

ANNEX B: FORMS

- Form 1** Emergency planning - request for an ambulance
- Form 2** Healthcare Plan
- Form 3 A** Parental agreement for school/setting to administer medicines
- Form 3 B** Parental agreement for school/setting to administer medicines
- Form 3 C** Parental agreement for school/setting to administer non-prescription analgesics
- Form 3 D** Parental agreement for school/setting to administer non-prescription medicines on school visits
- Form 4** Head teacher/Head of setting agreement to administer medication
- Form 5:** Record of medicine administered to an individual
- Form 6:** Record of medicines administered to all children
- Form 7:** Request for child to carry his/her own medicine
- Form 8:** Staff training record - administration of medicines
- Form 9:** Authorisation for administration of rectal diazepam

All forms set out below are examples that schools and settings may wish to use or adapt according to their particular policies on administering medicines.

FORM 1 - Contacting Emergency Services

Request for an Ambulance

Dial 999, ask for ambulance and be ready with the following information

1. Your telephone number
2. Give your location as follows: (insert school/setting address)
3. State that the postcode is
4. Give exact location in the school/setting (insert brief description)
5. Give your name
6. Give name of child and a brief description of child's symptoms
7. Inform Ambulance Control of the best entrance and state that the crew will be met and taken to

Speak clearly and slowly and be ready to repeat information if asked

Put a completed copy of this form by the telephone

FORM 2 - Healthcare Plan

Name of School/Setting Bedgrove Infant School

Child's name _____

Group/Class/Form _____

Date of Birth _____

Child's Address _____

Medical Diagnosis or Condition _____

Date _____

Review date _____

CONTACT INFORMATION

Family contact 1

Family contact 2

Name		Name	
Phone No. (work)		Phone No. (work)	
(home)		(home)	
(mobile)		(mobile)	

Clinic/Hospital contact

GP

Name _____ Name _____

Phone No. _____ Phone No. _____

Describe medical needs and give details of child's symptoms:

Daily care requirements: (e.g. before sport/at lunchtime)

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

Follow up care:

Who is responsible in an Emergency: (State if different for off-site activities)

Form copied to:

FORM 3A

Parental agreement for school/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 staff can administer medicine

Name of School/Setting Bedgrove Infant School

Name of Child: _____

Date of Birth: _____

Group/Class/Form: _____

Medical condition/illness: _____

Medicine

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

Date dispensed: _____

Expiry date: _____

Agreed review date to be initiated by
[name of member of staff]: _____

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: _____

Note: 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] and accept that this is 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:

FORM 3B

Parental agreement for school/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 staff can administer medicine.

Name of School/Setting Bedgrove Infant School

Date _____

Child's Name _____

Group/Class/Form _____

Name and strength of medicine _____

Expiry date _____

How much to give (i.e. dose to be given) _____

When to be given _____

Any other instructions _____

Number of tablets/quantity to be given to school/setting _____

Note: Medicines must be in the original container as dispensed by the pharmacy

Daytime phone no. of parent or adult contact _____

Name and phone no. of GP _____

Agreed review date to be initiated by *[name of 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.

Parent's signature: _____ Print Name: _____

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

FORM 3C**Parental agreement for school to administer occasional prescription medication****e.g. amoxicillin, penicillin, eye drops etc**

The school will not give your child medicine unless you complete and sign this form, and the school has a policy that staff can administer medicine.

Name of School/Setting	Bedgrove Infant School
Date	
Child's Name	
Group/Class/Form	
Name and strength of medicine*	
How much to give Child 1 - 5 years	
When to be given	Every 4-6 hours
Any other instructions	Maximum 4 doses in 24 hours
Daytime phone no. of parent or adult contact	
Name and phone no. of GP	
Agreed review date to be initiated by <i>[name of member of staff]</i> :	

I confirm that I have administered amoxicillin/penicillin/eye drops/other (*circle as appropriate*) without adverse effect to my child in the past.

I give consent to school staff to administer amoxicillin/penicillin/eye drops/other (*circle as appropriate*) in accordance with the school policy. I will inform the school immediately, in writing, if my child subsequently is adversely affected by the medication prescribed.

Parent's signature:

Print Name:

FORM 3D

Parental agreement for school to administer *occasional* non-prescription medicine for school journeys or residential trips, e.g. travel sickness tablets, antihistamines.

The school will not give your child medicine unless you complete and sign this form, and the school has a policy that staff can administer medicine.

Name of School/Setting	Bedgrove Infant School
Date	
Child's Name	
Group/Class/Form	
Name and strength of medicine	
Expiry date	
How much to give (i.e. dose)	
When to be given	
Any other instructions	
Number of tablets/quantity to be given to school/setting	
Note: Medicines must be in the original container, which must contain the Patient Information Leaflet	
Daytime phone no. of parent or adult contact	
Name and phone no. of GP	
Agreed review date to be initiated by <i>[name of member of staff]:</i>	

I confirm that I have administered this non-prescription medication, without adverse effect, to my child in the past.

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy.

I will inform the school immediately, in writing, if my child subsequently is adversely affected by the above medication

Parent's signature: _____ Print Name: _____

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

FORM 4

Confirmation of the Head's agreement to administer medicine

Name of School/Setting Bedgrove Infant School

It is agreed that _____ *[name of child]* will receive
_____ *[quantity and name of medicine]* every day at
_____ *[time medicine to be administered e.g. Lunchtime or
afternoon break]*.

_____ *[name of child]* will be given/supervised whilst he/she
takes their medication by _____ *[name of member of staff]*.

This arrangement will continue until _____ *[either end date
of course of medicine or until instructed by parents]*.

Date: _____

Signed: _____

[The Head teacher/Head of Setting/Named Member of Staff]

FORM 5

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 _____

Parent signature _____

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 _____

Date _____

Time Given _____

Dose Given _____

Name of member of staff _____

Staff initials _____

Date _____

Time Given _____

Dose Given _____

Name of member of staff _____

Staff initials _____

FORM 6**Record of medicines administered to all children**

Name of school/setting

Date	Child's name	Time	Name of medicine	Batch Number	Dose given	Any reactions	Signature of staff	Print name
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FORM 7

Request for child to carry his/her medicine

THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN

If staff have any concerns discuss request with school healthcare professionals

Name of School/Setting: _____

Child's Name: _____

Group/Class/Form: _____

Address: _____

Name of Medicine: _____

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.

FORM 8

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 (please state
how often)

Trainer's signature: _____

Date: _____

I confirm that I have received the training detailed above.

Staff signature: _____

Date: _____

Suggested Review Date: _____

FORM 9

Authorisation for the administration of rectal diazepam

Name of School/Setting Bedgrove Infant School

Child's name _____

Date of birth _____

Home address _____

GP _____

Hospital consultant _____

_____ *[name of child]* should be given Rectal Diazepam _____
mg. If he/she has a *prolonged epileptic seizure lasting over _____ minutes

OR

*serial seizures lasting over _____ minutes.

An Ambulance should be called for *at the beginning of the seizure

OR

If the seizure has not resolved *after _____ minutes.

(* please delete as appropriate)

Doctor's signature: _____

Parent's signature: _____

Print Name: _____

Date: _____

NB: Authorisation for the Administration of Rectal Diazepam

As the indications of when to administer the diazepam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state:

- when the diazepam is to be given e.g. after 5 minutes; and
- how much medicine should be given.

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

Records of administration should be maintained using Form 5 or similar