ASPIRE Primary School Procedure for the Administration of Medicines in Schools Appendix 1a

Health Care / Emergency Plan

CONTACT DETAILS

Child's Name:

_____

School:

_____

Home Address:

_____

_____

Date of Birth:

_____

Next of Kin:

_____

Contact Numbers: **Home:** _____ **Mobile:** _____

GP Name and Address:

_____

Contact Numbers:

_____

Hospital Contacts:

_____

_____

Description of Medical Condition:

_____

_____

_____

Description of Signs and Symptoms:

_____

_____

Daily treatment/medication needs in school

_____

Describe what is an emergency for the pupil

_____

_____

_____

_____

Describe actions should this emergency occur:

If: …… shows the following signs and symptoms:

a) _____

b) _____

c) _____

When this is an emergency then the following action should be taken:

For example:

If a) and b)	**Call an ambulance** **Then call parents** **Then call community nurse**
Or c)	**Call parents / community nurse to assess**

Emma Hickling is responsible in an emergency at school or offsite.

Plan copied to:	Parents	Yes/No
	Headteacher/class teacher	Yes/No
	Community Nurse	Yes/No
	Other specialist nurse	Yes/No

Parent and School Agreement

To the best of our knowledge the above information is correct. The staff, in agreement, will do their best to support and care for ……'s medical and emergency needs.

Parents signature: _____ Date: _____

School staff signature: _____ Date: _____

Head teacher's signature: _____ Date: _____

Nurse's signature: _____ Date: _____

(to confirm advice and training has been provided to school)

ASPIRE Primary School Procedure for the Administration of Medicines in Schools
Appendix 1b

This form is to be kept by the telephone

CONTACTING EMERGENCY SERVICES

<u>To request an ambulance</u>:

Dial 999 and be ready with the following information:

1. **Your telephone number (enter number)**
2. **Your location (*enter address*)**
3. **Your postcode (enter postcode)**
4. **Exact location (brief description e.g. next to church)**
5. **Your name**
6. **Child's name and brief description**
7. **The best entrance for ambulance crew and advise crew will be met and taken to child**

ASPIRE Primary School Procedure for
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Appendix 2

Risk Assessment Form

CONTACT DETAILS

Name of person completing the form _____

Date: _____

Child's Name: _____

Age: _____ **Year Group:** _____

School: _____

Medical Condition:_____

List significant hazards	Who is at risk?	Existing controls	List additional controls needed	Date of assessment	By Whom (e.g. Parent, School, Doctor)

ASPIRE Primary School Procedure for the Administration of Medicines in Schools Appendix 3

Parental agreement for the administration of medicines

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

Date: _____Childs Name_____

School: _____

Age _____Yr Group & Class _____ DOB _____

Condition / Illness _____

Name and Strength of Medicine _____

Where Medicine Kept : _____

Side Effects: _____

Expiry date: _____

How much (dose) to give: _____ Date of Provision_____

When to give it _____

Number of tablets given to school _____

Note : MEDICINES MUST BE IN THE ORIGINAL CONTAINER AS DISPENSED BY THE PHARMACIST. STUDENTS SHOULD NOT SELF ADMINISTER

Daytime contact number of parent or adult contact

_____

Name and contact number of GP

_____

Agreed review date _____

This information is, to the best of my knowledge, accurate at time of writing and I give consent to the school / setting staff, to administer the medicine in accordance with the school/setting procedure. 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.

Parent/Guardian signature _____
Print name _____
Date _____

ASPIRE Primary School Procedure for the Administration of Medicines in Schools
Appendix 4

Headteacher / Head of setting agreement to administer medicine where a Risk Assessment or Health Care Plan are not needed (e.g. asthma, period pains)

Name of school / setting:_____

It is agreed that _____will receive_____
(Quantity and name of medicine)

Every day at :_____

_____ (Name of child) will be given their medicine or supervised in taking it by

_____ (Name of member of staff)

This arrangement will continue until _____
(either end date or until instructed by parents)

Signed _____ Date:

_____
(Headteacher / Head of setting / named member of staff)

ASPIRE Primary School Procedure for the Administration of Medicines in Schools
Appendix 5

Record of medicines administered to an individual child

To ensure:

- **The right medicine**

For

- **The right child**

At

- **The right time**

At

- **The right dose**

Name of Child: _____

Date of Birth _____/_____/_____

Name of school _____

Class _____

Name and Strength of medicine _____

Date Medicine provided by Parent _____ Quantity Received _____

Dose and frequency of medicine _____

Staff Signature _____ Parent/Guardian Signature _____

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of Staff Member			
Staff Initials			

ASPIRE Primary School Procedure for the Administration of Medicines in Schools
Appendix 6
(to be completed for each member of staff involved in a care plan)

Record of advice, awareness raising, support and guidance to the school

Name of school / setting: _____

Name of staff: _____

Type of awareness raising received: _____

Date of Session: _____

Training provided by: _____

Profession: _____ Title: _____

I confirm that:

_____

Has received awareness training detailed above and is competent to carry out the appropriate procedures

I recommend that the training is updated:

_____
(State frequency)

Signature of health professional:

_____

Date:

_____

I confirm that I have received the awareness raising as detailed above

Staff signature:

_____

Date: _____

ASPIRE Primary School Procedure for the Administration of Medicines in Schools
Appendix 7

Authorisation for the administration of Rectal Diazepam

Name of school/setting: _____

Child's name: _____

Date of birth: _____

Home address: _____

_____

GP name and address: _____

_____

Hospital name and address: _____

_____

_____(name) should be given Rectal Diazepam _____mg if:

He/she has a prolonged epileptic seizure lasting over _____ minutes

OR

Serial seizures lasting over _____ minutes

OR

If the seizure has not been resolved after _____ minutes (please delete as appropriate)

Doctors signature: _____

Parents signature: _____

Date: _____

ASPIRE Primary School Procedure for the Administration of Medicines in Schools Appendix 8

Buccal Midazolam

Agreed Individual care plan to prevent status epilepticus
Agreed between parent/carer and school

Child's name: _____

Date of birth: _____

Name of Parent/Carer: _____

Contact details: _____ (Home/Work) _____(mobile)

Alternate contact name: _____(number)_____

Condition: _____

_____

Known allergies Current medication: _____

_____

_____

_____

For Seizure type: _____

Buccal Midazolam, ___ mg in: _____ ml may be given by a trained individual if

(Name) _____ has either a seizure lasting longer than FIVE (5) minutes, or….has one seizure after another without recovery in between lasting longer than FIVE (5) minutes or…has THREE (3) seizures) in HALF (1/2) an hour, (give at onset of 3rd seizure)

This should result in the seizure stopping within TEN (10) minutes. If the seizure does not stop within TEN (10) minutes a second dose of Buccal Midazolam ____mg in ____ml may / may not be given. If the seizures do not stop after TEN (10) minutes of the first / second dose **CALL AN AMBULANCE ON 999** and inform the operator that you have someone who may be in **Status Epilepticus**

An ambulance should also be called if:

- It is the child's first seizure
- The child has injured themselves badly
- They have breathing problems after a seizure

Date of first ever dose* / / *

It is recommended that no more than 2 doses may be given in any 24 hour period. If more seizures occur within this 24 hour period then it would be wise to seek a medical opinion.

IF IT IS THE FIRST TIME THAT THIS CHILD IS HAVING THE MEDICINE AN AMBULANCE SHOULD BE CALLED, AFTER IT HAS BEEN GIVEN, IN CASE THERE ARE ANY UNEXPECTED REACTIONS TO IT

Buccal Midazolam and the agreed individual care plan to prevent status epilepticus should be carried with the person at all times

---

The child's **main carer** is responsible for the safe storage of Buccal Midazolam ensuring that it is not out of date or gone off (turned milky) during storage.

Current expiry date is _____

Locations where this care plan may be found include :
……..
……..
……..
……..
……..
……..

This agreed care plan is due to be reviewed in
_____

Signed _____date _____ Dr prescribing medication

Signed_____ date _____ Parent / Carer

Signed_____ date _____ School

ASPIRE Primary School Procedure for the Administration of Medicines in Schools Appendix 9

Asthma Pumps in Primary Schools

Dear

Asthma Pumps

Your child _____ has an asthma pump in school.

I am writing to inform you of the School's guidelines with regard to asthma pumps in school.

1. All asthma pumps will be kept in an asthma box, of which there is one in every classroom.
2. All asthma pumps will be named.
3. With the pump there will be written evidence of the frequency of usage necessary for each individual child. This is to ensure that if a child appears to need their pump rather too frequently, then the parent can be informed.
4. We strongly encourage independence so your child will not be restricted from using their pump during the course of the school day, but it is considered courteous to make the normal requests of the teacher first.
5. If the child needs their pump during breaktimes, a request to a member of staff must be made first before entering the building. If the child always needs their pump during lunchtime, then the child can give it to a Midday Supervisor for safekeeping. It will be the child's responsibility to ensure the Midday Supervisor is given it, to take back to class following lunch.

If you wish to see the School Medical Procedure, please make a request to the school office.

Would you please sign and return the slip below indicating either your agreement or your wish not to keep the pump in the care of the teacher or other staff, thereby taking full responsibility yourself.

Yours sincerely

Headteacher

Form 9

Asthma Pumps

Please tick as appropriate

{ } I agree and accept the above guidelines regarding asthma pumps in school
Signed _____ Parent/Guardian

Date _____ Child's Name _____