****

**ORM 1**

**Contacting Emergency Services**

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

Put a completed copy of this form by the telephone

|  |  |
| --- | --- |
|  | **Request for an Ambulance****Dial 999, ask for ambulance and be ready with the following information** |
|  | 1. | Your telephone number01924303500 |
|  | 2. | Give your location as followsStoney Lane, Hall Green, Wakefield |
|  | 3. | State that the postcode isWF4 3LZ |
|  | 4. | Give exact location in the school/settingSchool located 2nd left after the Coop,Edgemore Drive and right onto Moorside Drive.OrSchool located first right after the school layby |
|  | 5. | Give your name      |
|  | 6. | Give name of child and a brief description of child’s symptoms      |
|  | *7* | *Give details of any medicines given or prescribed* |
|  | 8. | 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

Health Care Plan (this should be regularly reviewed)

|  |  |
| --- | --- |
| Name of school/setting |       |
| Child’s name |       |
| Group/class/form |       |
| Date of birth |    |    |      |  |
| Child’s address |       |
| Medical diagnosis or condition |       |
| Date |    |    |      |  |
| Review date |    |    |      |  |
| **Family Contact Information** |  |
| Name |       |
| Phone no. (work) |       |
| (home) |       |
| (mobile) |       |
| 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 *(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 (short-term)

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 the staff can administer medicine. You are also agreeing to other appropriate employees of the Local Authority (such as Home-School transport staff) to administer medicine if authorised to do so by the school/setting.

|  |  |
| --- | --- |
| Name of school/setting |       |
| Name of child |       |
| Date of birth |    |    |      |  |
| Group/class/form |       |
| 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 |       |
| Special precautions |       |
| Are there any side effects that the school/setting needs to know about? |       |
| Self administration | /*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.

*I understand that a non-medical professional will administer my child’s medication, as defined by the prescribing professional only.*

Date Signature(s)

FORM 3B

Parental agreement for school/setting to administer medicine (long-term)

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 the staff can administer medicine. You are also agreeing to other appropriate employees of the Local Authority (such as Home-School transport staff) to administer medicine if authorised to do so by the school/setting.

|  |  |
| --- | --- |
| Name of school/setting |       |
| 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/carer 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 and other authorised 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.

*I understand that a non-medical professional will administer my child’s medication, as defined by the prescribing professional only*

Parent/carer’s signature

Print name

Date

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

FORM 4

Head teacher agreement to administer medicine

|  |  |
| --- | --- |
| Name of school/setting |       |

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 parent/carers].

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/carer |    |    |      |  |
| Group/class/form |       |
| Quantity received |       |
| Name and strength of medicine |       |
| Expiry date |    |    |      |  |
| Quantity returned |       |
| Dose and frequency of medicine |       |

Staff signature

Signature of parent/carer

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date |    |    |    |    |    |    |    |    |    |
| Time given |       |       |       |
| Dose given |       |       |       |
| Name of member of staff |       |       |       |
| Staff initials |       |       |       |
|  |  |  |  |
| Date |    |    |    |    |    |    |    |    |    |
| Time given |       |       |       |
| Dose given |       |       |       |
| Name of member of staff |       |       |       |
| Staff initials |       |       |       |

Record of medicine administered to an individual child (Continued)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | Dane Royd Junior and Infant School |

 Date Child’s name Time Name of Dose given Any reactions Signature Print name

 medicine of staff

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |
|          |       |       |       |       |       |  |       |

FORM 7

Request for child to carry his/her own medicine

This form must be completed by parent/carers/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 anEmergency |       |
| **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.

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 |       |
| Child’s name |       |
| Date of birth |    |    |      |  |
| Home address |       |
| G.P. |       |
| Hospital consultant |       |

      should be given rectal diazepam       mg.

If  has a \*prolonged epileptic seizure lasting over       minutes

OR

\*serial seizures lasting over       minutes.

An Ambulance should be called for \*

OR

If the seizure has not resolved \*after       minutes.

**(\*please enter as appropriate)**

Doctor’s signature

Parent/carer’s signature

Date

The following staff have been trained:

Trainers name and post

**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**

FORM 10

Authorisation for the administration of buccal midazolam

|  |  |
| --- | --- |
| Name of school/setting |       |
| Child’s name |       |
| Date of birth |    |    |      |  |
| Home address |       |
| G.P. |       |
| Hospital consultant |       |

      should be given buccal midazolam       mg.

If has a \*prolonged epileptic seizure lasting over       minutes

OR

\*serial seizures lasting over       minutes.

An Ambulance should be called for \*

OR

If the seizure has not resolved \*after       minutes.

**(\*please enter as appropriate)**

Doctor’s signature

Parent/carer’s signature

Date

The following staff have been trained:

Trainers name and post

**NB: Authorisation for the administration of buccal midazolam**

As the indications of when to administer the midazolam 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 midazolam 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**