MARLBOROUGH PRIMARY SCHOOL

MEDICINES POLICY

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Personnel Committee: May 2011

Forms Amended: April 2014

INTRODUCTION
Staff at Marlborough Primary School **DO NOT** have a statutory duty to give medicines or provide medical treatment. However, medicines may be administered to enable the inclusion of pupils with medical needs and to enable regular attendance of all pupils. Furthermore, in an emergency all teachers and other staff in charge of children have a common law duty of care to act for the health and safety of a child in their care – this might mean giving medicines or medical care.

AIM OF THIS POLICY
To provide parents and staff with clear guidelines about how medicines are treated at Marlborough Primary School.

PRESCRIBED MEDICINES
Medicine should only be brought to school where it is essential that it is administered during the school day. In the vast majority of cases, doses of medicine can be arranged around the school day, thus avoiding the need to bring medication into the school. Antibiotics, for example, are usually taken three times a day and so can be given with breakfast, on getting home from school and then at bedtime.

If a GP prescribes a medicine that needs to be taken during the school day, parents may need to come into school at an agreed time to administer the medicine to their child.

If parents wish to request that a member of staff administers medicine to the child, they will need to complete an 'Request/Agreement for school to administer medicine form' (attached) and make an appointment with the Headteacher to obtain approval. The Headteacher will complete the 'Confirmation of the approval to administer medicines' form'.

On no account should a child come to school if he/she is unwell.

<u>Exceptions</u>
Prescribed medicines will NOT be given:-

- Where the timing of the dose is vital during school hours and where mistakes could lead to serious consequences.
- Where medical or technical expertise is required
- Where intimate contact would be necessary outside the normal remit of staff training;competence;safeguarding procedures set out in the school's Intimate Care Policy.

NON-PRESCRIPTION MEDICINES
Non-prescription medicines are not administered at school and pupils should not being them to school for self-administration. The only exception to this is travel sickness medication which can be administered if the 'Request for school to administer medicine form' has been completed and the Headteacher has given approval to this by completing a 'Confirmation of the approval of to administer medicines form'.

Parents should ensure that the medicine is suitable for the child's age. The medication must be supplied by the parent and must be in its original packaging, with the manufacturers instructions included. The parent will be asked to confirm that the medication has previously been administered to the child without adverse effect and must put a written note to this effect on the form.

PUPILS WITH LONG TERM OR COMPLEX MEDICAL ISSUES

Parents or carers should provide the Headteacher with sufficient information about their child's medical condition and treatment or special care needed at school. Arrangements can then be made, between the parents, Headteacher, School Nurse and other relevant health professionals to ensure that the pupil's medical needs are managed well during their time in school and a Health Care Plan will be drawn up .

The DFE *Managing Medicines in School and Early Years Settings* document provides guidance on the four most significant chronic conditions – Asthma, Epilepsy, Diabetes and Anaphylaxis – details of which are contained as part of this Policy.

Asthma

In accordance with the guidelines in *Managing Medicines in Schools and Early* Years, Marlborough Primary School has developed an Asthma Policy which has been produced with reference to the model school policy provided by Asthma UK.

Pupils taking their own medication

For certain long-term medical conditions, it is important for children to learn how to self-administer their medication. The most common condition where this applies is asthma.

For other conditions, appropriate arrangements for medication should be agreed and documented in the pupil's Health Care Plan and parents should complete a '*Request for a child to carry their own medicine*' Form. (attached)

EXPIRY DATES

It is the responsibility of the parent/carer to ensure that the medication held by the school is in date and to provide new medication as necessary.

REFUSAL OF MEDICINES

If a child refuses to take medication, staff will not force them to do so, but will note in the records that this has occurred and will inform parents as soon as is reasonably possible.

STAFF TRAINING

The Headteacher is responsible for ensuring that staff who administer medicine are fully briefed in general procedures and that they receive appropriate training to administer specific medicines, for example, epipens, insulin.

Training in the administration of specific medicines will be arranged via the School Nurse or other health professionals. Records of all training completed by staff will be maintained by the school and reviewed annually.

STORAGE AND ACCESS TO MEDICINES

All medicines, apart from emergency medicines (inhalers, epipens etc.) will be kept in a locked cupboard. Medicines should be stored in the original pharmacists's container. Pupils will be informed of where their medication is stored and who holds the key. In the event that a pupil requires an emergency medication that must be locked away, the Headteacher will ensure that staff are briefed on the procedures for obtaining the medication in an emergency.

Emergency medicines, such as inhalers and epipens, are either held by the pupil (with prior written consent from the parents and the approval of the Headteacher) or kept in a clearly identified container in his/her classroom. Class teachers and/or classroom support staff should ensure that emergency medication is available to hand during outside PE lessons and that it is taken on educational trips. A spare inhaler/epipen for each child should be stored in the school office.

Medication that requires refrigeration should be kept in the fridge in the main school office, clearly labelled and in an airtight container.

RECORD KEEPING

Any member of staff administering medication to a pupil must ensure that they complete the *record of medicines administered* form. Details of any medications administered during school trips should be recorded in the log as soon as the member of staff returns to school.

Each class have their own record file and this should "move up" with the class as they go through the school. This file will allow other members of staff and/or parents to check what medication has been given and aims to prevent double doses being administered in error.

For legal reasons, records of all medicines administered must be kept by the school until the pupil reaches the age of 21. When a pupil leaves the school, the class teacher must ensure that the records of medicines administered are returned to the school office for retention in the archieves.

EMERGENCY PROCEDURES

In a medical emergency, first aid should be given by qualified First Aiders, an ambulance should be called and the parents/carers notified. Should an emergency situation occur to a pupil who has a Health Care Plan, the emergency procedures detailed in that plan should be followed and a copy of the Health Care Plan given to the ambulance crew.

Instructions for calling for an ambulance are displayed in the school office.

EDUCATIONAL VISITS

Children with medical needs should be given the same opportunities as other children. Staff may need to consider what reasonable adjustments they may have to make to enable children with medical needs to participate fully and safely on visits. This should include carrying out a risk assessment for such children. Parents and any appropriate medical professionals should be consulted well in advance of the trip to ensure that all necessary measures are in place.

The classteacher is responsible for ensuring that staff have all the necessary medical information on a child and there is a named member of staff who will be administering the medication. Where medication is administered out of school, the named member of staff must ensure that the details of the medicine given are recorded in the school log upon their return to school.

DISPOSAL OF MEDICINES

Marlborough Primary School staff are not responsible for the disposal of medication. It is the responsibility of individual parents to ensure that date-expired medicines are returned to the pharmacy for safe disposal. Parents need to ensure that they collect medicines from the school at the end of the agreed administration time period.

COMMON CONDITIONS – PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS

(Extracts from *Managing Medicines In Schools & Early Years Settings* document: reference 1448-2005DCL-EN)

INTRODUCTION

The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This section provides some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children are assessed on an individual basis.

From April 2004 training for first-aiders in early years settings must include recognising and responding appropriately to the emergency needs of babies and children with chronic medical conditions.

ASTHMA

What is Asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children have asthma in the UK.

The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

However in early years settings staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is therefore imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for children with asthma when this happens. This should be supported by written asthma plans, asthma school cards provided by parents, and regular training and support for staff. Children with significant asthma should have an individual health care plan.

Medicine and Control

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise**.** Whilst **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

Children with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting.

The signs of an asthma attack include:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. An ambulance should be called if:

- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to speak
- the child is becoming exhausted
- the child looks blue

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents should arrange the review and make sure that a copy of their child's management plan is available to the school or setting. Children should have a reliever inhaler with them when they are in school or in a setting.

Children with asthma should participate in all aspects of the school or setting 'day' including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

Reluctance to participate in physical activities should be discussed with parents, staff and the child. However children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate.

Children with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate.

All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and medical needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK). The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

All staff, particularly PE teachers, should have training or be provided with information about asthma once a year. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

EPILEPSY

What is Epilepsy?

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children have epilepsy and around 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)
- any unusual "feelings" reported by the child prior to the seizure
- parts of the body demonstrating seizure activity e.g. limbs or facial muscles
- the timing of the seizure – when it happened and how long it lasted
- whether the child lost consciousness
- whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and Control

Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.

Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured themselves badly
- they have problems breathing after a seizure
- a seizure lasts longer than the period set out in the child's health care plan
- a seizure lasts for five minutes if you do not know how long they usually last for that child
- there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

Any health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam. Instructions for use **must** come from the prescribing doctor.

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being provided.

DIABETES

What is Diabetes?

Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

Each child may experience different symptoms and this should be discussed when drawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control

The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump. Most children can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results.

When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional.

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycaemic reaction** (hypo) in a child with diabetes:

- hunger
- sweating
- drowsiness
- pallor
- glazed eyes
- shaking or trembling
- lack of concentration
- irritability
- headache
- mood changes, especially angry or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

If a child has a hypo, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

- the child's recovery takes longer than 10-15minutes
- the child becomes unconscious

Some children may experience **hyperglycaemia** (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea this can lead to dehydration.

If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

ANAPHYLAXIS

What is anaphylaxis?

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

Medicine and Control

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

Should a severe allergic reaction occur, the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the head, the child's parents and medical staff involved.

Where children are considered to be sufficiently responsible to carry their emergency treatment on their person[1], there should always be a spare set kept safely which is not locked away and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

Studies have shown that the risks for allergic children are reduced where an individual health care plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

Important issues specific to anaphylaxis to be covered include:

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practice with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' could be put in place.

Parents often ask for the head to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect – except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

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Headteacher: Jessica Finer MA
Deputy Headteachers: Sarah Howell & Sam Birnage

Tel: 020 7589 8553
Fax: 020 7581 9374

Parental request/agreement for school to administer medicine

The school will not give your child medicine unless you complete and sign this form. The school has a policy that staff can only administer medicine once written approval from the Headteacher has been obtained.

Name of School: MARLBOROUGH PRIMARY SCHOOL

Name of Child: _____

Date of Birth: _____

Class: _____

Medical condition/illness: _____

Medicine

(All medication must be in the original container as dispensed by the pharmacy)

Name/Type of Medicine (as described on the container): _____

Date dispensed: _____

Expiry date: _____

Amount of Medication received: _____

_____

Agreed Start Date for Medication: _____

Agreed End Date for Medication _____

Dosage and method: _____

Timing: _____

Special Precautions: _____

Are there any side effects that the school/setting needs to know about? _____

Self Administration: Yes/No (delete as appropriate)

Procedures to take in an Emergency: _____

Contact Details

Name: _____

Daytime Telephone No: _____

Relationship to Child: _____

Address: _____

_____

GP Details

Name: _____

Address: _____

Phone Number: _____

I understand that I must deliver the medicine personally to _____ (School to insert name) and accept that this is a service that the school is not obliged to undertake.

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

Date: _____

Signature(s): _____

Name (Printed): _____

Relationship to child: _____

If more than one medicine is to given a separate form must be completed for each one.

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HEADTEACHER APPROVAL FOR ADMINISTERING MEDICINE

Name of School:	MARLBOROUGH PRIMARY SCHOOL
Name of Child:	
Date of Birth:	
Class:	
Medical condition/illness:	
Name of Medicine:(Please print)	
Dosage: e.g.	
Amount of Medication Received	
Time medicine to be taken:	

I confirm that _____ (name of member of staff) will administer the medication stated above to the name child at the agreed time.

OR

I confirm that _____ (name of member of staff) will supervise this child taking the medication specified above at the agreed time.

This arrangement will continue until: _____
(either enter end date for course of medicine or until instructed by the parents)

Signed: _____ Headteacher

Date: _____

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REQUEST FOR PUPILS TO CARRY THEIR OWN MEDICINE

THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN

If staff have any concerns discuss request with school healthcare professionals

Name of School:	MARLBOROUGH PRIMARY SCHOOL
Name of Child:	
Date of Birth:	
Class:	
Medical condition/illness:	
Name of Medicine:(Please print)	
Procedures to be taken in an emergency	

Contact Information

Name: _____

Daytime Phone No: _____

Relationship to child: _____

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

Signed: _____ Date: _____

If more than one medicine is to be given a separate form should be completed for each one.

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RECORD OF MEDICINES ADMINISTERED

Name of Pupil	
Name of Medicine Administered	
Amount Administered	
Date & Time Administered	
Administered by (Print name)	
Signature of member of staff completing this form	
Comments	

Name of Pupil	
Name of Medicine Administered	
Amount Administered	
Date & Time Administered	
Administered by (Print name)	
Signature of member of staff completing this form	
Comments	