Sonas

Special Junior Primary School
Carrigaline Education Campus
Ardnacloghy
Carrigaline
Co. Cork P43 EF95
Email: admin@sonascork.ie
Web: www.sonascork.ie
Tel: 021-4373164

Roll No. 20162O

ADMINISTRATION OF MEDICATION POLICY

The Board of Management of Sonas requests that parents inform the Board in writing of any medical condition suffered by a child in their class. Children who have epilepsy, diabetes, asthma or who are prone to anaphylactic shock syndrome may have an attack at any time. It is vital therefore to identify symptoms so that treatment can be given by authorised persons.

The administering of any medication in Sonas can only be done under strictly controlled guidelines. The Board of Management, Sonas advises that:

(1) Parents of the pupil concerned should write to the Board of Management requesting the Board to authorise member(s) of staff to administer the medication.

(2) Only medications prescribed by a registered medical practitioner will be administered. Paracetamol, Calpol etc. will not be administered by staff without a letter from the parent. If a child has a temperature of over 38˚C parents will be rung to collect the child and bring them home.

NB medicine.

(3) The following information from the G.P. is required by the Board of Management:

- **Child's full name and address.**
- **Name of medication to be administered.**
- **The exact dosage and time of administration.**
- **Procedure to be followed in administering medication.**
- **Signature of parent / guardian**.

(4) If children require special procedures (i.e. emergency epilepsy medication, insulin, asthma inhalers) written instructions will be required from the child's G.P. / Consultant and sent to the Principal.

In the case of children who have epilepsy and require stesloid or buccal midazolam to be administered, it is necessary that all staff working with them will require formal training from qualified health personnel. Sonas Epilepsy Seizure Care Plan/Asthma/Diabetes/Anaphylactic Care Plan is required to be completed by relevant personnel for all students who have been diagnosed with any of the above conditions.

Staff will not administer medication without the specific authorisation of the Board of Management.

- In administering medication to pupils, staff will exercise the standard of care of a reasonable and prudent parent. If possible 2 staff should be present during the administering of medication, 1 to administer, 1 to witness.
- The Board of Management will inform the school's insurers accordingly.
- The Board of Management will seek an indemnity from the parent(s) in respect of any liability that may arise regarding the administration of medication, requiring them to sign a letter of indemnity.
- During activities outside school or on school outings at least one of the designated staff should be present.
- Where possible it is requested that medical practitioners arrange times for medication to be taken outside school hours.
- Parents will be requested to collect a child with a high temperature as recorded on a thermometer. A high temperature is usually 100 ˚ F or 37 ˚C.
- The administering of medication record form must be signed on each occasion and kept in the child's file. A copy must be sent to parents and parents must be notified by phone if medication is administered.

STORAGE AND TRANSPORTATION OF MEDICATION.

- **Medication must not be given to pupils to bring to school. Medication must be handed to the student's bus escort or teacher or School Principal.** It is the responsibility of the parent to ensure that the teacher actually receives the medicine. Parents are welcome to phone the school to check.
- All medicines must be sent to school in a child proof container which is clearly pharmacy labelled with child's name and instructions. If a child is on prescribed medication, please send in that day's dosage only in syringe or tablet form.
- Children requiring special procedures (administration of oxygen, emergency epilepsy medication, asthma inhalers or anaphylaxis medication) will have a special medication administering plan which will be displayed inside the store cupboard in the classroom and kept in a medication bag high out of the reach of children. The class team will regularly check medication dates and inform parents if expiry date is approaching.

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Roll No. 20162O

Dear Chairperson,

I am requesting the Board of Management to authorise staff of Sonas Special Junior Primary School to administer medication to ______________.

As parents of ___________ we hereby indemnify the Board of Management, Sonas from and against all claims which may arise regarding administration of the medication.

- I attach a copy of the current prescribed medication and any special instructions pertaining to the administration of the medication.
- I will provide new / changed prescriptions to the Board of Management as they arise.
- I will inform the Board of Management in writing of any special instructions pertaining to the administration of the medication.
- I will undertake to send medication to school in a tamper proof container which is pharmacy labelled.

Signed: ___________________ Date: ______________
Parents

Signed: ___________________ Date: _______________
Class Teacher

Signed: ___________________ Date: _______________
Principal.

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INSTRUCTION DOCUMENT

ADMINISTERING OF MEDICATION PROTOCOL

DATE: ______________

Name of student: ______________________________
Address: ______________________________
____
____

Date of Birth: ______________________________

Doctor's Name and Contact details: ______________________________

Parent's Name and Contact details: ______________________________
____
____

INSTRUCTIONS FOR ADMINISTERING MEDICATION

Name of Medication: ______________________________

Exact dosage and time of medication: ______________________________

Procedure to be followed: ______________________________

Signatures of Authorised Persons:

____

For Review and Ratification by Sonas Board of Management on January 29th 2020

Parents Signature: ______________________

Sonas
Special Junior Primary School
Cork Road, Carrigaline, Co. Cork
P43 C838
Telephone/Fax: (021) 4377839
Website: www.sonascork.ie
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Roll No. 20162O

Name of Child/Adult:		
Date of Birth:	School: Sonas Special Junior Primary School Residence/Respite:	Prescribing Weight: (Children)

Seizure Classification /Description

1. Description of Seizure: (Include what happened before, during and after, description of seizure as observed)

2. Usual duration of Seizure: Length of time (Aprox) e.g. 3-5mins. Include usual recovery time

3. Usual frequency of Seizure: how often seizure occurs e.g. number of times a day, weekly, monthly:

4. Any triggers, particular environment, usual time:

5. Current Epilepsy Medication:

6. **Management of Seizure: Any particular way of managing the seizure- Specific instructions**

(*To be completed by Staff Team/ Parents/Guardians*)

Emergency Medication			
To be completed in consultation with prescribing Hospital Consultant or G.P.			
Name :			**Date of Birth:**
	Seizure Phase -Ist Line		**Prolonged Phase -2nd Line**
	Aura	Initial Dose	(Subsequent Dose)
Name of Emergency Medication:			
Dose to be administered:			
Route of Administration:			
Criteria for administration:	Administered when:	Administered when:	Administered when:

<u>Additional Instructions:</u>

Emergency Services should be contacted: (*Please Tick*)	
⇒ If it's the person's first seizure ⇒ If the seizure lasts longer than 5mins ⇒ Or longer than is normal for the person	⇒ If one seizure follows another without the person regaining consciousness ⇒ If the person is injured during the seizure ⇒ If the person needs medical attention

Does the person have to be hospitalised for the first dose of this medication?

Yes/No ____________________ (*Signature of Hospital Consultant /G.P.*)

If there are difficulties in the administration of _______________ what action should be taken?
Precautions: Are there any circumstances under which this emergency medication should not be given?
Prescribed By: _____________________ Date: ______________________ Review Date: ____________________

(*To be completed by Hospital Consultant OR G.P.)*

Sonas Special Junior Primary School	Roll No. 20162O
In the event of a Seizure Please Contact/ Inform:	
Parent/Guardian/ Advocate:	Mobile No:
Line Manager:	Mobile No
Medical Practitioner:	Contact No:
Other:	Contact No:

Authorised Staff trained to Administer Emergency Medication in the event of Seizures:

Print Name	Trained	Signature: Date:
Print Name	Trained	Signature: Date:
Print Name	Trained	Signature: Date:
Print Name	Trained	Signature: Date:
Print Name	Trained	Signature: Date:
Print Name	Trained	Signature: Date:
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Print Name	Trained	Signature: Date:

This Plan Has Been Agreed By:

Hospital Consultant / G.P.
(Signature) ______________________________ Date: ________________

Person/ Parent/ Guardian:
(Signature) _____________________________ Date: ________________

Area Manager /School Principal/Clinic Manager)
(On behalf of the organisation) ______________________________ Date: ________________

Please Note:
ONLY Authorised, trained staff, currently certified are covered to administer Emergency Medication. (*Staff must be re-certified every 2 years*)

This Plan should be available for examination at every medical review for this person.

Copies to be held by: ______________________ Plan Review Date: ________________________

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l Seizure Diary	Date	Recorded By:	Type of Seizure	Length &/or number of Seizures	<u>First Line</u> Initial Dose (or Aura)	Outcome: Full Recovery Ambulance	<u>Second Line</u> (If Any) Subsequent Dose	Outcome	Observations:	Parent/Guardian Informed	Medical Practitioner Informed	Other Information	Re-Order Emergency Rescue Medication	Name of Person Re-ordering	Date & Signature