

Early Years Medication Forms

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Please print and complete the appropriate form. Medication administration should be appropriately documented following the School/Nursery Medication Administration Record.

Prescribed controlled drugs, such as Methylphenidate, require the signature of a witness and staff should use the School Medication Record for Methylphenidate found within Appendix 12.

Form 1: Request for nursery to issue non-prescribed medication - Paracetamol

This form may be used exclusively for paracetamol and should be completed daily with medication returned to parent/carer on collection.

For queries regarding other non-prescribed medication, or required for more than 7 days, please contact the ASL Nurse [ASLS.Healthcare@ea.edin.sch.uk].

To be completed **daily** by the parent/carer

Pupil's name	Date of birth
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I request that the above pupil be given the following medication while at nursery:

Name of Medication	Dose to be given	Minimum time between doses	Date & time of last dose
<u>Paracetamol</u> (120mg/5ml oral suspension)		<u>4 hours</u> (MAX 4 doses in 24 hours)	



Please list the symptoms for which the medication is to be given OR note set times to administer:

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If there are any concerns regarding administering the medication, adverse reaction or medication does not have desired effect, parents will be contacted as soon as possible to discuss next steps.

Medication is provided in the container in which it was purchased and is clearly labeled with the child's name in full and the dose to be given. I have given the first dose of this medication to my child and no adverse reaction has been observed.

I realise that this is not a service that the nursery is obliged to undertake. I accept responsibility for informing the nursery if my child has been given a dose of this medication before attending today. I accept responsibility for ensuring that the medicine has not expired and that there will be enough medicine supplied to the nursery for my child's needs.

Parent/carer's name (please print)	
 Contact 1:	 Contact 2:
Signature	Date

Note: The nursery will not accept medication unless this form is completed and signed by the parent/carer of the child and the nursery manager agrees the administration of the medication. The nursery manager reserves the right to withdraw this service.

Form 2: Request for nursery to issue non-prescribed topical creams

This form may be used exclusively for non-steroid topical creams (i.e. nappy ointment, moisturiser, emollients, sun cream) and should be reviewed every 3 months.

For queries regarding other non-prescribed medication please contact the ASL Nurse [ASLS.Healthcare@ea.edin.sch.uk].

To be completed by the parent/carer

Pupil's name	Date of birth
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I request that the above pupil be given the following product while at nursery:

Name of Product	Amount to be given	Minimum time between application	Date & time of last application



Please list the symptoms for which the cream is to be given OR note set times to administer:

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If there are any concerns regarding administering, adverse reaction or does not have desired effect, parents will be contacted as soon as possible to discuss next steps.

Product is provided in the container in which it was purchased and is clearly labeled with the child's name in full. I have applied this product to my child and no adverse reaction has been observed.

I realise that this is not a service that the nursery is obliged to undertake. I accept responsibility for informing the nursery if my child has required an application before attending nursery. I accept responsibility for ensuring that the product has not expired and that there will be enough supplied to the nursery for my child's needs.

Parent/carer's name (please print)	
 Contact 1:	 Contact 2:
Signature	Date

Note: The nursery will not accept topical creams unless this form is completed and signed by the parent/carer of the child and the nursery manager is in agreement. The nursery manager reserves the right to withdraw this service.

Form 3: Request for nursery to issue prescribed medication

To be completed by the parent/carer

Pupil's name	Date of birth
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I request that the above pupil be given the following prescribed medication while at nursery. I have given the first dose of this medication to my child and no adverse reaction has been observed:

Name of Medication	Dose to be given	Route of administration (i.e. oral/topical)	Time/s of dose to be given

Please note any special instructions (i.e. taken with food or on empty stomach, preparation or storage instructions, symptoms which indicate medication required)

Start date of prescription:	End date of Prescription: (please state N/A if long-term medication)
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If any concerns arise regarding administering the medication, adverse reactions or medication does not have desired effect, parents will be contacted as soon as possible to discuss next steps.

The GP, pharmacist or hospital doctor has prescribed the above medication. It is in the container in which it was dispensed, clearly labeled with the contents, dosage and child's name in full.

I realise that this is not a service that the nursery is obliged to undertake. I accept responsibility for informing the nursery if my child has been given a dose of this medication before coming to nursery. I accept responsibility for ensuring that the medicine has not expired and that there will be enough medicine supplied for my child's needs. I will collect any unused medication at the end of the period the medication is prescribed for.

Name of GP/Pharmacy:	
Address of GP/Pharmacy:	GP/Pharmacy:
Parent/carer's name (please print):	
Contact 1:	Contact 2:
Signature:	Date:

Form valid for 3 months from date of signature.

Note: The nursery will not accept medication unless this form is completed and signed by the parent/carer of the pupil and the nursery manager agrees the administration of the medication. The nursery manager reserves the right to withdraw this service.

Form 4: Request for nursery to issue long-term 'as required' prescribed medication

To be completed by parent/carer

Pupil's name	Date of birth
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I request that the above pupil be given the following prescribed medication while at nursery. I have given the first dose of this medication to my child and no adverse reaction has been observed:

Name of Medication	Dose to be given	Route of administration (i.e. oral/topical)	Minimum time between doses
Symptoms which indicate medication required:			
Additional information (i.e. preparation or storage instructions):			

If any concerns arise regarding administering the medication, adverse reactions or medication does not have desired effect, parents will be contacted as soon as possible to discuss next steps.

The GP, pharmacist or hospital doctor has prescribed the above medication. It is in the container in which it was dispensed, clearly labeled with the contents, dosage and child's name in full.

I realise that this is not a service that the nursery is obliged to undertake. I accept responsibility for informing the nursery if my child has been given a dose of this medication before coming to nursery. I accept responsibility for ensuring that the medicine has not expired and that there will be enough medicine supplied for my child's needs. I will collect any unused medication at the end of the period the medication is prescribed for.

Name of GP/Pharmacy:	
Address of GP/Pharmacy:	☎ GP/Pharmacy:
Parent/carer's name (please print):	
☎ Contact 1:	☎ Contact 2:
Signature:	Date:

Form valid for 3 months from date of signature.

Note: The nursery will not accept medication unless this form is completed and signed by the parent/carer of the pupil and the nursery manager agrees the administration of the medication. The nursery manager reserves the right to withdraw this service.

Prior to administration please check against the medication form and medication label;
RIGHT person (ask to state their name) **RIGHT dose**
RIGHT medication **RIGHT route** (oral, topical etc.)
RIGHT time (as prescribed OR minimum time passed between doses)

- Medication should not be accepted unless it is sealed in the original packaging with information leaflet inside (with the exception of short term antibiotics).
- Pharmacy labels should be clearly legible.
- Please check the medication has not exceeded the expiry date.

Pupil's name: _____ **Date of birth:** _____ **Class:** _____

Date	Time	Name of Medication	Dose and route	Amount	Name of giver PLEASE PRINT	Signature of giver	Amount actually taken by pupil
01/01/01	00:00	Paracetamol	120mg Oral	5mls	JOHN SMITH	<i>John Smith</i>	all/spat/refused