



Medical Needs Policy

Form 1: Contacting emergency services

**Request for an Ambulance**

- Dial **999**, ask for an ambulance, and be ready with the following information where possible.
- State your telephone number. **01978 352406**
- Give your location as follows: **ST MARY'CATHOLIC PRIMARY SCHOOL, WREXHAM**
- State that the postcode is: LL13 7NA- **STATE NEED TO ACCESS SCHOOL VIA TENTER'S SQUARE AND NOT LEA ROAD .**
- Give the exact location in the education setting:
- Give your name.
- Give the name of the learner and a brief description of symptoms.
- Inform Ambulance Control of the best entrance and state that the crew will be met and taken to [**name location**]. i.e. **Via TENTERS LANE / SCHOOL DRIVE**
- Don't hang up until the information has been repeated back. Speak clearly and slowly and be ready to repeat information if asked to.

**Put a completed copy of this form by all the telephones.**

**St Mary's Catholic Primary School**  
**Medical Needs Policy**



**Form 2: Parental agreement for school to supervise/ administer medication**

**St Mary's Catholic Primary School needs your permission to supervise/ give your child medicine. Please complete and sign this form to allow this.**

**Name of Child :**  **Date of Birth :**  **Class:**

**Healthcare Need:**

**Medication**

**Name/ type of medication (as described on the container)**

**Date dispensed:**  /  /  **Expiry date:**  /  /

**Agreed review date to be initiated by ( \_\_\_\_\_ )**  
**Name of staff member.**

**Dosage and method:**

**Timing:**

**Special precautions:**

**Are there any side effects that we should be aware of?**

**Self administration:** Yes/ No

**Procedures to take in an emergency:**

**St Mary's Catholic Primary School**  
**Medical Needs Policy**



**Form 2: Parental agreement for school to supervise/ administer medication**

**Contact details**

**Name of Parent:**

**Daytime telephone number/s:**

**Relationship to child:**

**Address:**

**I understand that I must deliver the medicine personally to the school office– Mrs Beccy Pugh/ Mrs Katherine Davies or ( ) agreed member of staff.**

**I understand that I must notify the school of any changes in writing,**

**Date:**

**Signature/s:**

**St Mary's Catholic Primary School**  
**Medical Needs Policy**



**Form 3: Headteacher agreement to administer medication at St Mary's Catholic Primary School**

It is agreed that (name of learner):

will receive (quantity or quantity range and name of medication)

every day at \_\_\_\_\_ (time to be administered e.g lunchtime/ morning break)

Name of learner:

will be supervised while they take their medication by \_\_\_\_\_ (member of staff)

This arrangement will continue until (either end date of the course of medication or until instructed by parents/ carers.) \_\_\_\_\_

Date: \_\_\_\_\_

Signed \_\_\_\_\_ (Headteacher/ Assistant Headteacher)



**St Mary's Catholic Primary School**  
**Medical Needs Policy**



**Form 5: Request for learner to carry and administer own medication.**

**This form must be completed by the parent/ carer**

**If staff have any concerns discuss the request with healthcare professionals.**

**Learner's name:** \_\_\_\_\_

**Class:** \_\_\_\_\_

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

**Name of medication:** \_\_\_\_\_

**Carry and administer:**

**Administer from a stored location:**

**Procedures to be taken in an emergency:**

**Contact information:**

**Parent/s name:** \_\_\_\_\_ **Relationship to child;** \_\_\_\_\_

**Daytime contact details** \_\_\_\_\_

**I would like my child to carry and administer their own medication**

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**I agree to carry and administer my own medication. If I do not take my medication as agreed, then this agreement will be reviewed.**

**Learner's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**St Mary's Catholic Primary School**  
**Medical Needs Policy**



**Form 6: Staff Training Record for members of staff with responsibility for supervision of pupils with specific healthcare needs.**

**Please ensure the EWC registration is updated accordingly.**

**Name:** \_\_\_\_\_

**Type of training received:** \_\_\_\_\_

**Date training completed:** \_\_\_\_\_ -

**Training provided by:** \_\_\_\_\_

**Profession and title:** \_\_\_\_\_

I confirm that (name of staff member ) \_\_\_\_\_ has received the training detailed above and is competent to carry out necessary treatment.

I recommend that the training is updated (state how often)

\_\_\_\_\_  
**Trainer's signature:** \_\_\_\_\_

**Date** \_\_\_\_\_

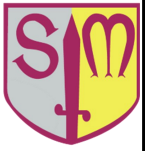
I confirm that I have received the training detailed above.

**Staff signature:** \_\_\_\_\_

**Date** \_\_\_\_\_

**Suggested review date** \_\_\_\_\_

**St Mary's Catholic Primary School**  
**Medical Needs Policy**



**Form 7: Medication/ healthcare incident report (pt 1)**

**Learner's name** \_\_\_\_\_

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

**Telephone number:** \_\_\_\_\_

**Date and time of incident:** \_\_\_\_\_

**Correct medication and dosage:** \_\_\_\_\_  
\_\_\_\_\_

**Medication normally administered by:**

**Learner**

**Learner with staff supervision**

**Nurse/ school staff member**

**Type of error:**

**Dose administered 30 minutes after scheduled time:**

**Omission:**  **Wrong dose:**  **Additional dose:**

**Wrong learner:**

**Dose given without permission on file:**  **Dietary:**

**Dose given by unauthorised person:**

**Description of incident:**



**St Mary's Catholic Primary School**  
**Medical Needs Policy**



**Form 7: Medication/ healthcare incident report (pt 2)**

**Action taken:**

Parent notified: name, date and time

---

School nurse notified: name, date and time

Physician notified: name, date and time

Poison control notified

Learner taken home

Learner sent to hospital

Other \_\_\_\_\_

**Notes:**