



# Medication Policy & Procedures

August 2021

(Review August 2023)

## Bonnyrigg Primary School - Medication Policy and Procedures

### Introduction

The policy and procedures have been formulated according to current needs and in reference to Midlothian Council Policy Guidelines as stated in Pupil Welfare :4.5 (4<sup>th</sup> Revision) 'Administration of Medication for Children and Young People in Schools and Centres'.

The Acting Head Teacher (Mrs Caroline Findlay) accepts responsibility, in principle, for school staff giving or supervising children taking prescribed medication during the school day.

Wherever possible, parents should ensure that their children's medication is prescribed in dose frequencies that enable it to be taken outwith school time.

The school office will store all original information related to medication with copies held with individual pupil's medication.

**Please note that 2 staff signatures are required any time any medication is administered. (Copy of record sheet in appendices)**

### Non-prescription medication

If a pupil suffers regularly from acute pain, e.g. migraine, parents should authorise in writing and supply appropriate pain killers for their child's use, with written instructions about when the child should take the medication. A member of staff should supervise the pupil taking the medication. Please note this medication should be kept by the school office.

### Pupils with long term or complex medical needs

Pupils with long term or complex medical needs will have their medicines administered by office staff. Medicines will be kept by the school office and pupils will attend at pre-arranged times to receive medication. An individual health care plan (MED3) will be in place for such pupils and this will be reviewed and updated annually or more frequently if needs change.

### Prescription Medication

Prescription medication such as asthma inhalers require a MED1 or MED2 (when the medication is to be self administered) form to be filled in and handed into the school office. Medication will be stored in each classroom in zip lock bags with a completed form and details of dosage. All medication will be clearly labeled with pupil's name. A copy of the MED1 or MED2 form will be

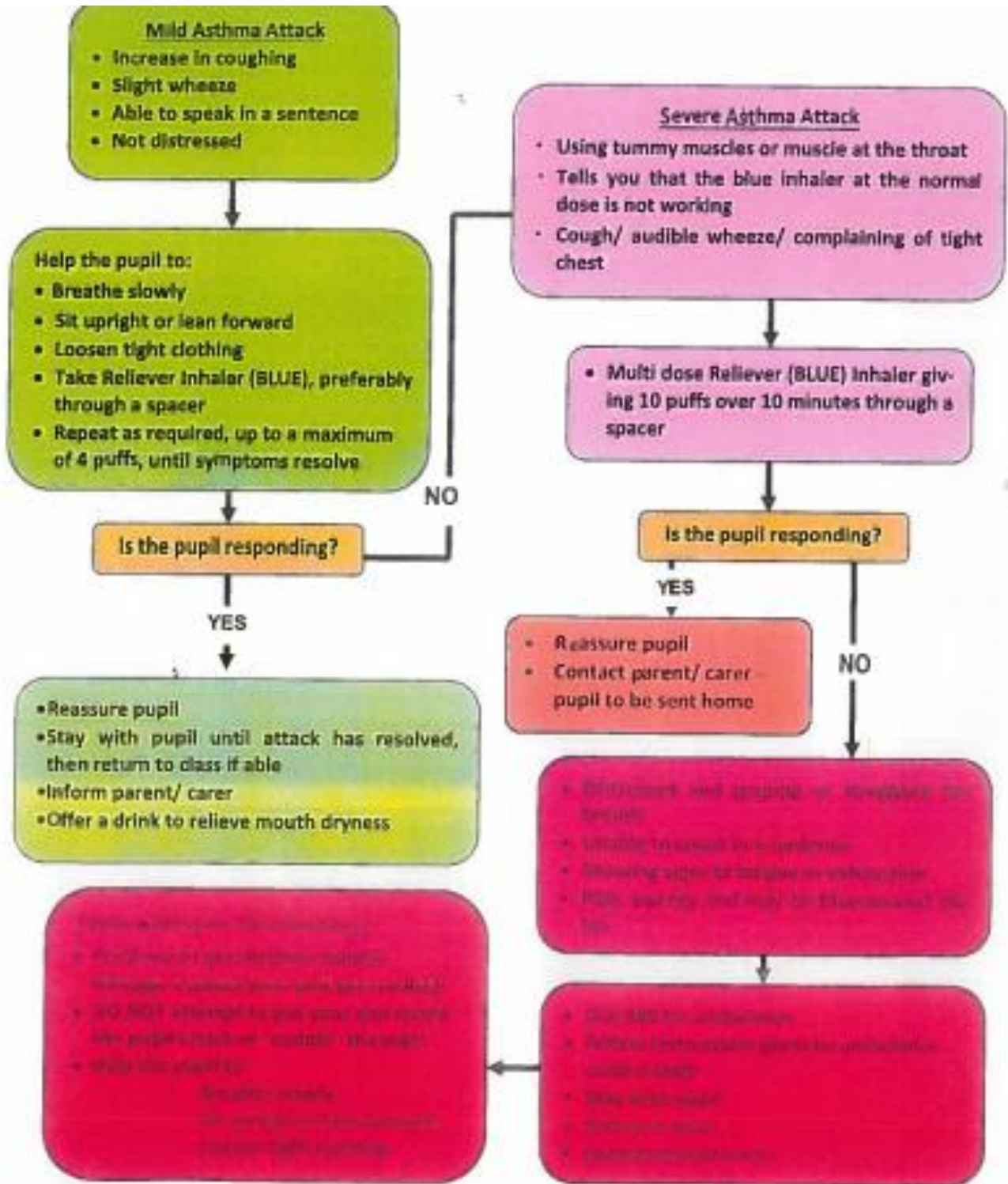
stored in the same bag to provide clear information on dosage. Pupils will have access to this store at all times and staff will supervise and record when it is used. If a pupil, who has a MED2 form uses their inhaler, or takes medication without a member of staff being present they must inform them to ensure this is recorded. The guidelines on the asthma flowchart will be followed and this is in the first aid book in each atrium. When medication has expired or run out staff will send home the appropriate letter with the medication for parents to dispose of and provide new medication.

### Emergency medication

Emergency medication such as EPI pens will be kept in a cabinet in each classroom. Each EPI pen will be contained within a sealed box. This will have photo identification on the outside and labeled medication inside. It will also contain a copy of the Individual Healthcare Plan which will be reviewed annually or earlier if needs change.

**All medication will be sent home at the end of the summer term. Parents must provide medical information on the appropriate form each year.**

# ASTHMA ATTACK FLOW CHART



# Symptom and Action Flowchart for Allergic Reaction Including an Adrenaline Pen

Refer to School Healthcare Plan and medication container for dosages



## Symptom and Action Flowchart for Generalised Tonic Clonic/Tonic/Clonic Seizures

Photograph of pupil

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Symptoms:** goes stiff, would fall if standing, is unresponsive, eyes may deviate, colour may change, all limbs jerk/shake/twitch.

DO NOT try to move the pupil  
DO NOT try to stop the pupil's dent  
DO NOT put anything in the pupil's mouth

1. Note time.
2. Move furniture/object pupil could bang against.
3. Place something soft under pupil's head.
4. When possible put pupil on his/her side.

Does the seizure last longer than 5 minutes or the time specified in the pupil's individual healthcare plan?

YES

NO

Is emergency medication prescribed for use in school?

YES

NO

Give medication as per school healthcare plan.

Has the pupil stopped jerking or is relaxing after a further 5 minutes?

NO

YES

YES

NO

YES

NO

YES

NO

YES

YES

NO

YES

NO

YES

NO

YES

NO

When pupil stops jerking/relaxes place on their side and cover them from the waist down in case of incontinence to minimize embarrassment.

Does the pupil have any injury that requires treatment?

NO

Is the pupil responding to stimuli?

YES

Are you unsure or worried?

NO

• Dial 999 immediately if the pupil has a seizure that lasts longer than 5 minutes.  
• If you are unsure or worried by ambulance arrival.  
• If you are unsure or worried.  
• If you are unsure or worried.  
• If you are unsure or worried.

- After a seizure the pupil will probably feel sleepy.
- Allow pupil to rest in a quiet area.
- Inform parents/carers.
- Fill in epilepsy record chart.

My child has taken this medication previously at home and has not suffered any side effects

Signed \_\_\_\_\_ Parent/ Guardian

**MED1**

### REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you have completed and signed this form and the Head Teacher has agreed that school staff can administer the medication.

#### 1. DETAILS OF PUPIL

Pupil's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School: \_\_\_\_\_ Class \_\_\_\_\_

Tel No: \_\_\_\_\_ Home: \_\_\_\_\_ Emergency: \_\_\_\_\_

#### 2. DETAILS OF MEDICATION

Condition or illness: \_\_\_\_\_

Name/Type of medication \_\_\_\_\_  
(as described on the container)

Prescribed by: (please tick as appropriate)

GP Name: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_

Other Name: \_\_\_\_\_

Address: \_\_\_\_\_

For how long will your child take this medication? \_\_\_\_\_

**Full directions for use:**

**Dosage and method:** .....

**Times at which medicine(s):** .....  
**to be given**

**Special precautions:** .....

**Side effects:** .....

**Procedures to be taken in an emergency:** (e.g. asthma - maximum number of doses to be administered for treatment of acute wheezing)

.....

.....

.....

### 3. STAFF INDEMNITY

**"Midlothian Council hereby indemnifies all authorised staff at the school from and against claims for alleged negligent actions, costs, charges, losses, damages and expenses which they or any of them shall or may incur or sustain by reason of any alleged negligent act or omission by them in the administration of the medication to the Pupil, provided always that the alleged negligent act or omission was done in the course of their employment."**

### 4. PARENTAL RESPONSIBILITY

- (i) I understand that I must deliver the medicine(s) personally to you, and to replace them wherever necessary and accept that this is a service which the school is not obliged to undertake.



(ii) I accept responsibility for advising you immediately of any change of treatment prescribed by any doctor or hospital.

(iii) I understand the terms of the Staff Indemnity.

Signature: ..... Date: .....

**Parent/Carer** \_\_\_\_\_

Date Received by School: .....Signature: .....**Head Teacher**

ACTION TAKEN
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My child has taken this medication previously at home and has not suffered any side effects

Signed \_\_\_\_\_ Parent/ Guardian

**MED2**

**REQUEST FOR MEDICATION TO BE SELF ADMINISTERED**

This form must be completed by parents/carers of pupils under 16

1. DETAILS OF PUPIL

Pupil's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

School: \_\_\_\_\_ Class \_\_\_\_\_

Tel No: Home: \_\_\_\_\_ Emergency: \_\_\_\_\_

2. DETAILS OF MEDICATION

Condition or illness: \_\_\_\_\_

Name/Type of medication \_\_\_\_\_

(as described on the container)

Prescribed by: (please tick as appropriate)

GP

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Address: \_\_\_\_\_

Other

Name: \_\_\_\_\_

Address: \_\_\_\_\_

For how long will your child take this medication? \_\_\_\_\_

**Full directions for use:** .....

**Dosage and method:** .....

**Times at which medicine(s) to be given:** .....

**Special precautions:** .....

**Side effects:** .....

**Procedures to be taken in an emergency:** (e.g. asthma - maximum number of doses to be administered for treatment of acute wheezing)

.....  
.....  
.....

**3. PARENTAL RESPONSIBILITY**

- (i) I would like my daughter/son to keep her/his medication on her/him for use as necessary.
- (ii) I understand that I must deliver the medicine(s) personally to you and to replace them wherever necessary

*Delete (i) or (ii) as appropriate.*

- (iii) I accept responsibility for advising you immediately of any change of treatment prescribed by any doctor or hospital.

Signature: .....

Date: .....

**Parent/Carer** \_\_\_\_\_

Date Received by School: ..... Signature: .....

**Head Teacher**

<b>ACTION TAKEN</b>
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# INDIVIDUAL HEALTHCARE PLAN

## MED3

### 1. PUPIL DETAILS

Pupil's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

School: \_\_\_\_\_ Class \_\_\_\_\_

### 2. EMERGENCY CONTACTS

#### Family Contact 1

#### Family Contact 2

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Tel: (Home) \_\_\_\_\_

Tel: (Home) \_\_\_\_\_

(Work) \_\_\_\_\_

(Work) \_\_\_\_\_

Relationship \_\_\_\_\_  
to pupil

Relationship \_\_\_\_\_  
to pupil

#### Clinic/Hospital contact

#### General Practitioner

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Tel: \_\_\_\_\_

Tel: \_\_\_\_\_

### 3. DETAILS OF MEDICAL CONDITION

(To be completed by or in consultation with appropriate health professional)

Condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Details of pupil's individual symptoms: \_\_\_\_\_

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Daily care requirements: \_\_\_\_\_

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Describe what constitutes an emergency for the pupil, and the action to take if this occurs. (eg epilepsy: - record all details of seizures - goes stiff, falls, convulsions last 3 minutes; rectal diazepam after certain length of time or number of seizures)

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4. DETAILS OF MEDICATION

Medicine	Dose	Comment

Storage and access: \_\_\_\_\_

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5. BRIEFING OF STAFF

It is the Council's responsibility to provide briefing and training for staff. Arrangements for interim training, if required, will be considered on a case specific basis.

Briefing \_\_\_\_\_ Date \_\_\_\_\_

## 6. STAFF VOLUNTEERS

The following staff have agreed to administer medication in case of an emergency to (name of pupil)

\_\_\_\_\_.

NAME (Block capitals	SIGNATURE	DATE OF AGREEMENT	DATE OF TRAINING

## 7. STAFF INDEMNITY

**"Midlothian Council hereby indemnifies all authorised staff at the school from and against claims for alleged negligent actions, costs, charges, losses, damages and expenses which they or any of them or may incur or sustain by reason of any alleged negligent act or omission by them in the operation of specific healthcare plans for the Pupil, provided always that the alleged negligent act or omission was lawful, it occurred in the course of their employment and the member of staff was acting within the scope of their authority and in terms of the guidance provided."**

### CONCLUSION AND AGREEMENT

- (i) These notes will be held by School, Parents, local Health Centre, Community Paediatrician and Education, Communities and Economy Directorate.
- (ii) In the event of any revision of the treatment plan, a new agreement will be drawn up and circulated as above.
- (iii) The parents, school and Midlothian Council hereby acknowledge and agree that medication will be administered to the pupil in accordance with the provisions of this Agreement.
- (iv) AGREEMENT

I wish my son/daughter to have the above medication administered by school staff in the case of emergency.

I understand that staff will have been provided with training by appropriate Health Professionals prior to administering any such emergency treatment.

I have read and understood the staff indemnity provided by Midlothian Council for the protection of staff.

Signed: ..... Date: .....

(Parent/Carer) \_\_\_\_\_

Counter signed by:

Head Teacher: ..... Date: .....

Copy to:

- Community Paediatrician  Date sent .....
- Manager, Support for Learning, CSCYP  Date sent .....



Date \_\_\_\_\_

Dear Parent,

We currently hold medication for your child

\_\_\_\_\_

in school. This medication is now finished and we require a replacement.

The medication we are referring to is;

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please send in replacement medication as soon as possible. We will return the empty medication to you for safe disposal.

Thank you for your help in this matter.

Mrs Caroline Findlay

Acting Head Teacher

Date \_\_\_\_\_

Dear Parent,

Today your child \_\_\_\_\_ of P \_\_\_\_\_

was given non prescription medication in school.

The medication we are referring to is

\_\_\_\_\_.

This dose administered was \_\_\_\_\_ and this was given at

\_\_\_\_\_ (time)

Mrs Caroline Findlay

Acting Head Teacher