**HBEEC – ‘ADMINISTRATION OF MEDICATION AT SCHOOL CAMPS**

**SURNAME: ………………**

# **NON ROUTINE AND ROUTINE/SHORT TERM MEDICATION**

Emergency medication requires an ***Administration of medication at school (emergency medication)* form** (eg.Ventolin/Epipen/Midazolam)

**Privacy Statement:** The Department of Education (DoE) is collecting this personal information for the purpose of enabling school staff to administer the necessary medication to your child while at school camp. This information will only be accessed by authorised departmental employees, including school staff. In accordance with section 426 of the Education (General Provisions) Act 2006 (regarding student’s personal information) and the Information Privacy Act 2009 (parent/carer’s personal information) this information will not be disclosed to any other person or body unless you have given DoE permission or DoE is required or authorised by law to disclose the information.

|  |
| --- |
| ***Parents complete shaded section*** |
| **School Name** |  | **Camp Dates** |  / / to / /  |
| **Camp Name &/or Location** |  | Insert Student Photo ID  |
| **Student Name** |  | **DOB** |  / / |
| **Parent/Carer Name** |  | **Contact numbers** |  |
| **PARENT CONSENT:** I give consent for DoE school staff to administer to my child, the medication I have provided and named in this form, during this school camp, in line with the process outlined in this form. |
| **Parent/Carer Signature** |  | **Date** |  / / |

**This form is only to be used for school camps and only for the:**

* **recording of the administration of prescribed routine/short term medication on parent request**
* **recording of the administration of other non-routine medications (e.g. paracetamol, ibuprofen) under parent instructions**

**ADMINISTERING NON ROUTINE MEDICATION**

***Prior to administering NON ROUTINE MEDICATION:*** Confirm that:

1. The parent has completed the shaded sections of this form;
2. The original medication package has a valid pharmacy label which includes the name of the medical practitioner (to confirm that it is prescription medication); and the pharmacy label instructions match the medication information section of the request to administer form
3. The parent has been contacted, has provided clear instructions for administration and has confirmed that the student has previously received the medication with no ill effect.

***After administrating NON ROUTINE MEDICATION, complete notes in relevant box with sufficient detail.***

*Contact the parent if the medication has not been supplied for administration, if the student refuses to take the medication or if any non-routine medications are required.*

Below is **an example** of a completed recording for other non-routine medication e.g. paracetamol

|  |  |
| --- | --- |
| The parent is contacted immediately prior to the administration of the medication and must confirm that the student has previously received this medication with no ill effects. | ***Staff use only -*** **Notes below must include:**Date/Time/Contact with parent/Instructions from parent/Medication administered/Signature |
| **Medication Name** | *PANADOL* | 20/3/2018 At 7 pm Jake stated he has a headache. Has been drinking water but it has not improved.Mother contacted and requested he have one tab of Panadol - given at 7.15pm Susan Smith |
| **Strength(e.g. 100mg)** | *500mg* | **Dose** | *1 tablet* |
| **Route ( e.g. oral)** | *Oral*  |
| **Additional information** | *May be needed for headache* |

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| **ADMINISTERING NON ROUTINE MEDICATION (e.g. paracetamol, ibuprofen, antihistamine)** |
| ***Parents complete shaded section – please print clearly*** | ***Staff use only -*** **Notes below must include:**Date /Time /Contact with parent/Instructions from parent/Medication administered /Signature |
| The parent is contacted immediately prior to the administration of the medication and must confirm that the student has previously received this medication with no ill effects. |
| **Medication Name** |  |  |
| **Strength(e.g. 100mg)** |  | **Dose** |  |
| **Route ( e.g. oral)** |  |
| **Additional information** |  |
| **Medication Name** |  |  |
| **Strength(e.g. 100mg)** |  | **Dose**  |  |
| **Route ( e.g. oral)** |  |
| **Additional information** |  |

**HBEEC – ‘ADMINISTRATION OF MEDICATION AT SCHOOL CAMPS SURNAME: ………………**

# **ADMINISTERING ROUTINE/SHORT TERM MEDICATION**

***Prior to administering ROUTINE/SHORT TERM MEDICATION:*** Confirm that:

1. The parent has completed the relevant shaded sections of this form;
2. The original medication package has a valid pharmacy label which includes the name of the medical practitioner (to confirm that it is prescription medication); and the pharmacy label instructions match the medication information section of the request to administer form

***After administrating ROUTINE/SHORT TERM MEDICATION, initial the appropriate box to confirm that the medication was administered.***

Below is **an example** of a completed prescribed routine/short term medication request

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date  Time to be given | *26/3/18* | *27/3/18* | *28/3/18* | *29/3/18* | *30/3/18* |
| **Medication Name** | *EPILIM* | *7am* | AG | AG |  |  |  |
| **Strength (e.g. 100 mg)** | *500mg* | **Dose** | *One tablet* | *1pm* | AG |  |  |  |  |
| **Route (e.g. Oral)** | *oral* | *8pm* | AG |  |  |  |  |
| **Additional information** | *Give with food or glass of milk* |  |  |  |  |  |  |

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| **ADMINISTERING ROUTINE/SHORT TERM MEDICATION** |
| ***Parents complete shaded section – please print clearly*** |
| **Student Name:**  | ***Staff use only:*** Staff administering medications must initial to indicate date and time of dosage |
| **School: DOB:** |
| 1 CONDITION Date  Time to be given |  |  |  |  |  |
| **Medication Name** |  |  |  |  |  |  |  |
| **Strength (e.g. 100 mg)** |  | **Dose** |  |  |  |  |  |  |  |
| **Route (e.g. Oral)** |  |  |  |  |  |  |  |
| **Additional information** |  |  |  |  |  |  |  |
| 2 CONDITION Date  Time to be given |  |  |  |  |  |
| **Medication Name** |  |  |  |  |  |  |  |
| **Strength (e.g. 100 mg)** |  | **Dose** |  |  |  |  |  |  |  |
| **Route (e.g. Oral)** |  |  |  |  |  |  |  |
| **Additional information** |  |  |  |  |  |  |  |
| 3 CONDITION Date  Time to be given |  |  |  |  |  |
| **Medication Name** |  |  |  |  |  |  |  |
| **Strength (e.g. 100 mg)** |  | **Dose** |  |  |  |  |  |  |  |
| **Route (e.g. Oral)** |  |  |  |  |  |  |  |
| **Additional information** |  |  |  |  |  |  |  |
| 4 CONDITION Date Time to be given |  |  |  |  |  |
| **Medication Name** |  |  |  |  |  |  |  |
| **Strength (e.g. 100 mg)** |  | **Dose** |  |  |  |  |  |  |  |
| **Route (e.g. Oral)** |  |  |  |  |  |  |  |
| **Additional information** |  |  |  |  |  |  |  |

**HBEEC – ADMINISTRATION OF MEDICATION AT SCHOOL RECORD SHEET SURNAME: ………………**

**(EMERGENCY MEDICATION)**

| *Section 1 – Details of emergency medication which may be required to be administered by school staff (Parent/Carer to complete)* | *Insert student* *photo below.* |
| --- | --- |
| **Student name** |  | **Date of birth** |  |
| **Parent/carer name** |  | **Contact phone number** |  |  |
| I hereby request that school staff administer the following emergency medication to my child, if required, during school or school-related activities, as specified in this section |
| **Name of medication** | **Dosage****(e.g. 1 tablet)** | **Strength****(e.g. 10mg)** | **Route (e.g. oral)** | **Indications for use** **(e.g. instructions for when and how this medication is to be administered)**  |
|  |  |  |  |  |
| **Additional information** |  |
| **Parent/carer signature** |  | **Date** |  |
| *Section 2 – Record of administration of a student’s prescribed emergency medication (School use only)* |
| **Date** | **Time** | **Dose given** | **Emergency services contacted** | **Outcome** | **Signature** |
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🞏 Parent/carer has collected unused medication that is no longer required to be administered at school.