Thriveology Wellness CIC

Supporting pupils with medical conditions and medical needs.

September 2025

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Introduction

Here at Thriveology we aim to support all service user's medical needs. Our Policy aims to give support and guidance to staff, children and families and other allied professionals.

Our aim is to support all children in maintaining their medication needs. In this we will be able to support with short term or long term medications that is able to be given without a medically trained member of staff.

Where specific training is required we aim to support in attending where possibly. The following forms must be completed in order for us to support and carry out medication administering.

Our support will cover such items as tablets, nasal sprays, omonilents, patches, tablets, eye drops for example. Where a child is able to self administer we are happy to support by observing and recording the child took the correct medication.

All medications will be kept in a locked cupboard or locked storage box in the fridge depending on requirements of the drug. In the event of no medication form completed we would not be able to support in administering the medications.

In the event of emergencies we would use the previous signed medical consent forms from parents to consent to staff adhering to medically trained professionals in attending and giving of medical attention as per their own guidelines. In the event of a minor injury first aid trained staff will administer first aid, under the company insurance and first aid training and policies.

Template A: individual healthcare

Name of school/setting				
Child's name				
School year				
Date of birth				
Child's address				
Medical diagnosis or condition				
Date completed				
Review date				
Family Contact Information				
Name				
Phone no. (work)				
(home)				
(mobile)				
Relationship to Child				
Name				
Phone no. (work)				
(home)				
(mobile)				
Relationship to child				
G.P.				
Name				
Surgery Name, Address				
Telephone number				

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

Other Daily medication requirements

Specific support required of this setting

Other information

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

Template B: parental agreement for setting to administer medicine

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

Parent Name
Childs Name
Child DOB

Medication Information Section

Name of Drug
Expiry Date
Batch number

Dose Section

Drug	Dose	time to be given	Dose to be given
Drug	Dose	time to be given	Dose to be given
Drug	Dose	time to be given	Dose to be given

Parent Signature Parent Name Date Signed
Thriveology Staff Name Signature Date Signed

Template C: record of medicine administered to an individual child

Name of staff completing form	
Name of child	
Date medicine provided by parent	
Name of staff administering	

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			

C: Record of medicine administered to an individual child (Continued)

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			

Staff signature _____

Signature of parent _____

Template D: record of medicine administered to all children

Name of school/setting	

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

Template E: staff training record – administration of medicines

Name of 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 _____

Template F: Transfer of Medication form

Transfer of drug / Medication Form

Please complete this form when your child's medication is transferred from home/ setting to setting / home

Childs Name:
Child Date of Birth

Method of drug / medication transfer:

With named child ☐

With school taxis escort ☐

With parent / assigned adult ☐

Other (please state):……

Drug / medication Information

Name of Drug / Medication:
Dose of medication per tablet / bottle (if required, such as 5mg):
Total amount of tablets/ bottle:
Description (such as 1x strip of 10 tablets and 1 x strip of 3 tablets making the total 13 tablets) or (half a bottle full of the liquid medication)
Name of Drug / Medication:
Dose of medication per tablet / bottle (if required, such as 5mg):
Total amount of tablets/ bottle:
Description (such as 1x strip of 10 tablets and 1 x strip of 3 tablets making the total 13 tablets) or (half a bottle full of the liquid medication)

Name of Drug / Medication:
Dose of medication per tablet / bottle (if required, such as 5mg):
Total amount of tablets/ bottle:
Description (such as 1x strip of 10 tablets and 1 x strip of 3 tablets making the total 13 tablets) or (half a bottle full of the liquid medication)

Prepared and signed by, Name:……

Signed:……

Date:…….

Hand Over

Name of setting:
Name of Staff
Medication checked and agreed received amount correct Yes / No
Signed By Staff

Template G: contacting emergency services

Request an ambulance - dial 999, ask for an ambulance and be ready with the information below.

Speak clearly and slowly and be ready to repeat information if asked.

1. your telephone number
2. your name
3. your location as follows [insert school/setting address]
4. state what the postcode is – please note that postcodes for satellite navigation systems may differ from the postal code
5. provide the exact location of the patient within the school setting
6. provide the name of the child and a brief description of their symptoms
7. inform Ambulance Control of the best entrance to use and state that the crew will be met and taken to the patient
8. put a completed copy of this form by the phone

Template H: model letter inviting parents to contribute to individual healthcare plan development

Dear Parent

DEVELOPING AN INDIVIDUAL HEALTHCARE PLAN FOR YOUR CHILD

Thank you for informing us of your child's medical condition. I enclose a copy of the school's policy for supporting pupils at school with medical conditions for your information.

A central requirement of the policy is for an individual healthcare plan to be prepared, setting out what support the each pupil needs and how this will be provided. Individual healthcare plans are developed in partnership between the school, parents, pupils, and the relevant healthcare professional who can advise on your child's case. The aim is to ensure that we know how to support your child effectively and to provide clarity about what needs to be done, when and by whom. Although individual healthcare plans are likely to be helpful in the majority of cases, it is possible that not all children will require one. We will need to make judgements about how your child's medical condition impacts on their ability to participate fully in school life, and the level of detail within plans will depend on the complexity of their condition and the degree of support needed.

A meeting to start the process of developing your child's individual health care plan has been scheduled for xx/xx/xx. I hope that this is convenient for you and would be grateful if you could confirm whether you are able to attend. The meeting will involve [the following people]. Please let us know if you would like us to invite another medical practitioner, healthcare professional or specialist and provide any other evidence you would like us to consider at the meeting as soon as possible.

If you are unable to attend, it would be helpful if you could complete the attached individual healthcare plan template and return it, together with any relevant evidence, for consideration at the meeting. I [or another member of staff involved in plan development or pupil support] would be happy for you contact me [them] by email or to speak by phone if this would be helpful.

Yours sincerely