

Breadsall Hill Top Primary School
Toileting and Intimate Care Plan

Name of Child:

Class:

Year:

Breadsall Hill Top Primary School Personal care plan

Childs Name: _____ Date of Birth: _____

Completed by: _____ (member of staff)

Date of Plan: _____ Date to review Plan: _____

Who will change the child?
How will be the child be changed? e.g. standing up in a toilet cubicle, lying down on a mat on the floor Copies of procedure for changing given to parent where available
Who will provide the resources? e.g. wipes, nappies, disposable gloves
How will the changing occasions be recorded and how this will be communicated to child's parent/ carer Consider using the Record of Intimate Care Intervention Table
How will wet/ soiled clothes be dealt with?
What the member of staff will do if the child is unduly distressed or if marks or injuries are noticed Consider referring to the schools child protection policy and procedures

Agree a minimum number of changes
How will the child be encouraged to participate in the procedure?
Any other comments/ important information: e.g. medical information

This plan has been discussed with me and I agree to change my child at the last possible moment before he/she comes to school, provide the resources indicated above and encourage my child's participation in toileting procedures at home as appropriate and where possible.

Signed: _____

Parent/Carer's Full Name: _____

Staff: _____

Breadsall Hill Top Primary School - Intimate Care Risk Assessment

Child's Name:

Date of Risk Assessment:

	Yes	Notes
1 Does weight / size / shape of a pupil present a risk?		
2 Does communication present a risk?		
3 Does comprehension present a risk?		
4 Is there a history of child protection concerns?		
5 Are there any medical considerations? Including pain / discomfort?		
6 Has there ever been allegations made By child or family?		
7 Does moving and handling present a risk?		
8 Does behaviour present a risk?		
9 Is staff capability a risk? (back injury / pregnancy)		
Are there any risks concerning individual capability (Pupil)? General fragility Fragile bones Head control Epilepsy Other		
Are there any environmental risks? Heat/Cold		

Date: **Signed:**

Name:

Breadsall Hill Top Primary School – Record of Intimate Care Intervention

Child's Name: Class / Year Group

Name of Support Staff Involved:

Date	Time	Procedure	Staff signature

PARENTAL CONSENT
ADMINISTRATION OF MEDICINES IN SCHOOL

TO BE COMPLETED BY THE PARENT/GUARDIAN OF ANY CHILD REQUESTING THAT DRUGS ADMINISTERED UNDER THE SUPERVISION OF SCHOOL STAFF OR WHERE A CHILD IS BRINGING MEDICINE INTO SCHOOL WHICH THEY WILL SELF- ADMINISTER.

If you need help to complete this form, please contact the school. Please

complete in block letters

Name of Child _____ Date of Birth _____

Address _____

_____ _____

_____

Doctor's Name _____

NON-PRESCRIBED MEDICINES

My child requires the following non-prescribed medicines:

_____

_____

_____

_____

PRESCRIBED MEDICINES

The Doctor has prescribed (as follows) for my child:

1. Name of drug or medicine to be given.
2. When? (e.g. lunchtime? after food? when wheezy? before exercise?).
3. How much? (e.g. half a teaspoon? 1 tablet? 2 drops?).
4. Route, e.g. by mouth or in each ear.
5. Any special storage instructions?

1. _____
2. _____
3. _____
4 _____
5. _____

** Please destroy when the course of medication is complete. Please alert the office that the medication is finished.

(Child's Name) _____

can administer his/her own medication*/requires supervision to administer his/her own medicine*/requires assistance in administering his/her medicine*.

_____

_____

I request that the treatment be given in accordance with the above information by a named member of the school staff who has received all necessary training. I understand that it may be necessary for this treatment to be carried out during educational visits and other out-of- school activities, as well as on the school premises.

I undertake to supply the school with the drugs and medicines in the original duplicate labelled containers, provided by the Dispensing Chemist.

I accept that whilst my child is in the care of the school, the school staff stand in the position of the parent and that the school staff may, therefore, need to arrange any
medical aid considered necessary in an emergency, but I will be told of any such action as soon as possible.

I can be contacted at the following address/telephone during school hours:

Name_____
Contact Address _____

_____ _____

_____ _____

Emergency Telephone Number:

Signed _____ Date

_____

*Delete that which does not apply

THIS FORM SHOULD BE DISCARDED/DESTROYED WHEN THE MEDICATION IS COMPLETED OR CHANGED.

** Please destroy when the course of medication is complete. Please alert the office that the medication is finished.

SCHOOL MEDICINE RECORD

Both sides of form must be completed

Child's Name & Class	
Name of Medicine	
What is the medicine treating?	
How much to give (i.e. dose)	
When to be given (time) and details (i.e. before food)	
How much medicine has been given to school? (no of tablets or days dosage)	
Tel No of parent or adult contact	
Parent's signature	
Staff signature who accepted the medication	
Staff signature who will administer/supervise the medication being taken/given	

If more than one medicine is to be given,
a separate form should be completed for each

Additional comments & Photograph (where appropriate)

** Please destroy when the course of medication is complete. Please alert the office that the medication is finished.

SCHOOL MEDICINE RECORD

Date												
Time given/taken												
Staff Initials												

Date												
Time given/taken												
Staff Initials												

Date												
Time given/taken												
Staff Initials												

Date												
Time given/taken												
Staff Initials												

Date												
Time given/taken												
Staff Initials												

Date												
Time given/taken												
Staff Initials												

** Please destroy when the course of medication is complete. Please alert the office that the medication is finished.

Working Towards Independence Record

Child's Name _____ DOB _____

Name of Support Staff Involved _____

Date of Record _____ Review Date _____

I can already

Aim: I will try to

Signed _____ Parents/ Carers

Signed _____ Member of Staff

Signed _____ Second Member of Staff

Signed _____ Child (if appropriate)

Toilet Management Plan

Child's Name _____ Class/ Year Grp _____

Name of Support Staff Involved _____

Date of Record _____ Review Date _____

Area of Need	
Equipment required	
Location of suitable toilet facilities	
Support required	Frequency of support

Working towards Independence

Child will try to	Personal Assistant will	Target achieved (date)

Signed _____ Parents/ Carers

Signed _____ Member of Staff

Signed _____ Second Member of Staff

Signed _____ Child (if appropriate)



Agreement between child and personal assistant

Child's Name _____ Class/ Year Grp _____

Name of Support Staff Involved _____

Date _____ Review Date _____

Support Staff

As the personal assistant helping you in the toilet you can expect me to do the following:

- When I am the identified person I will stop what I am doing to help you in the toilet. I will avoid all unnecessary delays.
- When you use our agreed emergency signal, I will stop what I am doing and come and help.
- I will treat you with respect and ensure privacy and dignity at all times.
- I will ask permission before touching you or your clothing
- I will check that you are as comfortable as possible, both physically and emotionally
- If I am working with a colleague to help you, I will ensure that we talk in a way that does not embarrass you.
- I will look and listen carefully if there is something you would like to change about your Toilet Management Plan

Child

As the child who requires help in the toilet you can expect me to do the following:

- I will try, whenever possible to let you know a few minutes in advance, that I am going to need the toilet so that you can make yourself available and be prepared to help me
- I will try to use the toilet at break time or at the agreed times
- I will only use the agreed emergency signal for real emergencies.
- I will tell you if I want you to stay in the room or stay with me in the toilet
- I will tell you straight away if you are doing anything that makes me feel uncomfortable or embarrassed. I may talk to other trusted people about how you help me. They too will let you know what I would like to change

Signed _____ Member of Staff

Signed _____ Child (if appropriate)

Permission for school to provide intimate care

Child's Full Name	
Male/ Female	
Date of Birth	
Parent/ Carer's Full Name	
Address	

I understand that;

I give permission to the school to provide appropriate intimate care support to my child e.g. changing soiled clothing, washing and toileting.

I will advise the head teacher or senior first aider of any medical complaint my child may have which affects issues of intimate care

Signed _____

Full Name _____

Relationship to Child _____

Date _____