



Herrick Primary School
Lockerbie Avenue, Leicester. LE4 7NJ
Telephone : 0116 266 5656
E-mail: office@herrick.leicester.sch.uk
Website: www.herrick.leicester.sch.uk

Headteacher – Miss S Odedra

Chair of Governors – Mr S Martin

FORM A: Request for the School to Administer Medication

The school will not give your child medicine unless you complete and sign this form and the school has a policy that the staff can administer medicine.

Section 1: Pupil Details

Pupil Name:	
Date of Birth:	
Class/Form:	
Medical Condition:	

Section 2: Medicine Details

Name of Medicine:	
Strength/Dose:	
When to be given:	
Method of administration:	
Expiry Date:	
Are there any side effects?	
Special storage requirements:	

Section 3: Self-Administration

I would like the school to store and help to administer my child's medicine	☐
I would like my child self-administer their own medicine, with school supervision	

Section 4: Emergency Contact Details

Parent/Carer Name:	
Relationship to Child:	
Daytime Telephone:	
Mobile Telephone:	
Address:	

Section 5: Declaration

I understand that I must deliver the medicine personally to the school office and accept that this is a service that the school is not obliged to undertake. I understand that I must notify the school immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Parent/Carer Signature:	
Print Name:	
Date:	

For Office Use Only

Date Received:	
Received By:	
Medicine Quantity:	
Storage Location:	



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CHILD PHOTO

FORM B: Individual Healthcare Plan (IHCP)

Section 1: Pupil Information

Pupil Name:	
Date of Birth:	
Class/Year Group:	
Date Plan Created:	
Review Date:	

Section 2: Medical Condition Details

Medical Condition(s) / Diagnosis:
Symptoms / Triggers / Warning Signs:

Section 3: Daily Care Requirements

Medication Required During School Hours:
Name:
Dose:
Time:
Storage Location:
Side Effects:

Section 4: Emergency Procedures

Signs that emergency action is required:
Action to be taken in an emergency:

Section 5: Contact Information

Parent/Carer 1:		Parent/Carer 2:	
Tel:		Tel:	
GP Name:			
GP Telephone:			
Hospital Consultant:			
Hospital/Clinic:			

Section 6: Staff Training and Responsibilities

Staff Member Name	Training Received	Date



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FORM C: Record of Medicine Administered to an Individual Child

Pupil Name:	
Class/Form:	
Date of Birth:	
Medical Condition:	
Name of Medicine:	
Prescribed Dose:	

Date	Time	Dose Given	Staff Signature	Witness Signature	Notes



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FORM D: Parental Consent for Emergency Salbutamol Inhaler Use

This form should be completed by parents/carers of children who have been diagnosed with asthma and prescribed a reliever inhaler.

Pupil Details

Pupil Name:	
Date of Birth:	
Class/Form:	

Asthma Information

My child has been diagnosed with asthma by a healthcare professional	☐
My child has been prescribed a reliever inhaler (usually blue)	☐

Name of prescribed inhaler:	
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Consent

I understand that the school holds an emergency salbutamol inhaler for use when my child's own inhaler is not available or is empty. I give consent for my child to use the emergency inhaler if necessary.

I understand that:

- The inhaler will only be used if my child's own inhaler is not available
- I will be informed if the emergency inhaler is used
- I am responsible for ensuring my child has their own inhaler in school
- This consent will remain valid until I withdraw it in writing

Parent/Carer Signature:	
Print Name:	
Relationship to Child:	
Date:	
Contact Telephone:	



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FORM E: Parental Consent for Emergency Adrenaline Auto-Injector (AAI) Use

This form should be completed by parents/carers of children who have been diagnosed with allergies and prescribed an adrenaline auto-injector (such as EpiPen, Jext, or Emerade).

Pupil Details

Pupil Name:	
Date of Birth:	
Class/Form:	

Allergy Information

My child has been diagnosed with allergies that put them at risk of anaphylaxis	☐
My child has been prescribed an adrenaline auto-injector	☐

Known Allergens:	
Brand of AAI prescribed:	
Dose prescribed:	

Consent

I understand that the school holds emergency adrenaline auto-injector(s) for use when my child's own device is not available, is broken, or out of date. I give consent for my child to receive the emergency AAI if necessary.

I understand that:

- The emergency AAI will only be used if my child's own AAI is not available or has misfired
- An ambulance will always be called when an AAI is administered
- I will be contacted immediately if the emergency AAI is used
- I am responsible for ensuring my child has their own in-date AAI(s) in school
- Staff will be trained to recognise anaphylaxis and administer adrenaline
- This consent will remain valid until I withdraw it in writing

Parent/Carer Signature:	
Print Name:	
Relationship to Child:	
Date:	
Contact Telephone:	

Medical Authorisation (For Office Use)

Written medical authorisation has been obtained for the use of the emergency AAI for this pupil:

Yes - authorisation attached / on file		☐
Verified by:		
Date:		



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Form F: Allergy incident and near miss record

Record every incident and every near miss

A serious incident includes any anaphylaxis, any administration of adrenaline, any allergic reaction requiring medical attention, and any occasion on which a pupil was given or came into contact with a known allergen.

A near miss is any occasion on which a pupil could have been exposed but was not — an allergen-containing meal caught before service, unlabelled food handed out in class, a missing or expired device found on a check.

Complete this form whether or not anyone was harmed. Failure to learn from incidents and near misses has contributed directly to the deaths of children in schools.

Section 1: Report details

Date and time of incident	
Date reported	
Reported by	
Reported by whom — staff / pupil / parent / healthcare professional	
Type	Serious incident ☐ Near miss ☐ Drill ☐

Section 2: Individual involved

Name	
Class or role	
Known allergy?	Yes ☐ No ☐ Not previously known ☐
IHP in place?	Yes ☐ No ☐

Section 3: What happened

Location and activity at the time
Suspected allergen and route of exposure
Symptoms observed
For a near miss: how was it caught, and what would have happened otherwise?

Section 4: Response

Adrenaline given?	Yes ☐ No ☐ Time of first dose:
Device used	Own ☐ School spare ☐ Dose:
Second dose given?	Yes ☐ No ☐ Time:
Reliever inhaler given?	Yes ☐ No ☐ Time:
Antihistamine given?	Yes ☐ No ☐ Time:
999 called?	Yes ☐ No ☐ Time:
Was the casualty kept lying flat and not moved?	Yes ☐ No ☐
Time observation began / ended (minimum 60 minutes)	
Outcome — hospital, sent home, returned to class	
Staff involved	

Section 5: Notification

Notified	Yes / No	Date and time	By whom
Parents / carers			
Allergy Safety Lead			
Headteacher			
Governing Body			
Catering provider			
Local authority environmental health (food safety)			
HSE (RIDDOR), if applicable			
Healthcare professional / school nurse			

Section 6: Review and lessons learned

Were the arrangements in place adequate? What went well, and what did not?
Changes required to the Allergy Safety Policy
Changes required to the pupil's IHP

Wellbeing support arranged — pupil, family, witnesses, staff involved
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Action	Owner	Deadline	Completed

Reviewed by	
Date of review	
Reported to governors on	

