Our Medication Policy

UN CRC Article 24
All children have the right to the highest attainable standard of health, including access to healthcare services and measures to combat disease and malnutrition.

Adopted: May 2018
Most recently Reviewed September 2025
Due for Review: September 2029

Policy Aim: Whiteabbey Primary School is an inclusive community that welcomes and supports pupils with medical conditions. This school provides all pupils with any medical condition the same opportunities as others at school.

1. The Board of Governors and staff of Whiteabbey Primary School wish to ensure that pupils with medication needs receive appropriate care and support at school. The Principal will accept responsibility in principle for members of the school staff giving or supervising pupils taking prescribed medication during the school day **where those members of staff have volunteered to do so. Please note that parents should keep their children at home if acutely unwell or infectious.**

2. Parents are responsible for providing the Principal with comprehensive information regarding the pupil's condition and medication (appropriate form on school website).

3. Prescribed medication will not be accepted in school without complete written and signed instructions from the parent.

4. Staff will not give a non prescribed medicine to a child unless there is specific prior written permission from the parents.

5. Only reasonable quantities of medication should be supplied to the school (for example, a maximum of four weeks supply at any one time).

6. Where the pupil travels on school transport with an escort, parents should ensure the escort has written instructions relating to any medication sent with the pupil, including medication for administration during respite care.

7. Each item of medication must be delivered to the Principal or Authorised Person, in normal circumstances by the parent, **in a secure and labelled container as originally dispensed**. Each item of medication must be clearly labelled with the following information:
   - Pupil's Name.
   - Name of medication.
   - Dosage.
   - Frequency of administration.
   - Date of dispensing.
   - Storage requirements (if important).
   - Expiry date.

The school will not accept items of medication in unlabelled containers.

8. Medication will be kept in a secure place, out of the reach of pupils.

9. The school will keep records, which they will have available for parents. If children refuse to take medicines, staff will not force them to do so, and will inform the parents of the refusal, as a matter of urgency, on the same day. If a refusal to take medicines results in an emergency, the school's emergency procedures will be followed.

10. It is the responsibility of parents to notify the school if the pupil's need for medication has ceased. Email office@whiteabbeyps.co.uk

11. It is the parents' responsibility to renew the medication when supplies are running low and to ensure that the medication supplied is within its expiry date.

12. The school will not make changes to dosages without parental instructions.

13. School staff will not dispose of medicines. Medicines, which are in School. Medicines, which are in use and in date, should be collected by the parent at the end of each term. Date expired medicines or those no longer required for treatment will be returned immediately to the parent for transfer to a community pharmacist for safe disposal.

14. For each pupil with long term or complex medication needs, the Principal, will ensure that a Medication Plan and Protocol is drawn up, in conjunction with the appropriate health professionals e.g. Type 1 Diabetes.

15. Where it is age appropriate to do so, our pupils will be encouraged to be independent and to administer their own medication, if necessary under staff supervision. Parents will be asked to confirm in writing if they wish their child to carry their medication with them in school.

16. Staff who volunteer to assist in the administration of medication will receive appropriate training/guidance through arrangements made with the School Health Service e.g. Type 1 Diabetes, Epipens .

17. The school will make every effort to continue the administration of medication to a pupil whilst on trips away from the school premises, even if additional arrangements might be required. However, there may be occasions when it may not be possible to include a pupil on a school trip if appropriate supervision cannot be guaranteed.

18. All staff will be made aware of the procedures to be followed in the event of an emergency.

19. Appendix 1: Consent Form for use of an Inhaler.

20. Appendix 2: Note home to parents reference use of inhaler.

Record of medicine administered <u>to an individual child</u>

Surname	
Forename (s)	
Date of Birth	___ /____ / ___ M ☐ F ☐
Class	
Condition or illness	
Date medicine provided by parent	
Name and strength of medicine	
Quantity received	
Expiry date	____ / ____ / ____
Quantity returned	
Dose and frequency of medicine	

Checked by:

Staff signature _____ **Signature of parent** _____

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			

Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

RECORD OF MEDICINES ADMINISTERED TO ALL CHILDREN

DATE	Child's Name	Time	Name of Medicine	Dose Given	Any Reactions	Signature of Staff	Print Name

WHITEABBEY PRIMARY SCHOOL

RECORD OF MEDICAL TRAINING FOR STAFF

Name _____

Type of training received _____

Name(s) of condition/ _____

medication involved _____

_____

Date training completed _____

Training provided by _____

I confirm that _____ has received the training detailed above and is competent to administer the medication described.

Trainer's signature _____ **Date** _____

I confirm that I have received the training detailed above

Trainee's signature _____ **Date** _____

Proposed Retraining Date _____

Refresher Training Completed –

Trainer _____ Date _____

Trainee _____ Date _____

Request by Parent for school to administer medication

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

Details of Pupil

Surname:					
Forename(s)					
Address:					
Date of Birth:		**M:**		**F:**	
Class					
Condition or illness					

Medication:

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

Medication 1	
Dose:	**Timing:**

Medication 2	
Dose:	**Timing:**

For how long will your child take this medication?

Date dispensed:

Other Information:

Full directions for use:	
Special precautions:	
Side Effects:	
Self-Administration:	
Procedures to take in an Emergency:	

Contact Details:

Name:	
Daytime tel. no.	
Relationship to Pupil:	

I understand that I must deliver the medicine personally to (agreed member of staff) and accept that this is a service which the school is not obliged to undertake.

Date:		**Signature(s):**	

Relationship to pupil:	

School's Agreement to administer medication

I agree that _____ (child's name) will receive _____(dose) of_____(name of medication) at _____(timing eg break time of lunch time). _____ (child's name) will be given/supervised while he/she takes their medication by _____ (member of staff). This arrangement will continue until _____ (end of medicine or until instructed by parent/guardian).

Date: _____

Signed: _____ (Parent)

Signed:_____ (Member of staff)

MEDICATION PLAN FOR A PUPIL WITH MEDICAL NEEDS

Date _____ **Review Date** _____

Name of Pupil_____

Date of Birth_____ Year_____

National Health Number _____

Medical Diagnosis_____

Contact Information

1 Family contact 1

Name: _____

Relationship: _____

Phone: Home/Mobile: _____

Work: _____

2 Family contact 2

Name: _____

Relationship: _____

Phone: Home/Mobile: _____

Work: _____

3 *GP*

Name_____

Phone No_____

4 Clinic/Hospital Contact

Name_____

Phone No:_____

Plan prepared by:

Name_____

Designation_____ Date_____

Describe condition and give details of pupil's individual symptoms:

_____

_____

_____

Daily care requirements (e.g. before sport, dietary, therapy, nursing needs)

_____

_____

Members of staff trained to administer medication for this child

(state if different for off-site activities)

_____

_____

_____

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

_____

_____

_____

Follow up care

_____

_____

_____

I agree that the medical information contained in this form may be shared with individuals involved with the care and education of _____

Signed_____ **Date**_____

Parent/carer

Distribution

School Doctor_____ School Nurse_____

Parent_____ Other_____

REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION

This form must be completed by parents/carers

Details of Pupil

Surname _____ Forenames(s) _____

Address _____

Date of Birth ____ / ___ / _____

Class _____

Condition or illness _____

Medication

Parents must ensure that in date properly labelled medication is supplied.

Name of Medicine

_____

Procedures to be taken in an emergency

_____

Contact Details

Name _____

Phone No: (home/mobile) _____

(work) _____

Relationship to child _____

I would like my child to keep his/her medication on him/her for use as necessary

Signed _____ **Date** _____

Relationship to child _____

Agreement of Principal

I agree that _____ (name of child) will be allowed to carry and self-administer his/her medication whilst in school and that this arrangement will continue until _____(either end date of course of medication or until Instructed by parents).

Signed _____ **Date** _____

The Principal/authorised member of staff.

The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to the named pupil carrying his/her own medication.

CONSENT FORM
USE OF INHALER

Child showing symptoms of asthma / having asthma attack

1. I can confirm that my child has been diagnosed with asthma / has been prescribed an inhaler (delete as appropriate).
2. My child has a working, in-date inhaler, clearly labelled with their name, which they will bring with them to school every day and the school also holds a spare inhaler prescribed for my child.
3. In the event of my child displaying symptoms of asthma, and if their inhaler and spare inhaler are not available or are unusable, I consent for my child to be brought to A&E.

Signed…… **Date**……

Name (print)……

Child's Name…… **Class**……

Details of inhaler and prescribed dosage:

……

……

……

……

20 -30 Old Manse Road
Newtownabbey
BT37 0RU

Tel: 028 90862185
Fax: 028 90853249

Principal: Mr Keith Wysner

Child's name: ……

Class: ……

Date: ……

Dear ……,

This letter is to formally notify you that …… has had problems with his/her breathing today at …… This happened when (brief description of what happened)

……

……

……

A member of staff helped them to use their inhaler.

The inhaler used was (please tick box that applies)

Pupil's own prescribed inhaler ☐

Pupils own prescribed spare inhaler ☐

Number of puffs given ……

Staff Signed ……