

ADMINISTRATION OF MEDICATION
IN SCHOOL POLICY



OMAGH HIGH SCHOOL

ADMINISTRATION OF MEDICATION IN SCHOOL POLICY

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POLICY FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

The Board of Governors and staff of **OMAGH HIGH 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.

- Parents are responsible for providing the School with comprehensive information regarding the pupil's condition and medication.
- Prescribed medication will not be accepted in school without complete written and signed instructions from the parent.
- Staff will not give non-prescribed medicine to a child unless there is specific prior written permission from the parents.
- Only reasonable quantities of medication should be supplied to the school (for example, a maximum of four weeks supply at any one time).
- 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.
- Each item of medication must be delivered to the School Welfare Officer, 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. Unless otherwise indicated all medication to be administered in school will be kept in a secure cabinet.
- The School Welfare Officer will keep records, which they will have available for parents (Forms AM4 and AM5).
- 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.
- It is the responsibility of parents to notify the school in writing if the pupil's need for medication has ceased.
- 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.
- The school will not make changes to dosages on parental instructions.
- 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 each pupil with long-term or complex medication needs, the Principal, will ensure that a Medication Plan is drawn up (AM1), in conjunction with the appropriate health professionals.
- 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 (Form AM3).
- Staff who volunteer to assist in the administration of medication will receive appropriate training/guidance through arrangements made with the School Health Service.
- The school will make every effort to continue the administration of 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.
- All staff will be made aware of the procedures to be followed in the event of an emergency.

APPENDICES

EMERGENCY CALL FORM

TO BE DISPLAYED BY THE OFFICE TELEPHONE

REQUEST FOR AN AMBULANCE

TO: OMAGH HIGH SCHOOL

Dial 999, ask for ambulance and be ready with the following information:

1. School Telephone Number: 028 82242656
2. Give location: Omagh High School
14 Crevenagh Road
Omagh BT79 0EQ
3. Give exact location within the school
4. Give your name
5. Give brief description of pupil's symptoms
6. Inform ambulance control of the best entrance and state that the crew will be met and taken to the pupil

SPEAK CLEARLY AND SLOWLY

OMAGH HIGH SCHOOL

FORM AM1

MEDICATION PLAN FOR A PUPIL WITH MEDICAL NEEDS

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 _____

REQUEST FOR A SCHOOL TO ADMINISTER MEDICATION

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.**

A REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION

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

**Record of medicine administered
to an individual child**

Surname	
Forename (s)	
Date of Birth	___ / ___ / ___ M <input type="checkbox"/> F <input type="checkbox"/>
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			

FORM AM4(Continued)

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			

**TEMPLATE FOR A RECORD OF
MEDICAL TRAINING FOR STAFF**

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 _____