

Gwenfro Community Primary School



Administration of Medicines Policy 2017/2018

EIA Assessed 2018

Agreed by the Governing Body:

Review date:

Signed:

Chair of Governors:

1. Introduction

This policy is drawn up in consultation with staff and is based on guidelines from the Welsh Assembly Government publication *Access to Education and Support for Children and Young People with Medical Needs*.

2. Medical needs

Most pupils will at some time have a medical condition that may affect their participation in school activities. For many this will be short-term; perhaps finishing a course of medicine. Other pupils have medical conditions that, if not properly managed, could limit their access to education. Most children with medical needs can attend a school regularly and take part in normal activities, sometimes with some support.

3. Aim

Our aim is to ensure that all children and young people in our school continue to have access to as much education as their medical condition allows. Children with medical needs have the same rights of admission to a setting as other children.

4. Responsibilities

There is no legal duty which requires school staff to administer medicine; this is a voluntary role. Staff who provide support for pupils with medical needs or who volunteer to administer medicine will require access to relevant information and training. The school and family will liaise in providing maximum support for the child or young person.

Parents or guardians have the prime responsibility for their children's health and should provide the school with information about any medical condition. Medication should only be taken to school when absolutely essential. It is helpful if, where possible, medication can be prescribed in dose frequencies which enable it to be taken outside school hours. Parents should ask the prescribing doctor or dentist about this. However, the school recognises that sometimes children do need to take medicines in school time; that is where it would be detrimental to a child's health if the medicine were not administered during the school day.

If this is the case, there has to be prior written agreement, from parents for any medication, prescribed or non-prescription, to be given to a child. This written agreement must also include the dosage.

5. Receiving medicine

The school will not generally give non-prescribed medication to pupils. We will only accept medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber. Medicines must always be provided in the original container as dispensed by a

pharmacist and include the instructions for administration. They must be handed over to the class teacher in a named container.

As a setting we will never accept medicines that have been taken out of the original dispensed container or make changes to dosages on parental instructions (documented on form 3)

6. Long term Medical Needs

The school needs to know about any medical needs before a child starts school, or when a pupil develops a condition. The school will need to know:

- Details of the condition
- Special requirements
- Medication and any side effects
- What to do, and who to contact in an emergency
- The role the school can play Administering Medicines

7. Administering medicine

No child will be given medication without their parents/carers written consent (form 3).

Medicines to be administered will be authorised by the designated persons of the setting (Form 3). No other member of staff will accept medicines onto the premises or authorise administration. Any member of staff giving medicines to a child will check:

- Pupil's name
- Prescribed dose
- Expiry date
- Written instructions provided by prescriber on the label/container
- Form 3 completed by the parent/carer

Staff administering medicines will complete and sign form 4 as a record of medicines given.

Good practice would be for another member of staff to witness the administration.

Inhalers should be kept in the classroom in a safe place known and accessible to the children. All inhalers must be named.

8. Refusing Medication

If pupils refuse to take medication, the school will not force them to do so and will inform parents by telephone. A record of this will be kept.

9. Record Keeping

Parents are responsible for supplying information about medicines and for letting the school know of any changes to the prescription or the support needed. Parents/carers are responsible for ensuring any medication kept in school is contained in the original packaging, within the expiry date and to replace any medication with a replacement before expiry.

Details of medicines administered by the school (completed form 3and 4) will be kept for the duration of the academic year.

10. Storing medicines

Medicines will be stored in accordance with the manufacturer's instructions (paying particular note to temperature) and in the original container in which dispensed, in a secure place away from children. In certain circumstances medicines can be kept in the staffroom fridge, in a clearly labelled container. This fridge should be restricted access.

Any medication should be in a container that is labelled with the name of the pupil, name and dose of the drug and frequency of administration and within expiry date. Where a pupil needs two or more prescribed medicines, each should be in a separate container.

Large volumes of medicines will not be stored. Staff should only store, supervise and administer medicine that has been prescribed for an individual child.

All emergency medicines such as asthma inhalers and adrenalin pens will be readily available to children and stored in a labelled bag/basket.

11. School Trips

Pupils with medical needs are encouraged to participate in visits. Staff are made aware of any medical needs and arrangements for taking any necessary medication are put in place. Sometimes an additional adult might accompany a particular pupil. There may also be the need to undertake a risk assessment for a particular child. Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures. If a pupil has a health plan a copy of their health plan and any emergency treatment or medication should be taken on trips. The school will advise outward bound centres and other such suppliers of services of a child or young person's medical needs or disability so that a risk assessment can be prepared and suitable planning undertaken.

12. Sporting Activities

Our PE and extra-curricular sport is sufficiently flexible for all pupils to follow in ways appropriate to their own abilities. Some pupils may need to take precautionary measures

before, during or after exercise and be allowed immediate access to their medication if necessary, inhalers/diabetes for example. Teachers supervising sporting activities are made aware of relevant medical conditions.

13. Disposal of Medicines

Staff should not dispose of medicines. Parents are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal. They should also collect medicines held at the end of each term. If parents do not collect all medicines, they should be taken to a local pharmacy for safe disposal.

Sharp boxes should always be used for the disposal of needles. Sharps boxes can be obtained by parents on prescription from the child's GP or paediatrician. Collection and disposal of the boxes will be arranged with the Local Authority's environmental services. Hygiene Control Staff are familiar with normal precautions for avoiding infection and should follow basic hygiene procedures.

Staff have access to protective disposable gloves and take care when dealing with blood or other bodily fluids and disposing of dressings or equipment.

14. Emergency Procedures

Staff know how to call the emergency services and are all first aid trained. A pupil taken to hospital by ambulance will be accompanied by a member of staff if parents are not present and will arrange for parents to meet them at the hospital on arrival. Generally staff should not take pupils to hospital in their own car. However, in an emergency it may be the best course of action. The member of staff should be accompanied by another adult and have public liability vehicle insurance.

15. Health Care Plans

Some children require a health care plan to identify the level of support that is needed at school. The plans may identify specific training needed by volunteer staff. Staff should not give medication without appropriate training. Training is given on an individual child basis, by the local health authority (usually the school nurse) for administering insulin and epipens. Agreeing to administer intimate or invasive treatment is entirely up to each individual member of staff. No pressure is put on staff to assist in treatment. Two adults should be present for the administration of intimate or invasive treatment, unless there are exceptional circumstances.

Annexed to this policy is a breakdown of common medical conditions affecting children in our school. Also annexed is an index of model Welsh Government forms that this school has adopted for use, and a copy of each of the forms.

Annex 1

Common Medical conditions affecting pupils

The medical conditions in children and young people that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis).

Asthma

One in ten children and young people in the UK has asthma. 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 say that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some may only get symptoms from time to time.

Staff in early years settings 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 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.

Preventers (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

Children and young people with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines.

A spacer device may be used with the inhaler, particularly for a young child, and the child may need some help to use this. It is good practice to support them to take charge of and use their inhaler from an early age, and many do.

Children and young people 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 and parents 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. Parents should be informed when their child has been given or taken their inhaler during the school day.

A child with asthma should have a regular review with his/her 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 and young people should have a reliever inhaler with them when they are in school or in a setting.

Children and young people 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 and young people with asthma in the same way as other children and young people.

Some activities are more likely to bring on asthma symptoms. Some children and young people 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. Children and young people with asthma should not be forced to take part if they feel unwell. Children and young people should be encouraged to recognise when their symptoms inhibit their ability to participate.

Children and young people 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 and young people 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

Children and young people 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 has epilepsy and around 80 per cent of such children attend mainstream school. Most children and young people 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 and young people 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 and young people 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 and young people 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 so 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;

Such information should be an integral part of the school or setting's emergency procedures but also relate specifically to the child's individual health care plan. The 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. For more information on administration of rectal diazepam, see Form 8.

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.

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).

There are currently around 1,300 children with diabetes in Wales. Around 97% of these have

Type 1 diabetes, meaning that they are entirely dependent on injected insulin to live. There are also a small number of children with Type 2 diabetes and with other rarer forms of the condition, and the incidences of both Type 1 and Type 2 diabetes in children have been rising for a number of years.

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 blood glucose levels of the majority of children with diabetes are controlled by daily injections of insulin. Some children will be on a twice daily insulin regimen of a longer acting insulin and it is unlikely that these children will need to be given insulin during school hours.

Increasingly, however, many children with diabetes are moving to a multiple daily injection (MDI) regimen in order to better stabilise their diabetes, and such children will often need injections during school hours. In the case of younger children, it may be necessary for an adult to administer the injection. Some children may control their diabetes by use of an insulin pump, and as in the case of MDI, this is an increasingly common treatment.

Most children and young people 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 regimen when they were confident that the child was competent.

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 and young people 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 them if the school has staggered lunchtimes.

If a meal or snack is missed, or after strenuous activity, a child or young person may experience a hypoglycaemic episode (a hypo) during which blood glucose levels fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for them 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 10-15 minutes; and/or
- the child becomes unconscious

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.

Such information should be an integral part of the school or setting's emergency procedures but also relate specifically to the child's individual health care plan. Schools can call upon PDSNs for practical support and advice.

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 and young people are considered to be sufficiently responsible to carry their emergency treatment on their person, 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 and young people 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 their 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 Headteacher to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimize any risks to allergic children should be taken.

Children and young people who are at risk of severe allergic reactions are not ill in the usual sense. They are normal 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 they 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.

Annex 4

Forms

To assist schools with the administration for their support of children with medical needs we have prepared a number of examples of forms which are set out below.

Schools and settings may wish to use or adapt these according to their particular policies on administering medicines.

Form 1 *Contacting Emergency Services*

Form 2 *Health Care Plan*

Form 3 *Parental agreement for school/setting to administer medicine.*

Form 4 *Record of medicine administered to an individual child*

Form 5 *Request for child to carry his/her own medicine*

Form 6 *Staff training record - administration of medicines*

Form 7 *Authorisation for the administration of rectal diazepam*

These forms are downloadable as Word documents, so that it is possible to personalise for a particular school or setting, at: <http://wales.gov.uk/?lang=en>

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

 8. Don't hang up until the information has been repeated back.
- Speak clearly and slowly and be ready to repeat information if asked
- Put a completed copy of this form by all the telephones in the school**

FORM 2: Health Care Plan

The health plan should specify:

- The child or young person's view where possible.
- Parental wishes for the child.
- The care co ordinator/key worker for the child.
- Any anticipated changes in the child or young person's care routine.
- The contact details of the paediatric healthcare team providing medical advice, care and support.
- Protocols for exchanging information between education and health services (with clearly defined lines of responsibility and named contacts) including the provision of accurate and regularly updated information about the needs of individual children and young people.
- The medication the child or young person takes both in and out of school hours.
- The permission of parents and the headteacher for the administration of medicines by staff or self administration by the child or young person (Form 3 and 4).
- Arrangements for any emergency or invasive care, or for the administration of medication.
- Emergency procedures should be set out in conjunction with health care professionals.
- Risk assessment should be carried out and would include the identification of potential emergency situations in relation to the health needs of that particular child - better planning leads to fewer real emergencies.

- Any special health care needs which may affect the child or young person's use of services such as transport or play activities at the school, implementation of therapy programmes etc.
- The use, storage and maintenance of any equipment.
- Any arrangements for the provision of education or associated services when the child is too unwell to attend school or is in hospital or another appropriate health care setting.
- Health care plans should be jointly written by health professionals and parents. Completed plans should be signed by the parents, Headteacher and health professionals. A copy of the plan should also be available to all the above and to accompany the child on out of school trips.
- Health care plans should be reviewed annually at the child or young person's annual school review. If the plan needs revising the school health professionals should meet with parents and the plan would then be written again and signed by all parties. If the plan needs to be altered between reviews this should always take place with parents and be signed.
- The importance of very clear procedures for emergency treatment for all children and young people with complex health needs.
- The plan should also be made available to all staff coming into contact with the child or young person.
- Copies of any relevant forms should form part of the healthcare plan.

Healthcare Plan

Name of School/setting	
------------------------	--

Child's name	
--------------	--

Group/class/form	
------------------	--

Date of birth	
---------------	--

Child's address	
-----------------	--

Medical diagnosis or condition	
--------------------------------	--

Date	/ /
------	-----

Review date	/ /
-------------	-----

Contact member of staff	
-------------------------	--

Family Contact Information

Name	
------	--

Phone no. (work)	
------------------	--

Home	
------	--

Mobile	
--------	--

Clinic/Hospital Contact

Name	
------	--

Phone No	
----------	--

G.P

Name	
------	--

--	--

Phone No	
----------	--

Describe medical needs and give details of child's symptoms

--

Daily care requirements (eg before sport/at lunchtime/home/school trips)

--

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

--

Who is responsible in an emergency? (state if different for off-site activities)

--

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Form copied to

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FORM 3 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

Name of child

Date of birth

Group/class

Medical condition or 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

Administer until –

Are there any side effects that
The school/setting needs to
Know about?

Self administration (delete as appropriate) Yes/No

Procedures to take in an emergency

Contact Details

Name

Daytime telephone no.

Relationship to child

Address

I understand that I must deliver the medicine personally to [agreed member of staff]

I 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 of parent/Carer (s)

Signature of authorising staff member

.....

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

FORM 4: Record of medicines administered to all children and young people

Name of school/setting

Date	Child's name	Time	Name of Medicine	Dose given	Any reactions	Signature of staff	Print name
/ /							
/ /							
/ /							
/ /							
/ /							

FORM 5: Request for child to carry his/her own medicine

This form must be completed by parents/guardian

If staff have any concerns discuss this request with 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

FORM 6: 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 signatureDate

I confirm that I have received the training detailed above.

Staff signature Date

Suggested review date

FORM 7: Authorisation for the administration of rectal diazepamName of school/setting Child's name Date of birth Home address GP Hospital consultant

.....should be given Rectal Diazepammg.

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 *afterminutes (*please delete as appropriate)

Doctor's signature Date

Parent's signature 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 eg 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.

Equality Impact Assessment

Responsible Officer (Head Teacher)	Kate Owen-Jones
Assessment Owner	Kate Owen-Jones
e-mail address	headteacher@gwenfro-pri.wrexham.sch.uk
Full job title	Headteacher
Title of Policy	Administration of Medicines Policy
Rationale: Why is it being considered? What need is being addressed?	Annual Policy update Policy update
Aim: What is the intended outcome of the policy?	Administration of Medicines Policy reflects guidelines and procedures are followed to ensure appropriate administration of medication.
How: How will it be delivered, by whom and by when?	All staff. On-going
Who: Who are the people likely to be affected by this policy? How have you consulted with the people who are likely to be affected?	All staff, parents/carers, pupils Discussed at staff meetings.
Measures: How will you know you have achieved your aims? What are your measures / indicators of success?	Policy will be reviewed and updated where necessary. Policy will be shared with staff and procedures followed.

<p>Identify any other policy or decision [internal or external] that may affect your proposal. Consider this in terms of:</p> <ul style="list-style-type: none">• Statutory requirements; local policies e.g.• Regional decisions e.g. those made by cross county partnerships for your schools; and / or• National policies e.g. Welfare Reforms	<p>This is a statutory policy which has to be reviewed annually and shared with staff.</p>

good relations between these groups and the wider community?														
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Where you have identified a positive impact (+) in the Screening Tool, please outline this briefly using bullet points:

- It will ensure that all staff, parents/carers and pupils are treated equally and fairly regardless of protected characteristics

If your proposal will not have any impact on 'people' please outline why this is the case below:

PLEASE NOTE:

It is very rare that a project or proposal will not impact on people (you should also consider staff as well as client users/customers)

If your policy or change is as a result from a UK or Welsh Government directive, then you should impact assess the impact of this policy or change locally.

If you have indicated a possible negative effect on any Protected Characteristic within the screening tool, please complete the relevant sections of the Matrix below that correspond to that possible negative effect. You will need to consider:

- **What is the likely scale of the impact and how this can be reduced?**
- **Who are the people that are likely to be affected by this proposal, could they experience multiple disadvantage e.g. if they are young and have a disability.**

EIA: Are we being fair?

Please complete the <u>relevant</u> sections of the Matrix below that correspond to any ‘-’ symbols you have recorded in the screening tool	List what information you have used to identify these issues e.g. consultation, stakeholder involvement, reports, data ...	Based on the information you have gathered give a summary of key issues that have been identified.	How will you mitigate these issues to improve the service?	Who is officer responsible for delivering the mitigation?	Which other partners will you work with to achieve this? (Governors, PTA etc.)	By when
Age CYP						
Age Adult						
Disability						

Gender / Sex						
Pregnancy and Maternity						
Race/ Ethnicity						
Religion or Belief						
Sexual Orientation						
Marriage and Civil Partnership						

Gender Reassignment						
Welsh Language and Culture						
Poverty						

