**Ballylifford Primary School**



# Administration of Medication Policy

The Board of Governors and staff of Ballylifford Primary School wish to ensure that pupils with medication needs receive appropriate care and support at school.

**Please note that parents should keep their children at home if acutely unwell or infectious and the Public Health Agency advice Guidance Infection control in schools will be referred to.**

**Prescribed Medication**

* 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**.
* Parents are responsible for providing the Principal with **comprehensive information regarding a pupil’s condition and medication**.
* Prescribed medication will not be accepted in school without **complete written and signed instructions from the parent**.

**Non-Prescribed Medication**

Staff will give a non-prescribed medicine to a child with written consent from the parent/guardian. The correct dosage must be stated on the written consent.

**General information relating to Prescribed Medication**

* Only reasonable quantities of medication should be supplied to the school (for example, a maximum of four weeks supply at any one time).
* Each item of medication must be delivered to the Principal or Class Teacher 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.
* Medication will be kept in a secure place, out of the reach of pupils. All medication to be administered in school will be kept either in the classroom or the fridge in the staffroom.
* If children refuse to take medicines, staff will not force them to do so, and will inform the parents of the refusal, as a matter of urgency, on the same day. If a refusal to take medicines results in an emergency, the school’s emergency procedures will be followed.

**Where administration of medication is requested, a relevant form must be completed in advance by parents/carers, in consultation with the Principal / Designated Member of Safeguarding Team, as necessary.**

**Forms, copies of which are enclosed, are available from school.**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BoG Chairperson**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Principal**

**Approved by Governors: February 2022**

**Next Review: February 2025**

**Ballylifford PS FORM AM1**

**MEDICATION PLAN FOR A PUPIL WITH SPECIAL MEDICAL NEEDS**

**Date Review Date**

|  |  |
| --- | --- |
| **Name of Pupil** |  |
| **Date of Birth** |  |
| **Class** |  |
| **National Health Number** |  |
| **Medical Diagnosis** |  |
| **Contact Information** |  |
|  | **Family Contact 1** |
| Name  |  |
| Phone Number |  |
| (Home / Mobile) |  |
| Work |  |
| Relationship |  |
|  | **Family Contact 2** |
| Name  |  |
| Phone Number |  |
| (Home / Mobile) |  |
| Work |  |
| Relationship |  |
|  | **GP** |
| Name |  |
| Phone Number |  |
|  | **Hospital / Clinic Contact** |
| Name |  |
| Phone Number |  |

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ballylifford PS FORM AM2**

**REQUEST FOR A SCHOOL TO ADMINISTER PRESCRIBED MEDICATION, eg. Inhalers**

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

and the Principal has agreed that school 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

(agreed member of 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 eg 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.**

**Ballylifford PS FORM AM3**

**REQUEST FOR PUPIL TO CARRY HIS/HER OWN MEDICATION (eg. Inhalers)**

This form must be completed by parents/carers.

## *Details of Pupil*

Surname Forenames(s)

Address

Date of Birth / /

Class

Condition or illness

## *Medication*

***Parents must ensure that in date properly labelled medication is supplied.***

Name of Medicine

Procedures to be taken 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

medication 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**