St Mary's Catholic Primary School

Administration of Medication

Whenever possible medication should be administered at home. If this is not possible medication may be sent into school for your child following the guidelines below:

1. School staff are not allowed to administer medication, only supervise a child whilst he/she takes the medication. For this reason please ensure that any medication provided is in 'easy to take' form eg tablets, sachets, measured syringes, inhalers etc.
2. Both sides of this form must be completed to indicate: (a) the Health Care needs of the child, (b) details of the medication required, along with information regarding its administration
3. An entry should be made in your child's planner to inform the class teacher of the need your child has for the medication. Whilst every effort will be made to ensure that your child receives his/her medication at the correct time, staff cannot be held responsible for non-administration.
4. For long term medical conditions eg. Epilepsy, asthma etc this form will be kept on record for the full academic year, unless advised otherwise. For short term medical conditions, eg a course of antibiotics, the form will be kept for the duration of the need and then destroyed.
5. It is the parent's responsibility to ensure that any medication brought into school is in date, and clearly labelled with the child's full name and class. It is also the responsibility of the parent to collect any unused medication. In the case of long term medication, this will be returned at the end of the academic year.

MEDICATION	1	2	3
Name: eg Salbutamol, Calpol etc			
Type of medicine: eg Inhaler, pain relief etc			
Dosage eg 2 puffs, 5 ml etc			
Timing eg when wheezy, every 4 hrs, before food etc			
Qty provided: eg I inhaler, strip of 5 tablets			
Duration of need: Eg before PE, 5 day course etc			
Other instructions: eg Ensure spacer is used, Keep in fridge etc			

I, _____ (Name), give my consent for _____ (Child)

to take the medication detailed above, for the medical condition(s) noted overleaf.

Signed: _____ Date: _____

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HEALTHCARE PLAN

Name:			
DOB:		**Class:**	
GP Pract:		**GP Phone:**	

Photo
(For office use)

CONDITION (1): eg Asthma	
Symptoms:	**Action:**
CONDITION (2): eg Frequent headaches	
Symptoms:	**Action:**

Contact Name:		**Phone No.**	**Phone No.**
	1		
	2		
	3		

	Name	**Signature**	**Date**
Plan agreed by parent/guardian:			
Medication received in school by:			
Plan received by class teacher:			
Location of medication:	**Classroom**	**School Office**	**Not required**