

## **BELFAST ROYAL ACADEMY**

### **BEN MADIGAN PREPARATORY SCHOOL**

#### **POLICY ON MEDICATION**

The Board of Governors and staff of Ben Madigan Prep. wish to ensure that pupils with medication needs receive appropriate care and support at school.

It is important to note that:-

1. while staff may be asked to administer medication they cannot be directed to do so.
2. administration of medication remains the responsibility of the parent/guardian.
3. medication should only be taken to school if absolutely essential and with the agreement of the Principal.
4. parents should request, where possible, that medication be prescribed in dose frequencies which enable it to be taken outside school hours e.g. morning, after school and bedtime.
5. staff will not administer Aspirin or Ibuprofen except where clear medical guidance is provided in writing e.g. from a G.P.
6. children who are quite unwell or infectious must not be sent to school.

#### **WHEN MEDICATION IS SENT TO SCHOOL**

- A. OCCASIONAL BASIS, e.g. ANTIBIOTIC
  - (i) Form AM2 (Appendix 1) must be completed and returned to the class teacher for signature by the Principal before any medication may be administered.
  - (ii) Parents are responsible for providing accurate and comprehensive information regarding the pupils' condition and medication.

- (iii) Each item of medication should be delivered to the Principal or Class Teacher by the parent in a secure and labelled container as originally dispensed. It must be clearly labelled with:

Pupil's name  
Name of medication  
Dosage  
Frequency of administration  
Date of dispensing  
Storage requirements (if important)  
Expiry date

**SCHOOL WILL NOT ACCEPT MEDICATION IN UNLABELLED CONTAINERS.**

- (iv) The school will keep a record of when medication has been administered or a child has self-medicated when the teacher has the medication in his/her keeping (Form AM4 or 5 as appropriate).
- (v) If the child refuses to take the medication, staff can not force them to do so and parents will be notified by telephone. If this refusal causes an emergency, the normal emergency procedures will be followed.
- (vi) It is the parents' responsibility to notify the school, in writing, if the pupils' need for medication has ceased, also to renew medication if the supply runs low or reaches its expiry date.
- (vii) School will not change doses on a parent's verbal instruction nor will they dispose of medication - it will be returned to parents for disposal.
- (viii) Where appropriate, pupils will be encouraged to administer their own medication, if necessary under staff supervision. In general children should **not** carry medication with them in school. Parents must put in writing a request for a child to do this e.g. for a blue asthma inhaler (Form AM3). When an asthmatic child carries their own inhaler, a spare (named) inhaler should be left with the class teacher in case of loss or forgetting to bring.
- (ix) Staff who volunteer to assist with medication will receive appropriate training, if applicable, through the School Health Service e.g. epi-pen training.
- (x) The school will make every effort to continue the administration of medication on school trips 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 unless a parent accompanies them to ensure appropriate supervision, e.g. residential trips.

If self-medication has been forgotten and the school does not have a spare supply, children will not be able to travel out of school on trips. Parents will be contacted to provide necessary medication, however departure on trips will not be delayed until its arrival.

## B. EMERGENCY MEDICATION

This relates to 4 main areas:

- acute asthmatic attack
- diabetic hypoglycaemic attack
- anaphylactic reaction requiring epi-pen
- prolonged epileptic seizures.

Pupils who may be subject to the above must be identified to the school and a medical plan prepared (Form AM1 or equivalent). Staff will be advised annually of these pupils' needs and training will be provided and regularly updated.

## APPENDICES

Forms: AM1, 2, 3, 4, 5.

Name of School \_\_\_\_\_

**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**

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

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Daily care requirements (e.g. before sport, dietary, therapy, nursing needs)

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Members of staff trained to administer medication for this child (state if different for off site activities)

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

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Follow up care

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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 \_\_\_\_\_

Name of School \_\_\_\_\_

**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

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### 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 e.g. 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.**

Name of School \_\_\_\_\_

**TEMPLATE FOR A REQUEST FOR PUPIL  
TO CARRY HIS/HER MEDICATION**

This form must be completed by parents/carers.

If staff have any concerns discuss this request with healthcare professionals.

**Details of Pupil**

Surname \_\_\_\_\_ Forename(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.**

Name of School \_\_\_\_\_

**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			

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			

