*** ADMINISTRATION OF MEDICATION POLICY***

***SCOIL TRIEST.***

The Board of Management of Scoil Triest is committed to ensure the safety of students with chronic health conditions. This policy reflects guidance on the administration and storage of medication in school. “Managing Chronic Health Conditions at School” – a resource pack for teachers and parents is circulated to classes in which students present with chronic health conditions.

The Board of Management Scoil Triest requests that parents inform teachers in writing of any medical condition suffered by a child in their class. Students 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 Scoil Triest can only be done under strictly controlled guidelines.

The Board of Management, Scoil Triest advises that:

Parents of the pupil concerned should write to the Board of Management requesting the Board to authorise members of staff to administer the medication and indemnifying the Board of Management, Scoil Triest from and against all claims which may arise regarding administration of medication. (Appendix A)

The Board of Management, having considered parental request, will authorise named staff to administer the medication. The principal will seek volunteers from teachers and special needs assistants to administer medication. Staff will receive appropriate training on chronic conditions and what to do in an emergency.

Only medications prescribed by a registered medical practitioner will be administered. Paracetemol, calpol etc. are also required to be prescribed by the G.P. The following information from the G.P. is required by the Board of Management (Appendix B):

* Student’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.

In the case of children who have epilepsy and require stesloid or buccal midazolin to be administered, it is necessary that all staff working with them will require formal training from qualified health personnel. Scoil Triest Epilepsy Seizure Care Plan is required to be completed by relevant personnel for all students who have been diagnosed with epilepsy. (Appendix C)

* 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.
* 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 38 ˚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.
* Epilepsy rescue medication (Buccal Midazolin) does not need to be signed for each day but must be transferred from bus escort to school staff. This medication must be with the staff accompanying the student at all times.
* Other medicines such as paracetamol, Ritalin, Rispirodol etc. must be sent to school in a child proof container which is clearly pharmacy labelled with student’s name and has clear instruction from the G.P/Consultant .All medication should be stored in a locked medication box in the classroom store cupboard.
* When students are attending respite and have medication prescribed, all medication should be accounted for on the medication handover sheet which is signed by parent, escort, school staff, and respite staff. On return from respite visit, the signing process is in reverse. School staff also sign the respite handover sheet as well as Scoil Triest medication handover sheet.

*REF: “Managing Chronic Health Conditions at School” - A Resource pack for teachers and parents.*

*Written by - Asthma Society of Ireland, Diabetes Federation of Ireland, Brainwave The Irish Epilepsy Association and Anaphylaxis Ireland.*





**Scoil Triest Special School**

**Lota, Glanmire, Co Cork**

**021 4556284/4556280/4822916**

**Fax: 021 4821711**

**email: info@scoiltriest.ie**

**Roll No: 19760E**

Appendix A

Dear Chairperson,

I am requesting the Board of Management to authorise staff of Scoil Triest to administer medication to \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

As parents of \_\_\_\_\_\_\_\_\_\_\_ we hereby indemnify the Board of Management, Scoil Triest 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.





**Scoil Triest Special School**

**Lota, Glanmire, Co Cork**

**021 4556284/4556280/4822916**

**Fax: 021 4821711**

**email: info@scoiltriest.ie**

**Roll No: 19760E**

Appendix B

*INSTRUCTION DOCUMENT*

***ADMINISTERING OF MEDICATION PROTOCOL***

Name of student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name and Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent’s Name and Contact details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*INSTRUCTIONS FOR ADMINISTERING MEDICATION – attached*

***Signatures of Authorised Persons:***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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***Parents Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Appendix C: SCOIL TRIEST EPILEPSY SEIZURE CARE PLAN**

|  |  |  |
| --- | --- | --- |
| Name of Child/Adult: | | |
| Date of Birth: | 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) | | |
| 1. Usual **duration** of Seizure: Length of time (Approx.) e.g. 3-5mins. Include usual recovery time | | |
| 1. Usual **frequency** of Seizure: how often seizure occurs e.g. number of times a day, weekly, monthly: | | |
| 1. Any **triggers**, particular environment, usual time: | | |
| 1. Current Epilepsy **Medication**: | | |
| 1. **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:** |
| Name of Emergency  Medication: | **Seizure Phase -1st Line** | | | **Prolonged Phase -2nd Line**    (Subsequent Dose) |
| Aura | Initial Dose | |
|  |  | |  |
| 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: | |
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| Print Name Trained Signature:  Date: | |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

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| **Seizure Diary** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Date** | **Recorded By:** | **Type of Seizure** | **Length & /or number of Seizures** | **First Line**  **Initial Dose (or Aura)** | **Outcome: Full Recovery**  **Ambulance** | **Second Line ( 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** |

***APPENDIX D: MEDICATION HANDOVER SHEET***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***SCOIL TRIEST – CLASS : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | | | | | | | | | | | | | |
| ***NAME OF STUDENT*** | ***DATE*** | ***NAME OF MEDICATION*** | *Handed over by*  *Parent* | *Received by*  *Escort* | *Received by*  *Staff* | *Handed over by*  *Staff* | *Received by*  *Respite* | *Handed over by*  *Respite* | *Received by*  *Staff* | *Handed over by*  *Staff* | *Received by*  *Escort* | *Received by*  *Parent* |
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