

Medicinal Needs

For Primary pupils with short term medicinal needs at school

1. Pupil's Information:

Name of Pupil: Date of Birth: Member of staff responsible for home school communication: Mrs. A. Bharj (Pastoral Lead) Teaching Assistant:	Photo:
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2. Details of pupil's short terms medicinal need.

Medical Condition/Health issue/s:
Signs and symptoms of this pupil's condition/s:
Triggers or things that make this pupil's conditions worse:

Short term medication taken during school hours

Medication 1 - any medication stored or bought into school, can only be accepted if it has been prescribed by a doctor, and is dispensed/clearly labelled by a pharmacist:	
Name/type of medication (as described on the container):	
Expiry date of medication:	
Dose and method of administration (the amount taken and how the medication is taken, eg tablets, inhaler, injection)	
When it is taken (time of day)?	

Medicinal Needs

Are there any side effects that could affect this pupil at school?	
Are there any contraindications (signs when this medication should not be given)?	
Self-administration: can the pupil administer the medication themselves?	
Where is the medication to be stored?	
Is the medication to stay in school or go home each evening?	
Which member of staff will administer the medication?	

Short Term Medication Log

Date	Time	Staff member 1 present (sign)	Staff member 2 present (sign)

Parental Agreement

Pupil Name: _____

I agree that the medical information contained in this plan may be shared with individuals involved with my/my child's care and education (this includes emergency services). I understand that any medication stored or bought into school, can only be accepted if it has been prescribed by a doctor, and is dispensed/clearly labelled by a pharmacist. I authorise the school named person to administer the medication described for a period of _____ school days. I understand that I must notify the school if the medication needs to continue beyond this time.

Signed Parent _____ Date _____

Head teacher agreement/DDSL/First Aid Lead

It is agreed that (name of child) _____

will receive the above listed medication at the above listed time

This arrangement will continue until _____