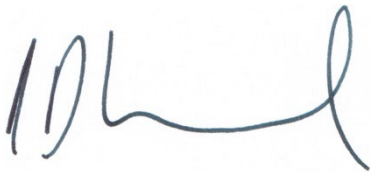
ADMINISTRATION OF MEDICATION POLICY

Overall responsibility:	Assistant Principal of Academic & Vocational Support
Implementation:	SAVS
Date issued:	December 2025
Date for review:	December 2026

Endorsed and approved by Policy & Strategy Group Date: December 2025

Jason Lancaster Principal



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1. INTRODUCTION

Northampton Colleges wishes to ensure that students with medical needs receive proper care and support at college.

It is expected that in most cases, students requiring medication during college hours will be able to self-medicate and no staff intervention will be required.

2. POLICY STATEMENT

Where students are unable to self-medicate, the College will accept responsibility, in principle, for members of staff supervising students taking prescribed medication during the college day, where those members of staff have been nominated, appointed and trained to do so. This also applies to rare cases when staff are required to directly assist in the administration of medication.

3. QUALITY STATEMENTS

1. Any parent/carer or student requesting the administration of medication should be given a copy of this policy. A risk assessment will be carried out by the College with the student and/or parents/carers/health care professionals

2. A detailed medication plan will be agreed upon with a healthcare professional in each case.

3. Any individual administering medication will have undergone documented training and will work under the direction or control of a health care practitioner.

4. Medication will only be accepted in college if it has been prescribed by a medical practitioner.

5. Medication will not be accepted anywhere in college without complete written and signed instructions from the student and/or parent/carer.

6. Only reasonable quantities of medication should be supplied to the college by a responsible person (no more than one academic term's supply) and recorded in the student's medication file

7. Each item of medication must be delivered in its original container and handed directly to a nominated person authorised by the medication agreement who will maintain appropriate records.

8. Each item of medication must be clearly labelled with the following information:

    a. Student's name
    b. Name of medication
    c. Dosage
    d. Frequency of dosage
    e. Date of dispensing
    f. Storage requirements (if important)
    g. Expiry date (if available)

9. Unless otherwise indicated all medication to be administered in college will be kept in a designated identified locked area. The location of this will be documented in a medication support plan.

10. Acceptable Treatments will be limited to:
    a. Ear/nose drop application
    b. Inhalers and nebulisers, limited to the provision of assistance to the user in the application or fitting of a mask
    c. Injections limited to the administration of pre-packed doses (intramuscular or subcutaneous only) required in a pre-planned emergency
    d. Medi pens (EpiPens or anapens) for anaphylactic shock with a pre-assembled pre-dosed EpiPen epinephrine or adrenaline/epinephrine
    e. Oral medication administered as prescribed by a health Care Professional subject to appropriate consent forms being obtained.
    f. Topical medication and application of patches using pre-prescribed medication creams and lotions only.

11. The college may provide parents/carers with details of when medication has or has not been administered to the student.

12. Where it is appropriate to do so, students will be encouraged to administer their medication under staff supervision.

13. It is the responsibility of the student/parents/carers to notify the college if there is a change in medication, a change in dosage requirements, or the discontinuation of the student's need for medication.

14. Staff who assist in the administration of medication will receive appropriate training/guidance through the student/parent/carers or their health care professional. The College reserves the right to request advice and/or training from a healthcare professional prior to providing any assistance.

15. Details of which staff are approved to administer medication will be held on a central electronic record and reviewed at least annually.

16. The College will make every effort to assist with the administration of medication to a student whilst on trips away from College premises, even if additional arrangements might be required. This will be reviewed as part of the College's offsite activity planning process.

17. Each student, where assistance with medication is necessary, will have a personal medication plan.

18. The College will make every effort to assist with planned administration of medication. However, if the College is unable to ensure the safety of a Student, due to the absence of trained staff, the College reserves the right to direct the student to remain off-site/return home if safe to do so. (See Appendix 5)

19. The following documentation will be completed, signed by the relevant parties and stored securely in line with GDPR regulations. (See Appendices for full documentation)

Document	Code
Request for College to Administer Medication	M1
Request for College to Supervise Self Medication	M1a
Record of Medication Received in College	M2
Medication Administration Record (MAR)	M3
Medication Plan	M4

4. LINKED POLICIES/PROCEDURES

- Data Protection Policy
- Health and Safety Policy
- Special Educational Needs, Disability & Learning Support Policy
- Offsite Activities Guidance
- Student Wheelchair User Assistance Policy
- Personal Emergency & Evacuation Procedures (PEEP)

5. Appendices:

Appendices	Name
1	Equality & Diversity Impact Assessment
2	Data Protection Impact Assessment
3	Communications Plan
4	Protocols in the event of absence of trained staff (student unable to self-medicate)
5	Request for College to Administer Medication Document
6	Request for College to Supervise Self Medication Document
7	Record of Medication Received in College
8	Medication Administration Record
9	Medication Plan Template

Appendix 1: EQUALITY & DIVERSITY IMPACT ASSESSMENT

This template has been designed to help you take action to improve services and practices which affect staff, students and other service users at Northampton College. By completing this template, you would have considered the impact that your policy, practice or service might have on particular social groups within the college community. The exercise will also provide you with the opportunity to demonstrate, where possible, that the College promotes equality, diversity, and inclusion.
Once this Equality Impact Assessment has been created, please include on the last page of your policy document.

Policy Details	
What is the policy?	
Is it new or existing?	
Department	
Policy Author (postholder title, name)	
Author of Equality Analysis	
Date of completion	

Aim and Objectives
Briefly describe the aims and objectives of the policy

Policy Assessment				
Consider whether your policy might have an impact on various groups identified within the categories listed below and explain why you have reached this conclusion. Please tick (√) the identified level of impact (positive, negative, or no impact) and provide details of your findings.				
	Positive Impact	Negative Impact	No Impact	Findings
Race				
Religion and/or belief				
Sex (Gender)				
Gender Identity				
Disability				
Age				
Sexual orientation				
Marriage and/or civil partnership				
Pregnancy and/or maternity (including surrogacy and adoption)				
Other identified group (e.g. carers)				

Action Planning		
How do you intend to mitigate or eliminate any negative impact identified?	If a positive impact is identified, how do you intend to promote or develop this opportunity?	Where negative impact has been identified, can it be justified? If so, explain how.

Monitor and Review	
How will you monitor the impact of your policy once it has been put into effect?	
The policy will be monitored through feedback from services users gathered via:	
Names and position of Impact Assessment Team (min of 3 preferably from areas across the College):	
Name	
Mark Owen	
Jan Hutt	
Ashok Dave	

Equality Analysis Sign-Off Signature and Date:	
Review Date:	

Appendix 2: DATA PROTECTION IMPACT ASSESSMENT

Data Protection Impact Assessment

Does this Policy

- require the collection and use of data in addition that normally collected by the College?

Yes / No (if Yes complete Assessment point number 1)

- require the sharing of data with partners?

Yes / No (if Yes complete Assessment point number 2)

1. Is additional data being collected? If so please detail:

Is data collected personal and/or sensitive?

How will you collect, use, store and delete data?

2. Will you be sharing data with anyone? Please detail what data, with who and confirm a **Data Sharing Agreement** is in place

Describe the purposes of the processing / sharing: What are the benefits of the processing/ sharing – for you, and more broadly?

Consider how to consult with relevant stakeholders: describe when and how you will seek individuals' views – or justify why it's not appropriate to do so.

Describe compliance and proportionality measures, in particular:
What is your lawful basis for processing?

How will you ensure data quality and data minimisation?

What information will you give individuals?

Please attach a Risk Assessment if there are significant risks to data protection

Signed by Data Protection Officer

Name:

Date:

Appendix 3: COMMUNICATIONS PLAN

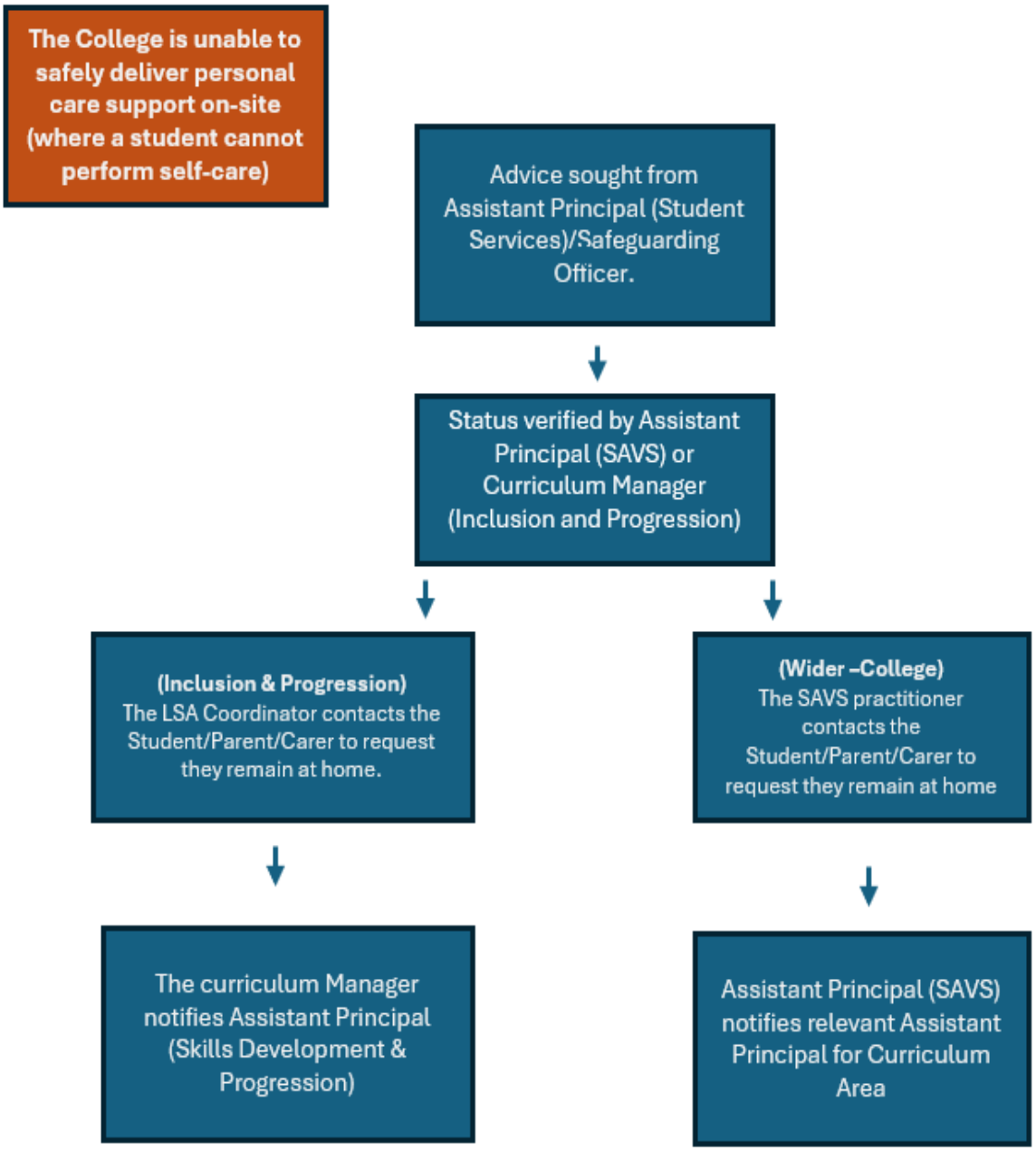
TITLE OF COLLEGE POLICY: Administration of Medication	**DATE APPROVED BY** Date:

AUDIENCE (select appropriate with √)					
Managers	X	Curriculum teams	X	Business Support teams	X
All staff	X	Parents	X	Partners	
Other - Students					

CHANNEL (select appropriate with √)					
Policy & Strategy Team (PST)		Quality Improvement Network (QIN)		Marketing team	
Meeting		Meeting		NC Update Intranet Website	
Individual team		Suppliers		Partners	
Document Library Noticeboards Team meeting Email		e.g. Letter or email Meeting		e.g. Letter or email Meeting	
College Management Team (CMT)		JCNC		CORPORATION	
Meeting		e.g. Meeting Email		e.g. Meeting Email	

COMMUNICATIONS PLAN ACTIVATED BY:		
Name: G Dugdale Department : SDP	Job title: Assistant Principal SDP	Date:

Appendix 4
Protocols in the event of absence of staff trained to administer student medication (student is not able to self-medicate)



Appendix 5: M1

M1

Request for College to Administer Medication

This college will only administer medicine prescribed by a Health Professional and then only if you complete and sign this form. N.B All medication must be brought into college in its original container.

Details of Student:

Surname: Gender:

Forename(s): Date of Birth:

Address:

Condition or Illness:

Does the Student have any allergies? _____

What reaction should we expect? _____

Course: _____Group/Year: _____

Academic Coach/Course Leader:_____

Medication 1

Name/Type of Medication (as described on the container):_____

Full Directions for use:

Dosage and method: _____

Timing: _____

Special Precautions: _____

Side Effects: _____

Self-Administration: _____

Procedures to take in an emergency: _____

_____

Any other medication _____

Medication 2

Name/Type of Medication (as described on the container):_____

Full Directions for use:

Dosage and method: _____

Timing: _____

Special Precautions: _____

Side Effects: _____

Self-Administration: _____

Procedures to take in an emergency: _____

_____

Any other medication _____

Contact Information

Name: _____ Daytime Telephone No: _____

Relationship to Student: _____

Address: _____

_____

Alternative Contact in emergency

Name: _____ Daytime Telephone No: _____

Relationship to Student: _____

Address: _____

_____

I request that the college administer the medication indicated above to:

_____

I will hand the medication directly to a member of staff who will record its acceptance on a record of medication received form (M3).

Signature(s):_____Date:_____

Relationship to Student: _____

Appendix 6: M1a

M1a

Request for College to Supervise Self Medication

The college will only supervise the taking of medication prescribed by a Health Professional and then only if you complete and sign this form. N.B All medication must be brought into college in its original container.

Details of Student:

Surname: Gender:

Forename(s): Date of Birth:

Address:

Condition or Illness:

Does the Student have any allergies?

What reaction should we expect?

Course: Group/Year:

Academic Coach/Course Leader:

Medication 1

Name/Type of Medication (as described on the container):_____

Full Directions for use:

Dosage and method: _____

Timing: _____

Special Precautions: _____

Side Effects: _____

Self-Administration: _____

Procedures to take in an emergency: _____

_____

Any other medication: _____

Medication 2

Name/Type of Medication (as described on the container):_____

Full Directions for use:

Dosage and method: _____

Timing: _____

Special Precautions: _____

Side Effects: _____

Self-Administration: _____

Procedures to take in an emergency: _____

_____

Any other medication: _____

Contact Information

Name: _____ Daytime Telephone No: _____

Relationship to Student: _____

Address: _____

_____

I request that the college supervise the taking of the medication indicated above to:

1. I will hand the medication directly to a member of staff who will record its acceptance on a record of medication received form (M3).

Signature(s):_____Date:_____

Relationship to Student: _____

Appendix 7: M2

M2

Record of Medication Received In College

Student's Name:

Name of Medication	Date Received	Expiry Date	Quantity Received	Staff Signature	Student/Guardian/ 2nd Staff Signature	Date Returned	Quantity Returned	Staff Signature	Student/Guardian/ 2nd Staff Signature

Appendix 8: M3

Northampton College

Medication Administration Record (MAR) **M3**

MO/YR: Start/Stop Date																																
Medication		**Hour**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
	Start																																
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Diagnosis:	**DIET (Special Instructions, e.g. Texture, Bite Size, Position, etc.)**	**Comments**

Allergies:	**GP Name:**	**A. Put initials in appropriate box when medication is given.**
		B. Circle initials when not given.
	Phone Number:	**C. State reason for refusal / omission on back of form.**
		D. PRN Medications: Reason given and results must be noted on back of form.
		E. X in box on non-college days.

NAME:	**Address:**	**Date of Birth:**	**Sex:**
Student ID:			

PRN AND MEDICATIONS NOT ADMINSTERED							Initials	Parent/Carer contacted	Staff Signature
Date	**Hour**	**Initials**	**Medication**	**Reason**	**Result**			**Result**	
						1			
						2			
						3			
						4			
						5			
						6			
						7			
						8			
						9			
						10			
						11			
						12			
						13			
						14			
						15			
						19			
Name								**MO/ YR**	

Key:

Appendix 9: M4

Medication Support Plan

This college will only administer medicine or supervise self-administration where it has been prescribed by a doctor and then only if required authorisations have been completed.

Details of Student:

Surname: Gender:

Forename(s): Date of Birth:

Address:

Condition or Illness:

Course_____Group/Year_____

Academic Coach/Course Leader_____

Medication 1

Name/Type of Medication (as described on the container):_____

Full Directions for use:

Dosage and method: _____

Timing: _____

Special Precautions:_____

Side Effects: _____

Self-Administration: _____

Procedures to take in an emergency: _____

_____

Any other medication _____

Name of staff members responsible for the supervision/administration of this medication:

.....

Where will the medication be stored?

.....

How is it administered?

.....

Where will it be administered?

.....

Medication 2

Name/Type of Medication (as described on the container):_____

Full Directions for use:

Dosage and method: _____

Timing: _____

Special Precautions:_____

Side Effects: _____

Self-Administration: _____

Procedures to take in an emergency: _____

_____

Any other medication _____

Name of staff members responsible for the administration of this medication:

.....

Where will the medication be stored?

.....

How is it administered?

.....

Where will it be administered?

.....

Contact Information

Name: _____ Daytime Telephone No:_____

Relationship to Student_____

Address: _____

_____

I request that the college administer/supervise the administration of the medication indicated above to _____.

I will hand the medication directly to a member of staff who will record its acceptance on a record of medication received form (M3).

Signature(s):_____Date:_____

Relationship to Student: _____