have received and understood the above training	signature

Additional training:

Type of training received	
Date of training completed	
Training provided by – print name and signature	
Refresher/update training date	
Profession and title	
I confirm I have received and understood the above training	signature

Type of training received	
Date of training completed	
Training provided by – print name and signature	
Refresher/update training date	
Profession and title	
I confirm I have received and understood the above training	signature

Template G: 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**

School telephone

2. **your location as follows [insert school/setting address]**

School address

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

Postcode

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

Best entrance is:

5. **your name**
6. **provide the exact location of the patient within the school setting**
7. **provide the name of the child and a brief description of their symptoms**
8. **put a completed copy of this form by the phone**

Insert Name of School

Template H – 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/Tutor Group**

If your child develops the relevant symptoms during the residential visit, with your consent 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 (insert method of communication).

The school will hold a small stock of the following medicines:

☐ **Paracetamol brand ……** ☐ **……..**

☐ **Ibuprofen (pupils age 12+) brand……** ☐ **……..**

☐ **Anti-histamine brand ……** ☐ **……..**

Please tick the non-prescription medications that you give your consent for the school to administer their stock of during the residential visit.

If you would like your child to be given travel sickness medication please supply medication suitable for their age and weight in its original packaging with the patient information leaflet

☐ **Travel sickness**

I give my consent for the medications ticked above to be administered by the school from their stock and confirm I have administered them to my child in the past without adverse effect.

Signature(s) Parent/Guardian Date

Print name