Administration of Medicines

A child who has an infectious illness, or who feels unwell, should ideally be at home. Instances do occur however when staff may be called upon to administer medication on behalf of a parent. Appletree Nursery School aims to support children and families in enabling regular attendance for those children with identified medical needs or on long term medication. Parents /carers who request the administration of medicines in the School must comply with the following policy.

"Medicines must not usually be administered unless they have been prescribed for a child… by a doctor, dentist, nurse or pharmacist" (EYFS statutory framework 2012).

Parents / carers are responsible for supplying adequate information regarding a child's condition and medication. This information must be in writing, signed and current to ensure that procedures for each individual child are clearly understood.

Staff may only administer medication if the appropriate forms have been signed. (see appendix) These ensure that appropriate information has been obtained about the child's needs for medication and that information is up to date.

Long Term Medication

If the medicine is for medium to long term use (e.g. treatment for asthma or eczema), the medical care plan pro-forma must be completed:

- a medical care plan (FORM 2);
- signed permission from parents (FORM 3);
- confirmation of the adult with a Duty of Care agreement (FORM 4).

Staff should not administer medicines without first receiving appropriate medical information or technical knowledge and/or training from a qualified medical practitioner.

Team leaders should ensure that bronchial inhalers are checked regularly

Short Term Medication

If the medicine is for short term use (e.g. antibiotics), it may only be administered when parents have completed the prescribed medicine permission form (FORM 3). This will detail:

- the child's name;
- the exact dosage and method required;
- time or times of day it is to be/has been administered;
- procedures to take in an emergency.

Agreement should also be obtained from the adult with a duty of care (FORM 4).

Over the Counter Medication

Ofsted guidance for registered childcare providers allows for the administration of medication recommended by a pharmacist or nurse without a written prescription. Legal guidance allows for administration of over-the-counter medication such as pain and fever relief or teething gel. However, written permission must be sought and the same recording procedures followed as for prescribed medicines.

Medication must only be administered if there is an accepted health reason to do so. The EYFS statutory framework states that medicines containing aspirin should only be given if prescribed by a doctor.

Administration

All medication should be presented in its original packaging and instructions from the parent/carer should match those on the pharmacy label or packaging. A dosage measuring spoon or container should also be provided. The setting should never accept medicines that have been taken out of the container as originally dispensed nor make changes to doses on parental instructions.

Medicines must be administered by a team leader and will always be witnessed by another member of staff.

A medicine administration form (FORM 5) will be completed and witnessed by another member of staff; copies will be given to parents on the same day or as soon as reasonably practicable.

Risk Assessment and Management Procedures.

Medicines should be stored strictly in accordance with product instructions. Some medicines need to be refrigerated. These should be stored in an airtight container and clearly labelled All medicines will be safely stored out of sight and reach of children.

The possession and administration of some medicines are controlled by the Misuse of Drugs Act 2005 and its associated regulations. Where children have been prescribed controlled drugs, staff need to be aware that these should be kept in safe custody.

Controlled drugs should be kept in a lockable non-portable container and only named staff should have access.

A record of controlled drugs held on the premises should be kept for audit and safety purposes.

Emergency Procedures

All staff should be made aware of the possibility of a crisis arising and the appropriate action to be taken should an emergency occur. Individual health care plans include how to manage individual children in an emergency

Review

This policy was developed in accordance with LCC Guidance for services working with children and young people and Ofsted childcare factsheet 'Giving medication to children in registered childcare' (2010) Ref 080290.

The day-care manager and Head of Centre are responsible for ensuring that this policy is observed and reviewed as part of the children's centre regular policy review cycle.

Forms relating to the administration of medicines are available to download from:
http://www.lancashire.gov.uk/education/paf/pid1142/form_templates.doc

Appletree Nursery School

Administration of Medicines and Creams

Medical treatment

Child's Name …….. Date ……

Name of medicine/treatment ……

Circumstance(s) where treatment should be administered ……

…….

Circumstance(s) when you should be contacted immediately …….

…….

Exact instructions for administration ……

…….

Exact instructions for storage ……

I give my consent for staff to administer the medicine/treatment as described above. I understand a written record of administration will kept and details will be given to me.

Parent's signature ……

Date and Time	Child's name	Medicine / treatment administered	Details of dosage/ application

FORM 1

Contacting Emergency Services

Request for an Ambulance

Dial 999, ask for an ambulance and be ready with the following information:

1. **Your telephone number:**

   01524 64132

2. **Give your location as follows:**

   Appletree Nursery School
   Lancaster

3. **State that the postcode is:**

   LA1 5QB

4. **Give exact location in the Centre (insert brief description):**

5. **Give your name:**

6. **Give name of child and a brief description of the child's symptoms:**

7. **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

FORM 2 - Healthcare Plan

Name of Setting: _____

Child's name: _____

Group/Class/Form: _____

Date of Birth: _____

Child's Address: _____

_____

Medical Diagnosis or Condition: _____

_____

Date: _____ **Review date:** _____

CONTACT INFORMATION

Family contact 1		Family contact 2	
Name:	_____	**Name:**	_____
Phone No: (work)	_____	**Phone No:(work)**	_____
(home)	_____	**(home)**	_____
(mobile)	_____	**(mobile)**	_____

Clinic/Hospital contact:		GP:	
Name:	_____	**Name:**	_____
	_____		_____
Phone No:	_____	**Phone No:**	_____

Describe medical needs and give details of symptoms:

_____

_____

Daily care requirements: (eg 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 3

Parental agreement for setting to administer prescribed medicine

The setting will not give your child medicine unless you complete and sign this form, and the setting has a policy that staff can administer medicine

Name of Setting: _____

Name of Child: _____

Date of Birth: _____

Group/Class/Form: _____

Medical condition/illness: _____

Medicine

Name the medicine is prescribed to on the container: _____

_____

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 eg Oral, inhaled: _____

Timing: _____

Special Precautions: _____

Are there any side effects that the setting needs to know about? _____

Self Administration (self administration form to be completed if yes): **YES/NO** *(delete as appropriate)*

Procedures to take in an Emergency: _____

_____

_____

Contact Details

Name: _____

Daytime Telephone No: _____

Relationship to Child: _____

Address: _____

_____

_____

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to the setting staff administering medicine in accordance with the setting policy. I will inform the 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 I must deliver the medicine personally to agreed member of staff and accept that this is a service that the setting is not obliged to undertake.

Signature(s): _____

_____

Date: _____

Relationship to child: _____

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

FORM 4

Confirmation of the Adult with a Duty of Care's agreement to administer medicine

Name of Setting: _____

It is agreed that _____ ***[name of child]*** **will receive** _____ ***[quantity and name of medicine]*** **every day at** _____ ***[time medicine to be administered eg 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 parents].

Signed: _____

Date: _____

[*The Head of Setting/Named Member of Staff*]

FORM 5

Record of medicine administered to an individual child

Name of Setting: _____

Name of Child: _____

Date medicine provided by parent: _____

Group/class/form: _____

Quantity received: _____

Name and strength of medicine: _____

Expiry date: _____

Quantity returned: _____

Dose and frequency of medicine: _____

Staff signature: _____

Parent signature: _____

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:			

Date:			
Time Given:			
Dose Given:			
Name of member of staff:			
Staff initials:			

FORM 6

Record of medicines administered in school/setting to all children

Name of Setting: _____

Child's Name:					
Date:					
Name of Medicine:					
Dose given:					
Time:					
Any Reactions:					
Other comments: (eg refusal of medicine)					
Print Name:					
Signature of Staff:					

Child's Name:					
Date:					
Name of Medicine:					
Dose given:					
Time:					
Any Reactions:					
Other comments: (eg refusal of medicine)					
Print Name:					
Signature of Staff:					

FORM 7

Request for child to carry his/her medicine

THIS FORM MUST BE COMPLETED BY PARENTS

If staff have any concerns discuss request with the appropriate healthcare professionals

Name of 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

FORM 8

Staff training record - administration of medicines

Name of 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 within the area of training given on this occasion. 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 Setting: _____

Child's name: _____

Date of birth: _____

Home address: _____

_____

GP: _____

Hospital consultant: _____

_____ *[name of child]* should be given Rectal Diazepam _____ mg if he/she has a *prolonged epileptic seizure lasting over _____ minutes.

OR

*serial seizures lasting over _____ minutes.

An Ambulance should be called for *at the beginning of the seizure

OR

If the seizure has not resolved *after _____ minutes.

(*please delete as appropriate)

Doctor's signature: _____

Parent's signature: _____

Print Name: _____

Date: _____