

Sonas

Special Junior Primary School
Cork Road, Carrigaline, Co. Cork
P43 C838
Telephone/Fax: (021) 4377839
Website: www.sonascork.ie
Email: admin@sonascork.ie



Roll No. 201620

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 medical practitioner. A child with a temperature of over 37°C

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 steroids 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. Teachers will regularly check medication dates and inform parents if expiry date is approaching.

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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: _____
Parents

Date: _____

Signed: _____
Class Teacher

Date: _____

Signed: _____
Principal.

Date: _____

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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:

Parents Signature: _____

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Name of Child/Adult:

Date of Birth:

School: Sonas Special Junior Primary School

Prescribing Weight:
(Children)

Residence/Respite:

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)

Reviewed and ratified by Sonas Board of Management on September 28th 2016

Emergency Medication

To be completed in consultation with prescribing Hospital Consultant or G.P.

Name :

Date of Birth:

	Seizure Phase ~1 st Line		Prolonged Phase ~2 nd 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:

Additional Instructions:

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.)

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:
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: _____

