JONES MEMORIAL PRIMARY SCHOOL

2021 / 2022

POLICY FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

1.1 The Board of Governors and staff of **Jones Memorial Primary School** wish to ensure that pupils with 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.

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

1.3 Prescribed medication will not be accepted in school without complete written permission from the parent.

1.4 Staff will not give a non-prescribed medicine to a child unless there is specific prior written permission from the parents. On most occasions children should not be at school if needing medication, even for an 'acute' sickness or infection. Parents could ask for medication which would be administered 3 times within a 24hr period and therefore would not need to be taken during school hours.

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

1.6 Where the pupil travels on school transport with an escort, parents should ensure the escort has written instructions relating to any medication sent with the pupil, including medication for administration during respite care.

1.7 Each item of medication must be delivered to the Principal or member of the teaching staff, 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.

1.8 Medication will be kept in a secure place, out of reach of pupils. Unless otherwise indicated all medication to be administered in school will be kept in a locked medicine cabinet.

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

1.10 If children refuse to take medicines, staff will not force them to do so, and will inform the parents of the refusal and return the child to the care of the parent as a matter of urgency, the school's emergency procedures will be followed. The refusal will be recorded on Form AM1, Medication Plan for a Pupil with Medical Needs.

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

1.12 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.

1.13 The school will not make changes to dosages on verbal parental instructions alone. Any change in medication must be made in writing to enable school information to be updated.

1.14 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.

1.15 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.

1.16 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.

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

1.18 The school will make every effort to continue the administration of prescribed 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.

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

JONES MEMORIAL PRIMARY SCHOOL

MEDICATION PLAN FOR A PUPIL WITH MEDICAL NEEDS **FORM AM1**

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 _____

JONES MEMORIAL PRIMARY SCHOOL

REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION FORM AM2

The school will not give your child medicine unless you complete and sign this form, and the Principal has agreed that 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 the School 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 a member of the teaching 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 e.g. 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.

JONES MEMORIAL PRIMARY SCHOOL

REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION **FORM AM3**

This form must be completed by parents/carers.

If staff have any concerns discuss this request with healthcare professionals.

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 of medication (as described on the container)

_____

Procedures to take 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 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 the named pupil carrying his/her own medication.

JONES MEMORIAL PRIMARY SCHOOL

RECORD OF MEDICINE ADMINISTERED TO AN INDIVIDUAL CHILD FORM **AM4**

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					

Name of Pupil

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					

Date					
Time given					
Dose given					
Any reactions					
Name of member of staff					

Staff initials					

JONES MEMORIAL PRIMARY SCHOOL

RECORD OF MEDICINES ADMINISTERED TO ALL CHILDREN **FORM AM5**

Date	Child's Name	Time	Name of medicine	Dose given	Any reactions	Signature of staff	Print name
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							
___ / ___ / ___							

JONES MEMORIAL PRIMARY SCHOOL

RECORD OF MEDICAL TRAINING FOR STAFF FORM **AM6**

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 _____

JONES MEMORIAL PRIMARY SCHOOL

SUPPORTING PUPILS WITH MEDICAL AND ASSOCIATED NEEDS

LOCAL CONTACT NUMBERS

Principal	Mrs Sandra Isherwood	028 66323420
Authorised Person	Mrs Sandra Isherwood	028 66323420
SENCO	Mrs Sandra Isherwood	028 66323420
SENCO DEPUTY	Mrs Roberta Bailie	028 66323420
School Nurse	Elaine Dunne	
Education Authority (Western Region)		028 82411411

SEN SECTION

EDUCATIONAL Psychology

HEALTH & SAFETY

WESTERN HEALTH & SOCIAL SERVICES BOARD

LOCAL HOSPITAL

LOCAL GP SURGERIES

COMMUNITY PAEDIATRICIAN

SCHOOL HEALTH SERVICE