18/05/2018

ROSEMOUNT PRIMARY & NURSERY SCHOOL

HELEN STREET, DERRY BT48 9DD 028 71265605

FORM AM1 MEDICATION PLAN FOR A PUPIL WITH MEDICAL NEEDS

Date _____ **Review Date** _____

Name of Pupil _____

Date of Birth ____/____/_____

Class _____

National Health Number _____

Medical Diagnosis _____

Contact Information

1 Family contact 1

Name _____

Phone No: (home/mobile) _____

(work) _____

Relationship _____

2 Family contact 2

Name _____

Phone No: (home/mobile) _____

(work) _____

Relationship _____

3 GP

Name _____

Phone No _____

4 Clinic/Hospital Contact

Name _____

Phone No: _____

Plan prepared by:

Name _____

Designation _____ Date _____

FORM AM1

continued

Describe condition and give details of pupil's individual symptoms:

Daily care requirements (e.g. before sport, dietary, therapy, nursing needs)

Members of staff trained to administer medication for this child
(state if different for off-site activities)

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

Follow up care

I agree that the medical information contained in this form may be shared with individuals involved with the care and education of

Signed _____ **Date** _____
Parent/carer

Distribution

School Doctor _____ School Nurse _____

Parent _____ Other _____

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FORM AM3 REQUEST FOR PUPIL TO CARRY HIS/HER MEDICATION

This form must be completed by parents/carers

Surname _____ Forenames(s) _____

Address _____

_____

Date of Birth ____ / ____/_____

Class _____

Condition or illness _____

_____

Medication

Parents must ensure that in date properly labelled medication is supplied.

Name of Medicine

_____

Procedures to be taken in an emergency

_____

_____

Contact Details

Name _____

Phone No: (home/mobile)_____
(work) _____

Relationship to child _____

I would like my child to keep his/her medication on him/her for use as necessary

Signed _____ **Date** _____

Relationship to child _____

Agreement of Principal

I agree that _____ (name of child) will be allowed to carry and self-administer his/her medication whilst in school and that this arrangement will continue until _____ (either end date of course of medication or until instructed by parents)

Signed _____ **Date** _____

The Principal/authorised member of staff

The original should be retained on the school file and a copy sent to the parents to confirm the school's agreement to the named pupil carrying his/her own

ROSEMOUNT PRIMARY & NURSERY SCHOOL

Helen Street, Derry BT48 9DD Tele No: 028 71265605

FORM AM4 Record of medicine administered to an individual child

Surname	
Forename (s)	
Date of Birth	___ /____ / ___ M ☐ F ☐
Class	
Condition or illness	
Date medicine provided by parent	
Name and strength of medicine	
Quantity received	
Expiry date	____ / ____ / ____
Quantity returned	
Dose and frequency of medicine	

Checked by:

Staff signature _____ **Signature of parent** _____

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

ROSEMOUNT PRIMARY & NURSERY SCHOOL **FORM AM4 (Continued)**

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

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Staff signature _____ **Signature of parent** _____

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
Time given			
Dose given			
Any reactions			
Name of member of staff			
Staff initials			

Date	___ / ___ / ___	___ / ___ / ___	___ / ___ / ___
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Dose given			
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Staff initials			