DANE ROYD SCHOOL

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
   01924242917

2. Give your location as follows
   Stoney Lane, Hall Green, Wakefield

3. State that the postcode is
   WF4 3LZ

4. Give exact location in the school/setting
   School located 2nd left after the Coop,Edgemore Drive and right onto Moorside Drive.
   Or
   School 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

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	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.

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 _____

FORM 4

Head teacher agreement to administer medicine

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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)

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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 Any reactions	Child's name Signature	Time Print name			Name of medicine	Dose given	
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DANE ROYD SCHOOL

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 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 _____

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

FORM 8

DANE ROYD SCHOOL

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 _____

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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 he 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

DANE ROYD SCHOOL

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 he 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