St. Joseph's RC Primary School

PERSONAL MEDICATION BOOKLET

Name of Pupil: _____ Date of Birth: _____

Address: _____ ☎ (home) _____

_____ ☎ (mobile) _____

_____ ☎ (work) _____

_____ ☎ (other) _____

Post Code: _____ ✉ (email) _____

Name of GP: _____ ☎ (GP phone) _____

Surgery Address _____

_____

Post Code: _____

Parental Declaration

I _____(name of Parent/Carer) confirm that my son/daughter above named:

Please select ☑ all relevant sections.

(a) ☐ **has <u>no</u> known allergies** at this time and I understand and accept my responsibility to inform the school in writing should this situation change

(b) ☐ **has known allergies** and I have completed in full the section of this booklet on allergies (Page 4)

(c) ☐ **has <u>no</u> known medical conditions** at this time and I understand and accept my responsibility to inform the school in writing should this situation change

(d) ☐ **has known medical conditions** at this time and I have completed in full the section of this booklet on medical conditions (Page 2)

(e) ☐ **does <u>not</u> suffer from asthma** at this time and I understand and accept my responsibility to inform the school in writing should this situation change

(f) ☐ **suffers from asthma** at this time and I have completed in full the section of this booklet on asthma (Page 3)

(g) ☐ **has <u>no</u> current Medical Management Plan** in place

(h) ☐ **has a current Medical Management Plan** in place and I attach a copy of that plan to this form.

I also confirm that I have read and understood the School's regulations on the provision and administration of medication in School and on all school activities. (Page 5)

Signed: _____ (Parent/Carer) Date: _____

MEDICAL CONDITIONS

Name of Medical Condition: _____

Full Details of Medical Condition: _____

_____

_____

Symptoms: _____

_____

Treatment: _____

_____

_____

Emergency Contact Details: Name of Contact 1: _____

Relationship to pupil: _____

☎ (first number) _____

☎ (additional number) _____

Emergency Contact Details (2): Name of Contact 2: _____

Relationship to pupil: _____

☎ (first number) _____

☎ (additional number) _____

Parental Declaration

I confirm that the information I have given here is given in full and is both true and correct. I accept, acknowledge and understand my responsibility to inform the School in writing should anything about my son/daughter's medical condition change.

I also confirm that I have read and understood the School's regulations on the provision and administration of medication in School and on all school activities.

Signed: _____ (Parent/Carer) Date: _____

Please note that if you son/daughter has more than ONE medical condition, you will be required to complete an additional form for each condition.

ASTHMA CARE PLAN

Treatment Type:

Please select ☑ all that apply.

☐ Regular Treatment to be taken in School

☐ Treatment to be taken before exercise

☐ relief treatment to be taken as necessary

Regular Treatment

Name of Treatment: _____

Time to be taken: _____

Treatment before Exercise

Name of Treatment: _____

Time before exercise: _____

Relief Treatment:

Name of Treatment: _____

Method of administration _____

Relief Treatment: for sudden shortness of breath, wheeze, cough or chest tightness

Parental Declaration

I confirm that: (please delete as applicable)

(a) my son/daughter is able to take responsibility for the self-administration of his/her asthma medication and is able to carry his/her asthma device at school.

(b) my son/daughter is not able to self-administer his/her asthma medication and will require assistance.

I also confirm that I will ensure that a spare inhaler is available to the School and give permission for this inhaler to be safely and securely stored in the School Medical Room.

Signed: _____ (Parent/Carer) Date: _____

OFFICE USE ONLY					
Spare Inhaler Received:	YES / NO	Date:	_____/_____/_____	Received by:	_____

ALLERGIES / ALLERGIC REACTIONS

Allergic to: _____

Full Details of Allergy: _____

_____

_____

Symptoms: _____

_____

Treatment: _____

_____

_____

Emergency Contact Details: Name of Contact 1: _____

Relationship to pupil: _____

☎ (first number) _____

☎ (additional number) _____

Emergency Contact Details (2): Name of Contact 2: _____

Relationship to pupil: _____

☎ (first number) _____

☎ (additional number) _____

Parental Declaration

I confirm that the information I have given here is given in full and is both true and correct. I accept, acknowledge and understand my responsibility to inform the School in writing should anything about my son/daughter's allergy change.

I also confirm that I have read and understood the School's regulations on the provision and administration of medication in School and on all school activities.

Signed: _____ (Parent/Carer) Date: _____

Please note that if you son/daughter has more than ONE allergy, you will be required to complete an additional form for each allergy.

OFFICE USE ONLY					
Spare Epipen Received:	YES / NO	Date:	_____/_____/_____	Received by:	_____

INFORMATION FOR PARENTS ON ADMINISTERING MEDICATION IN SCHOOL

Parents must:

(a) sign a consent form giving the school authorisation to administer prescribed medication to their son/daughter;
(b) make an appointment to discuss the request with the nominated person.
(c) NOT send the medication into school with their son/daughter;
(d) hand all medication to the School's nominated person only and in person;
(e) NOT hand medication to their son/daughter's teacher;
(f) ensure that all medication is provided in sealed pharmacy labelled packaging;
(g) if necessary, ensure that the supply in medication is split into two by a pharmacist (i.e. package for home and one for school);
(h) collect all medication from school when requested to do so;
(i) ensure that their son/daughter takes a prescribed medication for 24 hours before returning to school in case of an allergic reaction;
(j) complete an 'Administration of Medication in School' Form
(k) remember that it is ultimately their responsibility to administer medication to their child.

The School will:

(a) have a nominated and trained member of staff who will be responsible for the safe and appropriate administration and storage of all medication in school;
(b) assess each request to administer medication on its own merits;
(c) have a comprehensive care plan for every child receiving medication (except for periods of fewer than five days);
(d) have a room where all medication is administered ensuring privacy and confidentiality;
(e) have an authorised drug cabinet ensuring that all medication is stored safely and a register of all medication administered;
(f) ensure that your son/daughter is given his/her medication at the correct time and in the correct quantity;
(g) keep you informed as to the progress of your son/daughter's medication regime;
(h) act in accordance with DfE and Government Guidelines.
(i) take all reasonably practicable measures to ensure that any child with medical problems is given access to the curriculum and that they receive as full an education as possible.

Authorised Persons

The authorised person responsible for the administration of medication in this school is Mrs A Henderson. In the absence of the authorised person medication will be administer by one of the School's trained First Aiders. In the unlikely event that this is not possible, then parents/carers will be required to attend in order to administer the medication.

PARENTAL AGREEMENT FOR IN-SCHOOL ADMINISTRATION OF MEDICINE

The School will not give your son/daughter medicine unless you complete and sign this form. You are only required to complete this form as part of this Transition Medical Booklet if you son/daughter will be taking medicine at the time that he/she joins St Joseph's RC Primary School.

Surname of pupil: _____ First name of pupil: _____

Year Group: _____ Date of Birth: _____

Name of Medicine: _____ Strength of Medicine: _____

Prescription Date: _____ Expiry Date: _____

Dosage: _____ Time: _____

Please give clear details describing the amount of medicine and the required times for administration.

Further details: _____

_____

_____

Emergency Contact Details: Name of Contact 1: _____

Relationship to pupil: _____

☎ (first number) _____

☎ (additional number) _____

Emergency Contact Details (2): Name of Contact 2: _____

Relationship to pupil: _____

☎ (first number) _____

☎ (additional number) _____

Parental Declaration

I confirm that the information I have given here is given in full and is both true and correct. I accept, acknowledge and understand my responsibility to inform the School in writing should anything about my son/daughter's medication change.

Signed: _____ (Parent/Carer) Date: _____

Please note that if you son/daughter has more than ONE medication, you will be required to complete an additional form for each medication to be administer in school.

OFFICE USE ONLY			
Agreed Review Date: *(to be set by school)*	_____	Date set by:	_____

ADDITIONAL INFORMATION

If you consider that the school needs to be made aware of additional information regarding your son/daughter's health needs that are not covered by this document please record such details here:

OFFICE USE ONLY					
Form completed in full:	YES / NO	Date:	_____/_____/_____	Checked by:	_____
Read by Teacher:	YES / NO	Date:	_____/_____/_____	Initials:	_____
Read by First Aider:	YES / NO	Date:	_____/_____/_____	Initials:	_____

A copy of this form should be placed on the pupil file to be kept by HOY and where necessary a copy kept by the Authorised Person for Medical Needs.