Appendix 1 Templates
Supporting Pupils in Schools with Medical Conditions

Schools may wish to amend these forms to include their logo or adapt them for their particular policies on the administration of medicine but please ensure that all information on the standard form is included.

Please note Template I should not be amended, as the Paediatric Community Service has produced this form.

Template A: individual healthcare plan

Insert Pupil's Photo

Name of school/setting	
Child's name	
Group/class/form	
Date of birth	
Child's address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information

Name	
Phone no. (work)	
(home)	
(mobile)	
Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

G.P.

Name	
Phone no.	

Who is responsible for providing support in school	

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the pupil's educational, social and emotional needs

Arrangements for school visits/trips etc

Other information

Describe what constitutes an emergency, and the action to take if this occurs

Who is responsible in an emergency *(state if different for off-site activities)*

Plan developed with

Staff training needed/undertaken – who, what, when

Form copied to

Signed by: ……..

Job Title: ……

Date: ……...

Signed by: ……..

Name of Parent: ……

Date: ……...

Template B: parental agreement for school to administer medicine

The school will not give your child medicine unless you complete and sign this form.

Date for review to be initiated by	
Name of school/setting	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*		
Expiry date		
Dosage and method		
Timing		
Special precautions/other instructions		
Are there any side effects that the school/setting needs to know about?		
Self-administration – y/n		
Procedures to take in an emergency		
Prescription/Non-Prescription (Delete as appropriate)	Prescription	Non-prescription

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[agreed 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 staff administering medicine in accordance with the school's policy.

Prescribed Medication: I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped. *(delete as appropriate)*

Non-prescription medication: I confirm that I have administered this non-prescription medication, without adverse effect, to my child in the past. I will inform the school immediately, in writing, if my child subsequently is adversely affected by the above medication. *(delete as appropriate)*

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

Signature(s) _____ Date _____

Template C: confirmation of the Headteacher's agreement to administer medicine

Name of School _____

It is agreed that **……..** (*name of pupil)* will receive **……** **(***quantity and name of medicine)* every day at **……** **(***time medicine to be administered e.g. Lunchtime or afternoon break)*.

…… **(***name of pupil)* 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].*

Date: _____

Signed: _____

(The Headteacher/Named Member of Staff)

Template D: 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 _____

Signature of parent _____

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

D: Record of medicine administered to an individual child (Continued)

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			

Template E: record of medicine administered to all children

Name of school

Date	Child's name	Time	Name of medicine	Batch Number	Dose given	Any reactions	Signature	Print name of staff	**Reason for Administration**
/ /									
/ /									
/ /									
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Template F: request for child to carry his/her medicine

THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN

If staff have any concerns they should discuss this request with school healthcare professionals

Name of School: _____

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.

Template G: 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 [name of member of staff].

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

Template H: authorisation for the administration of rectal diazepam

Name of School

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:

NB: Authorisation for the Administration of Rectal Diazepam

As the indications of when to administer the diazepam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state:

- when the diazepam is to be given e.g. after 5 minutes; and
- how much medicine should be given.

  Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

Records of administration should be maintained using Template D or similar

Buckinghamshire NHS
Primary Care Trust

Template I: authorisation for the administration of Buccal Midazolam

PERSONAL DETAILS		
Name of Child/Young Person:	**Address:**	**Child/Young Person's Photo**
Date of Birth:	**GP:**	
Name of School:	**Next of Kin**:	
Date Health Care Plan Completed:	**Date to be Reviewed:**	
Family Contact 1	**Family Contact 2**	
Name:	Name:	
Phone No: (Home):	Phone No: (Home):	
(Work):	(Work):	
(Mobile):	(Mobile):	
Relationship:	Relationship:	
The Midazolam is kept in the medical cabinet in the first aid room. **Keys held by:**		

Emergency Medication

- Start timing seizure
- If seizure not resolved within 5 minutes
- Administer Midazolam into the buccal cavity between cheek and lower gums
- Dial 999
- Watch breathing does not become shallow
- Put person in recovery position

Midazolam Dose
In mg / ml

PARENT	Signature	Date
HEAD TEACHER:	Signature	Date
HEALTHCARE PROFESSIONAL:	Signature	Date

Note for parents: Parents/carers are reminded of the importance of informing school of any changes in treatment/medication or ongoing concerns/changes in seizure patterns.

Template J: contacting emergency services

Request an ambulance - dial 999, ask for an ambulance and be ready with the information below.

Speak clearly and slowly and be ready to repeat information if asked.

1. your telephone number
2. your name
3. your location as follows [insert school/setting address]
4. state what the postcode is – please note that postcodes for satellite navigation systems may differ from the postal code
5. provide the exact location of the patient within the school setting
6. provide the name of the child and a brief description of their symptoms
7. inform Ambulance Control of the best entrance to use and state that the crew will be met and taken to the patient
8. put a completed copy of this form by the phone

Template K: model letter inviting parents to contribute to individual healthcare plan development

Dear Parent

DEVELOPING AN INDIVIDUAL HEALTHCARE PLAN FOR YOUR CHILD

Thank you for informing us of your child's medical condition. I enclose a copy of the school's policy for supporting pupils at school with medical conditions for your information.

A central requirement of the policy is for an individual healthcare plan to be prepared, setting out what support the each pupil needs and how this will be provided. Individual healthcare plans are developed in partnership between the school, parents, pupils, and the relevant healthcare professional who can advise on your child's case. The aim is to ensure that we know how to support your child effectively and to provide clarity about what needs to be done, when and by whom. Although individual healthcare plans are likely to be helpful in the majority of cases, it is possible that not all children will require one. We will need to make judgements about how your child's medical condition impacts on their ability to participate fully in school life, and the level of detail within plans will depend on the complexity of their condition and the degree of support needed.

A meeting to start the process of developing your child's individual health care plan has been scheduled for xx/xx/xx. I hope that this is convenient for you and would be grateful if you could confirm whether you are able to attend. The meeting will involve [the following people]. Please let us know if you would like us to invite another medical practitioner, healthcare professional or specialist and provide any other evidence you would like us to consider at the meeting as soon as possible.

If you are unable to attend, it would be helpful if you could complete the attached individual healthcare plan template and return it, together with any relevant evidence, for consideration at the meeting. I [or another member of staff involved in plan development or pupil support] would be happy for you contact me [them] by email or to speak by phone if this would be helpful.

Yours sincerely

Template L: parent consent form – use of emergency salbutamol inhaler

…… *(insert school name)*

Child showing symptoms of asthma / having asthma attack

1. I can confirm that my child has been diagnosed with asthma / has been prescribed an inhaler *(delete as appropriate)*.

2. My child has a working, in-date inhaler, clearly labelled with their name, which they will bring with them to school every day.

3. In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.

Signed: ……..Date: ……..

Name (print)……

Child's name: ……...

Class: …….

Parent's address and contact details:

……

……

……

Telephone: ……

E-mail: ……

Template M: letter to inform parents of emergency salbutamol inhaler use

Child's name: ……

Class: …… Date: ……

Dear……..,

This letter is to formally notify you that…….has had problems with his / her breathing today. *(Delete as appropriate)*

This happened when……..

A member of staff helped them to use their asthma inhaler.
They did not have their own asthma inhaler with them, so a member of staff helped them to use the emergency asthma inhaler containing salbutamol. They were given …… puffs.
Their own asthma inhaler was not working, so a member of staff helped them to use the emergency asthma inhaler containing salbutamol. They were given …… puffs.

(delete as appropriate)

Although they soon felt better, we would strongly advise that you have your seen by your own doctor as soon as possible.

Yours sincerely,

Template N: witnessing a seizure (use this table to help record your observations)

Before the Seizure					
Location	Classroom	Playground	Sports Hall	Dining Area	Other
Precipitating Factors	None	Anxious	Stressed	Tired	Other
Preceding symptoms/feelings	Irritable	Impulsive	Nauseous	Strange Sensations	Other
Position at onset	Sitting	Standing	Lying	Other	

During the Seizure					
Time at onset					
Did the child fall?	Yes/No	Forwards/Backwards	Description		
Breathing	Rapid	Shallow	Deep	Laboured	
Colour	Note any changes in skin tone, particularly around the mouth and extremities				
Movements	Describe any movement of:				
	Head				
	Arms				
	Legs				
	Eyes	Deviated to the left?	Deviated to the Right?	Pupils dilated?	Comment
Level of awareness/ responsiveness	Fully aware	Reduced awareness	Responsive to voice	Responsive to touch	No responses
Any injury?	Tongue	Limbs	Head	Other	
Incontinence	Urinary: Yes/No		Faecal: Yes/No		
Time at end of seizure		Duration of Seizure			

Template N: witnessing a seizure (use this table to help record your observations)

witnessing a seizure continued

Action Taken				
After the seizure (briefly describe each of the following)				
Level of alertness: Immediately following seizure: 5 minutes after seizure:				
Maintenance of alertness				
Confusion				
Muscle weakness				
Duration of event				
Total recovery time				
Treatment given	Medication:	Dose:	Time given:	Response:
Parents informed				
Signed				
Print Name				
Date		Time		

Template O: how to recognise an asthma attack

HOW TO RECOGNISE AN ASTHMA ATTACK

The signs of an asthma attack are

- Persistent cough (when at rest)
- A wheezing sound coming from the chest (when at rest)
- Difficulty breathing (the child could be breathing fast and with effort, using all accessory muscles in the upper body)
- Nasal flaring
- Unable to talk or complete sentences. Some children will go very quiet.
- May try to tell you that their chest 'feels tight' (younger children may express this as tummy ache)

CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD

- Appears exhausted
- Has a blue/white tinge around lips
- Is going blue
- Has collapsed

Template P: what to do in the event of an asthma attack

WHAT TO DO IN THE EVENT OF ASTHMA ATTACK

- Encourage the child to sit up and slightly forward
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with the child while the inhaler and spacer are brought to them
- Immediately help the child to take two puffs of salbutamol via the spacer
- If there is no immediate improvement, continue to give two puffs at a time every two minutes, up to a maximum of 10 puffs
- Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better
- If the child does not feel better or you are worried at ANYTIME before you have reached 10 puffs,
  - CALL 999 FOR AN AMBULANCE
- If an ambulance does not arrive in 10 minutes give another 10 puffs in the same way