MINISTRY OF
EDUCATION, EMPLOYMENT
& GENDER AFFAIRS
CAYMAN ISLANDS GOVERNMENT

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Interim National Guidance for Supporting Students with Medical Conditions in education settings

Example Forms

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Appendix A: Request to administer medication schedule

The school/setting will not give your child medicine unless you complete and sign this form.

Name of school/setting	
Name of student	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	
Procedures to take in an emergency (including consent to call an ambulance)	

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details of parent

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally for [student] to:	[name of agreed member of staff]

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I am the Parent/Legal Guardian of [insert name of child] ('Child') and I consent to an authorized member of Staff at the [insert name of school] administering the medication, of the type and in the dosage set out in the above Schedule, to the Child and, in consideration of allowing an authorized member of Staff to do so, I hereby agree as follows:

(1) I acknowledge, understand and appreciate that as part of having an authorized member of Staff administer the medication to my Child there may be risks and dangers, both known and unknown, and have elected to allow my Child to receive the medication, in spite of those dangers.

(2) I have voluntarily accepted and assumed all risks associated with my Child receiving the medication by an authorized member of Staff.

(3) On behalf of the Child, I hereby release all authorised staff at [insert name of school], from and against any and all claims for negligent actions, costs, charges, losses, damages and expenses which they shall or may incur or sustain by reason of any negligent act or omission by them in the administration of the medication to the Child.

The above information is, to the best of my knowledge, accurate at the time of writing. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is to be stopped.

_____
Child's Name

_____
Parent/Guardian Name

_____
Parent/Guardian Signature

_____
Date

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Appendix B: Template for individual healthcare plan

Name of school/setting	
Student's name	
Group/class/form	
Date of birth	
Stuent's address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information

Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	
Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	

Clinic/ Hospital contact

Name	
Phone no.	

Physician

Name	
Phone no.	

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Who is responsible for providing support in school	

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc.

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the pupil's educational, social and emotional needs

Arrangements for school visits/trips etc.

Other information

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

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Describe potential problems and interventions

Who is responsible in an emergency *(state if different for off-site activities)?*

Plan developed with

Staff training needed/undertaken – who, what, when

Form copied to

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Appendix C: Templates for recording administration of medication

Record of medicine administered to an individual student

Name of school/setting	
Name of child	
Date medicine provided by parent	
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	
Quantity returned	
Dose and frequency of medicine	

Staff signature _____

Signature of parent _____

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Cont. /d

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

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Record of medicine administered to students

Name of school/setting

Date	Child's name	Time	Name of medicine	Dose given	Any reactions	Signature of staff	Print name

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Appendix D: Template for staff training record for administration of medicines

Name of school/setting	
Name	
Type of training received	
Date of training completed	
Training provided by	
Profession and title	

I confirm that [name of member of staff] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [name of member of staff].

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____