



POLICY FOR	ADMINISTRATION OF MEDICINES
PERSON RESPONSIBLE	Director of Business
DATE REVISED	January 2022
REVIEW DATE	April 2022
NEXT REVIEW DATE	April 2024
APPROVED BY	HEADTEACHER

Employees working under Teachers' Terms and Conditions have no contractual obligation to administer medicines. Any agreement so to do can therefore only be a voluntary act.

At The Malling School the following policy must be adhered to:

- Medicines may be stored and locked away by the office e.g. ADHD medication, if a written request has been received from the parent and:
 - date of expiry is noted
 - name, details of drug and amount/time to be released is noted on the package
 - The medicine is in its original packaging
- It is not school policy to issue any paracetamol to students. If you wish to send in a packet, clearly labelled with your son/daughters name, these may be stored for their use. These can be sent to either Mrs Stock or Guidance Managers along with a completed appendix 2
- A disclaimer is to be completed by the parent if there is a need for medicine e.g. ADHD medication/Epi-pen etc. to be issued.
- It is recommended that no member of staff should administer medication. Arrangements should be made for parent/carer to come to the school and administer a drug e.g. suppository. A qualified school nurse could be an authorised person. The exception to this is if a EHCP is in place and the member of staff with responsibility for care is qualified to administer (see appendix 5)
- The Head Teacher is in loco parentis of all students and will endeavour to ensure that students do not lose valuable lesson time.

If you would like a disclaimer form re ADHD medication/Epi-pens, please contact the Attendance Officer.

Appendix 1: individual healthcare plan

Name of school/setting

Child's name

Group/class/form

Date of birth

Child's address

Medical diagnosis or condition

Date

Review date

Family Contact Information

Name

Phone no. (work)

(home)

(mobile)

Name

Relationship to child

Phone no. (work)

(home)

(mobile)

Clinic/Hospital Contact

Name

Phone no.

G.P.

Name

Phone no.

Who is responsible for providing support in school

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Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the pupil's educational, social and emotional needs

Arrangements for school visits/trips etc

Other information

Describe what constitutes an emergency, and the action to take if this occurs

Who is responsible in an emergency (*state if different for off-site activities*)

Plan developed with

Staff training needed/undertaken – who, what, when

Form copied to

Appendix 2: parental agreement for setting to administer medicine

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 school/setting

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

Contact Details

Name

Daytime telephone no.

Relationship to child

Address

I understand that I must deliver the medicine personally to

[agreed member of staff]

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 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 _____

Appendix 3: 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			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

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

Date

Time given

Dose given

Name of member of staff

Staff initials

Date

Time given

Dose given

Name of member of staff

Staff initials

Date

Time given

Dose given

Name of member of staff

Staff initials

Appendix 4 :Record of medicine administered to all children

Name of school/setting

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

Appendix 5: staff training record – administration of medicines

Name of school/setting

Name

Type of training received

Date of training completed

Training provided by

Profession and title

I confirm that [name of member of staff] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [name of member of staff].

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____