

Epping Upland C. of E. Primary School Medical Policy

At Epping Upland C of E Primary School, we believe that all children have the same rights to admission and accept that most children at some time will have short term medical needs, perhaps entailing finishing a course of medicine such as antibiotics. Some children however, have longer term medical needs and may require medicines on a long term basis to keep them well. Other children may require medicines in particular circumstances, such as children with severe allergies who may need adrenaline injections. Children with asthma may have a need for daily inhalers or additional doses during a severe attack.

Most children with medical needs are able to attend school regularly and can take part in normal activities, sometimes this may require them to have some additional support or for members of staff to ensure that children with medical needs are not put at risk.

Parents

We expect parents to accept the prime responsibility that they have for their child's health. We expect parents to provide us with all the information that is relevant to their child's health and medical condition and where appropriate to supply us with associated and relevant clarification from their GP or Paediatrician.

Administration of Medicines by Staff

There is no legal duty that requires our staff in school to administer medicines to our pupils. However, in order to assist the smooth integration of children into the life of our school and to ensure that children are as included as possible, we will endeavour to ensure that staff will, wherever feasibly possible, administer medicine to pupils. Each case will be considered separately with the risk to staff and risk to the individual child calculated before agreement is given to administer the medicine required. The Headteacher will make the final decision as to whether she gives permission for staff to administer the required medicine and in her absence, the Deputy Headteacher.

Prescribed Medicines

Medicines should only be brought into school when essential – this is where it would be detrimental to a child's health if the medicine were not administered during the school day. We will only accept medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber. Medicines must always be provided in their original container as dispensed by the pharmacist and must include the prescribing instructions for administration and dosage.

Medicines that have been taken out of their original container as originally dispensed will not be accepted onto the school site.

Medicines will only be given in the prescribed dose as detailed by the dispenser. Amendments to dosage will not be given on parental instruction.

All medicines that are brought into school must be given to the office staff who will arrange for their safe keeping whilst also organising who will administer the medicine.

Non- Prescription Medicine

Non- prescription medicine ie: paracetamol will only be administered to pupils with the express permission of the parent or carer. Where non prescription medicine is administered a record must be kept of who the medicine was given to, who administered it and at what time it was given. The parent/carer must also receive notification of the time the medicine was given and of the dosage.

No children will be given aspirin containing medicine unless prescribed by a doctor

Long Term Medical Needs

When a pupil has a long term medical need, the school expects that sufficient information about the child's medical condition will be given, in detail, to them by the parent/carer.

It is important that, wherever possible, the child's medical needs are adequately supported so that they are not disadvantaged in their participation of school life. It is important to note that a medical condition may lead to difficulties which affect cognitive or physical ability, behaviour or emotional state. It is therefore essential that the child's educational needs are considered of high importance in their inclusion into school life. In this respect, our school will consider each case as an individual one in how best to accommodate the child's needs.

Where a child has a long term medical need, a health care plan will be written, in conjunction with parents/carers and relevant health professionals, where appropriate, outlining:

- details of a child's condition
- special requirements
- any side effects of any medicines
- what constitutes an emergency
- what action to take in an emergency
- what not to do in the event of an emergency
- who to contact in an emergency
- the role that staff will need to play

In each circumstance, if any child refuses to take their medicine, staff will not force them to do so but must inform the parents/ carers that this has been the case.

Educational Visits and Sporting Activities

Wherever practicable, the school will make reasonable adjustments to trips, visits and sporting activities so that children with medical needs are able to participate as fully as possible and as safely as possible.

Medicine Disposal

Staff will not have responsibility for disposal of any medicines. All medicines will be returned to parents/carers for safe disposal.

updated April 2016

COMMON CONDITIONS – PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS

INTRODUCTION

ASTHMA

What is Asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children have asthma in the UK. The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

However in early years settings staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is therefore imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for children with asthma when this happens. This should be supported by written asthma plans, asthma school cards provided by parents, and regular training and support for staff. Children with significant asthma should have an individual health care plan.

Medicine and Control

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise. Whilst **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

Children with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do

Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting.

The signs of an asthma attack include:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest

- being unusually quiet

When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. An ambulance should be called if:

- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to speak
- the child is becoming exhausted
- the child looks blue

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents should arrange the review and make sure that a copy of their child's management plan is available to the school or setting. Children should have a reliever inhaler with them when they are in school or in a setting.

Children with asthma should participate in all aspects of the school or setting 'day' including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

Reluctance to participate in physical activities should be discussed with parents, staff and the child. However children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate.

Children with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate.

All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and medical needs.

The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK). The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

All staff, particularly PE teachers, should have training or be provided with information about asthma once a year. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

EPILEPSY

What is Epilepsy?

Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children have epilepsy and around 80 per cent of them attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition. Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be recorded and communicated to parents including:

any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)

any unusual "feelings" reported by the child prior to the seizure

parts of the body demonstrating seizure activity e.g. limbs or facial muscles

the timing of the seizure – when it happened and how long it lasted

whether the child lost consciousness

whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

In some cases, such seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could

be a cause of deteriorating academic performance.

Medicine and Control

Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.

Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured themselves badly
- they have problems breathing after a seizure
- a seizure lasts longer than the period set out in the child's health care plan
- a seizure lasts for five minutes if you do not know how long they usually last for that child
- there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

Such information should be an integral part of the school or setting's emergency procedures as discussed at paragraphs 115 - 117 but also relate specifically to the child's individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam. Instructions for use **must** come from the prescribing doctor. For more information on administration of rectal diazepam, see Form 9.

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being provided.

DIABETES

What is Diabetes?

Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

Each child may experience different symptoms and this should be discussed when drawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control

The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump. Most children can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and

will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results. When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional. Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand. Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycaemic reaction** (hypo) in a child with diabetes:

hunger

sweating

drowsiness

pallor

glazed eyes

shaking or trembling

lack of concentration

irritability

headache

mood changes, especially angry or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

If a child has a hypo, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

- the child's recovery takes longer than 10-15minutes
- the child becomes unconscious

Some children may experience **hyperglycaemia** (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

Such information should be an integral part of the school or setting's emergency procedures as discussed but also relate specifically to the child's individual health care plan.

ANAPHYLAXIS

What is anaphylaxis?

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

Medicine and Control

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

Should a severe allergic reaction occur, the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer's instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back. The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the head, the child's parents and medical staff involved.

Where children are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location.

Studies have shown that the risks for allergic children are reduced where an individual health care plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the treating doctor.

Important issues specific to anaphylaxis to be covered include:

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine

- food management
- precautionary measures

Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practice with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' could be put in place.

Parents often ask for the head to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect – except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

ANNEX B: FORMS

Form 1 Emergency planning - request for an ambulance

Form 2 Healthcare Plan

Form 3 A Parental agreement for school/setting to administer medicines

Form 3 B Parental agreement for school/setting to administer medicines

Form 5: Record of medicine administered to an individual

Form 6: Record of medicines administered to all children

Form 7: Request for child to carry his/her own medicine

Form 8: Staff training record - administration of medicines

Form 9: Authorisation for administration of rectal diazepam

All forms set out below are examples that schools and settings may wish to use or adapt according to their particular policies on administering medicines.

Versions of these forms are available from

<http://www.teachernet.gov.uk/medical>

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
2. Give your location as follows: (insert school/setting address)
3. State that the postcode is
4. Give exact location in the school/setting (insert brief description)
5. Give your name
6. Give name of child and a brief description of 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

Put a completed copy of this form by the telephone

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FORM 2 - Healthcare Plan

Name of School/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 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

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 staff can administer medicine

Name of School/Setting

Name of Child:

Date of Birth:

Group/Class/Form:

Medical condition/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 (delete as appropriate)

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] and 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.

Date:

Signature(s):

Relationship to child:

FORM 3B

Parental agreement for school/setting to administer medicine

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 staff can administer medicine.

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 the original container as dispensed by the pharmacy

Daytime phone no. of parent 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 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.

Parent's signature: Print Name:

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

FORM 5

Record of medicine administered to an individual child

Name of School/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 School/Setting

FORM 7

Request for child to carry his/her medicine

THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN
If staff have any concerns discuss request with school 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.

FORM 8

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: