**EDWARD FEILD SCHOOLS MEDICATION PLAN**

**Parental/Headteacher agreement for school to adminster/supervise medication.**

Employees are not obliged to administer medicines to pupils unless this is written into their job description. They may volunteer to administer emergency or long/short term medication for which they have received recognised training and will have indemnity from the L.E.A. as long as the procedure has been adhered to. They may also volunteer to administer essential medication for which the appropriate paperwork has been completed and will have indemnity from the L.E.A. as long as the procedure has been adhered to.

The school will not adminster/supervise medication for your child unless you complete and sign this form. The school may refer this request to the School Nurse for advice before agreeing to it.

NAME OF CHILD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLASS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL CONDITION / ILLNESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Self Administration : | YES / NO (delete as appropriate) |
| Is training required? (If unsure HT will consult school nurse before signing.) | YES/NO If yes a health care plan will be required but please give basic details on this form. |
| Name/Type Quantity of Medicine (as described on the container): |  |
| Date dispensed : |  |
| Expiry date: |  |
| Agreed review date (to be initiated by parent):  |  |
| Dosage and method: |  |
| Timing: |  |
| Special Precautions: |  |
| Are there are side effects that the school/setting needs to know about? |  |
| Procedures to take in an Emergency:  |  |

**CONTACT DETAILS**

|  |  |
| --- | --- |
| Name: |  |
| Daytime Telephone number: |  |
| Mobile number: |  |
| E-mail (if appropriate as emergency contact) |  |
| Relationship to Child: |  |
| Address: |  |
|  |  |

I understand that I must deliver the medicine (daily dose unless otherwise agreed) personally to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(agreed member(s) of staff)

and I accept that this a service that the school/setting is not obliged to undertake.

I understand that I must notify the school/setting of any changes in writing.

|  |  |
| --- | --- |
| Date: |  |
| Signature(s): |  |
| Relationship to child: |  |

**CONFIRMATION OF THE HEAD’S AGREEMENT TO ADMINISTER MEDICINE**

The school will administer/supervise the medication at the time and in the quantity agreed. The child will be supervised/given the medication by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (member(s) of staff)

The arrangement will continue to the review date.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Head Teacher

The school setting will make every effort to provide this service, should for any reason the school be unable to provide this service the school/setting will inform the named contact at once, so that alternative arrangements can be made by the parent/carer.

MEDICATION TIMETABLE FOR :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Name of Supervisor/ Administrator | Dosage | Date & Time |
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