MEDICAL CONDITIONS AT SCHOOL

MANAGEMENT RESOURCE PACK

EAST RIDING OF YORKSHIRE COUNCIL
Public Health England
NHS

INTRODUCTION

Pupils with long-term and complex medical conditions may require ongoing support, medicines or care while at school to help them manage their condition and keep them well. This guidance is intended to help schools and their governing bodies meet their legal responsibilities based on good practice, aiming to support schools with advice on how this can be best managed in line with the guidance '*Supporting pupils at school with medical conditions*' (DfE December 2015).

This guidance not only looks at various conditions and the support that may be required for pupils whilst at school; but also advises on school attendance, individual healthcare plans, medication and interventions in emergency circumstances.

Throughout this guidance, where the wording parent/ guardian is used, this includes those who have parental responsibility for the child and/or any adult that has day to day care and responsibility.

A "parent" is defined as:
"...any person who, although not a natural parent, has care of a child or young person. Having care of a child or young person means that a person with whom the child lives and who looks after the child, irrespective of what their relationship is with the child, is considered to be a parent in education law."
– Section 576 of the Education Act 1996.

This resource pack replaces the original versions of the following East Riding documents:

- *Managing Chronic Health Conditions and Infection Control in schools* (January 2014)
- *Managing Medicines in Schools* (January 2014)
- *Medical Appointments and Illness Absence Guidance* (January 2014)
- *Medical Appointments and Illness Absence Procedures* (January 2014)

All individual sections and workable templates and forms can be found on the East Riding inSIGHT website within the Education Welfare Service area.

MEDICAL APPOINTMENTS AND ILLNESS ABSENCE

- GUIDANCE FOR SCHOOLS
- PROCEDURES

EAST RIDING OF YORKSHIRE COUNCIL

NHS

MEDICAL APPOINTMENTS AND ILLNESS ABSENCE

GUIDANCE FOR SCHOOLS

INTRODUCTION

The guidance outlined below has been approved by both the primary and secondary schools behaviour and attendance partnerships in the East Riding of Yorkshire. It is aimed at supporting school staff in managing pupil absence due to medical appointments and illness. It is intended to clarify, and ensure that consistent procedures are implemented across all schools, preventing avoidable and unnecessary absence which parents attribute to illness.

BACKGROUND

The Department for Education (DfE) has collated data which provides evidence to show that pupils who are persistently absent in secondary schools have had poor attendance levels at primary school. If pupils are allowed to establish a regular pattern of absence, it becomes increasingly difficult to change this situation. Intervention at an early stage is more likely to result in a successful outcome when addressing attendance issues, and prevent children becoming persistent absentees and disengaged from school.

Primary schools may be more reluctant to challenge poor attendance because of the fear of damaging relationships, but some families get into bad habits and parents may inadvertently get the message that attendance at primary school is not as important as it is at secondary school. *"The earlier poor patterns of attendance are addressed by schools, the less likely it is that it will become a persistent issue. That is why good primary schools take a zero tolerance approach to poor attendance from the very start of school life" (Government's expert adviser on behaviour, Charlie Taylor (Jan 2012) – www.gov.uk).*

The main reason for pupil absence from school is illness. In the academic year 2017-2018 schools lost 206,660 days due to medical appointments and illness absence in the East Riding of Yorkshire alone. Whilst pupils are not expected to attend school when they are not well enough to do so, they should not be kept away from school when they are well enough to go to lessons or when they have minor ailments which do not prevent them from taking part in their education.

Schools should have an established system in place to allow parents/carers to report their child's absence because of illness. There should be clear guidelines to address incidences of recurring absences where illness is given as a reason, if it is believed that the absence does not warrant the time off.

REQUESTING MEDICAL EVIDENCE

It is not expected that schools should request additional evidence every time a pupil misses school due to illness. Such requests should be restricted to when the school has concerns that a pupil was not ill or that the illness was trivial and did not warrant time off, so as not to add to the administrative burden on schools or health professionals.

When a parent/carer reports a pupil absence because of illness, it is reasonable for the school to ask the nature of the illness, expected return date and to request that parents contact the school again if the situation changes. If the absence is authorised and regular due to a chronic health condition, the pupil should be considered for an Individual Healthcare Plan and the register marked accordingly ensuring consistency of support when a change of staff occurs.

Schools have the right to consider whether to accept the parent's explanation for the absence, as there are occasions when parentally condoned absence is reported to the school as illness. If there are concerns that the pupil's absence from school is not genuine or is becoming a regular occurrence, DfE Guidance *(Supporting pupils at school with medical conditions -* DfE December 2015*)* states that schools can ask for proof of illness (appointment card, dated medication, prescription etc.) before marking a pupil as 'I'. Schools can still unauthorise if they doubt the absence. The local authority believes it to be good practice for schools when they have concerns about a pupil's absence, to consider the use of the local authority medical appointment card where parents are not supplying appropriate evidence; prior to a referral to the Education Welfare Service. If you request proof and do not receive it, this information should be entered on the referral form with dates requested etc.

SPECIAL SCHOOLS

Although children in special schools often have additional complex and challenging circumstances such as medical, social or emotional problems, we expect them - as with all other schools - to do as much as possible to keep all unnecessary and unjustified absence to a minimum.

EAST RIDING RELATED DOCUMENTS

The following documents are available on:

- insight.eastriding.gov.uk/directorates/cfs/children-young-people-specialist-services/education-welfare-metas-home-tuition

- *Medical Conditions at School - Management Resource Pack*
- Medical Appointment Card
- *Parent Information Leaflet* (2019)
- Home Tuition Service Information and Referral form
- Education Welfare Service Referral Form

STATUTORY GUIDANCE

The following documents are available on

- www.education.gov.uk

- *Supporting pupils at school with medical conditions* (DfE December 2015)
- *Ensuring a good education for children who cannot attend school because of health needs* (Statutory guidance for local authorities DfE January 2013)
- *Safeguarding Children in whom illness is fabricated or induced* (DfE 2008)
- *School Attendance* (DfE September 2018)

CONTACTS

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DfE school attendance team

- 0370 000 2288

This is an updated version of the guidance produced in September 2017.

MEDICAL APPOINTMENTS AND ILLNESS ABSENCE

PROCEDURES

INTRODUCTION

This is an updated version of the guidance produced in January 2014. The guidance outlined below has been approved by both the primary and secondary schools behaviour and attendance partnerships in the East Riding of Yorkshire. It is aimed at supporting school staff in managing pupil absence due to recurring illness and medical appointments. It is intended to clarify, and ensure that consistent procedures are implemented across all schools, preventing avoidable and unnecessary absence which parents attribute to illness.

PROCEDURES

The attendance register is a legal document and every absence from school has to be recorded and classified by the Headteacher (not by the parent) as either authorised or unauthorised. This is why the cause of any absence is always required; Code 'N' should be considered for the register until the reason for the absence is clarified and can be replaced with the appropriate code.

If no reason has been given within a two week period of the absence this should not be authorised. If the Headteacher chooses not to authorise the absence the parent or carer should be notified.

The absence must be recorded using Code 'O' (unauthorised absence). If the school accepts the parents/carers explanation that the pupil was not well enough to attend school, the absence should be authorised and recorded in the register using Code 'I' (illness, not medical appointments) or Code 'M' (medical appointments which include: attendance at a GP's surgery, attendance at a dentists' surgery or a hospital appointment, not a stay in hospital which should be recorded as Code 'I').

REPORTING PUPIL ABSENCE

Schools should ensure parents/carers are clear about what is expected from them with regard to reporting pupil absence and medical appointments.

If pupils are ill parents/carers should:

- Contact the school as soon as possible on the first day of absence, with a clear description of why the child is absent, expected date of return and any medical advice received or appointments/visits made.
- Contact the school on the third day with an update on the child's progress.
- Contact the school to update on progress on a regular basis should further absence be required. For absence of five days or more schools may request this is supported by medical evidence (appointment card, dated medication, prescription etc.).
- Ensure the pupil returns to school as soon as they are recovered.
- Communicate with the school the first day the pupil returns with an explanation of the absence.
- Endeavour to make medical appointments outside of school hours whenever possible.
- Ensure the school has up to date contact telephone numbers.

SCHOOL ACTIONS

The school should:

- Telephone parents/carers on the first day of absence if communication has not been received regarding an explanation for the non-attendance (this measure also acts as a safeguard for children who may have set off for school but have not arrived). The school should keep a record of the call, with the reason for the absence clearly recorded and the appropriate attendance code ('N') entered in the register.
- For recurring absences, decide what attendance code is to be entered in the register and write to parents/carers informing them of the decision made and the school's concern.
- Consider offering parent/carers an appointment with the school nurse.
- Consider completing a Health Care Plan to support the pupil whilst attending school. Should the condition require emergency treatment an Emergency Information sheet should be completed and (where appropriate) kept with the emergency medication in a plastic wallet accompanying the child whilst in school.

- Consider completing a Personal Emergency Evacuation Plan (PEEP) detailing the arrangements the school can put in place to support the child in safe evacuation as required. This may include delayed evacuation, buddy systems, use of refuge area, visual alarm systems, etc. A PEEP can be put in place for both long and short-term physical or sensory issues for which support may be required.
- Consider a referral to the Home Tuition Service if the child is expected to be absent for more than 15 school days or more.
- And/or if absence persists, parents/carers should be invited in to school to discuss the situation.
- Consider a penalty notice referral for persistent unauthorised absence.
- Refer the matter to the Education Welfare Service if, after support from the school, the pupils attendance does not improve.

If repeated absence appears to be a safeguarding issue a child protection referral should be made.

Upon receiving a referral the Education Welfare Service is able to investigate the legitimacy of absences due to illness. Supporting genuine cases of ill health and using sanctions and/or legal proceedings to improve attendance where the illness appears to be unfounded. Upon receipt of a referral the Education Welfare Service requests that the school does not authorise any absence due to illness, unless evidence is provided (appointment card, dated medication, prescription etc.).

Where the level of unauthorised absence is significant the local authority may consider taking legal action in order to try and bring about an improvement in the child or young person's attendance. This action would only be taken after support had been offered, advice given, and the parent had still failed to ensure their child's attendance had improved.

Schools are to refer for a penalty notice warning letter to be issued if a child has unauthorised absence of 10 or more sessions within a 13 week period. Prior to a penalty notice being issued to the parents they will be warned by letter that their child must have no further unauthorised absences during the following 15 school days otherwise a fine will be automatically issued and any absences as a result of illness must be supported by medical evidence as outlined above.

RELATED DOCUMENTS

The following documents are available on:

insight.eastriding.gov.uk/directorates/cfs/children-young-people-specialist-services/education-welfare-metas-home-tuition

- *Medical Conditions at School - Management Resource Pack*
- Medical Appointment Card
- *Parent Information Leaflet* (September 2019)
- Home Tuition Service Information and Referral form
- Education Welfare Service Referral Form
- PEEP Template available on InSight: **Safety Services > Resources > Risk Assessment Templates**

STATUTORY GUIDANCE

The following documents are available on

www.education.gov.uk

- *Supporting pupils at school with medical conditions* (DfE December 2015)
- *Ensuring a good education for children who cannot attend school because of health needs* (Statutory guidance for local authorities DfE January 2013)
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FLOWCHART FOR SCHOOL ABSENCE DUE TO ILLNESS/MEDICAL

Whilst any child may be absent from school because they are ill, sometimes there are other issues that affect their attendance. Robust procedures and swift contact between home and school is more likely to result in a successful outcome for addressing concerns and improving pupil attendance. It is not always necessary to accept a parent's reason for absence.

HAS AN EXPLANATION FOR NON-ATTENDANCE BEEN RECEIVED FROM PARENTS ON THE FIRST DAY OF ABSENCE?

YES

School should keep a record of the call, with the reason for absence clearly recorded and the appropriate attendance code entered in the register

NO

Telephone named people on pupils contact sheet (this measure also acts as a safeguard for children who have set off for school but have not arrived). School should keep a record of any calls made, with reason for the absence clearly recorded and the appropriate attendance code entered in the register

IS THIS A RECURRING ABSENCE?

NO

Monitor attendance for further absences

YES

Write to parents/carers informing them of school's concern. Consider if it is appropriate to:

- Make a referral to the Home Tuition Service
- Commence persistence absence support plan
- Request / supply medical appointment card
- Make a penalty notice referral for persistent unauthorised absence*

*Penalty notices should be considered as part of an early intervention procedure (10 sessions or more in 13 week period)

HAS ATTENDANCE IMPROVED?

YES

Monitor attendance for further absences

NO

Parents/carers should be invited in to school to discuss the situation. Consider offering parent/carers an appointment with the school

HAS ATTENDANCE IMPROVED?

YES

Monitor attendance for further absences

NO

Refer the matter to the Education Welfare Service if, after support from the school, the pupils attendance does not improve

IF REPEATED ABSENCE APPEARS TO BE A SAFEGUARDING ISSUE A CHILD PROTECTION REFERRAL SHOULD BE MADE

MANAGING MEDICINES

GUIDANCE AND PROCEDURES

EAST RIDING OF YORKSHIRE COUNCIL

NHS

MANAGING MEDICINES

GUIDANCE AND PROCEDURES

CONTENTS

This is an updated version of the guidance produced in September 2017.

INTRODUCTION

2.1

All schools should have a full and comprehensive policy on how to manage medicines and support children with medical needs. The aim should be to minimise the disruption that illness or disability can cause to a child's education. This guidance has been produced to help schools develop an effective management system when dealing with administering prescribed medication, give direction for staff that take on the responsibility for this work and ensure a consistent approach across all schools in the East Riding of Yorkshire.

Whilst this document is intended to develop good practice in schools, it does not attempt to deal with all the health issues of pupils; cases should be considered individually (particularly in respect of children with long term medical needs, complex needs or intimate care), and prescribed medicines administered to meet the needs of the child.

The Headteacher, in conjunction with the Governing body, is responsible for developing their own policy regarding managing medicines and for deciding whether the school can assist a child with medical needs.

There is no legal duty that requires school or setting staff to administer medicines. A number of schools are developing roles for support staff that build the administration of medicines into their core job description. Some support staff may have such a role in their contract of employment. Schools should ensure that they have sufficient members of support staff who are appropriately trained to manage medicines as part of their duties. However, partnerships should work together to make sure that children with medical needs have effective support in order to maintain regular school attendance.

The following guidance is based on advice contained within '*Supporting pupils at school with medical conditions*' (DfE December 2015) and has been issued with the intention to give county wide strategies to ensure there are consistent procedures throughout all the East Riding of Yorkshire schools. However, schools should make adjustments according to their own policies and working practice should there be cause to do so.

ROLES AND RESPONSIBILITIES

Anyone caring for children, including teachers and other members of staff in charge of children, has a common law duty of care. Staff need to make sure that children are healthy and this could extend to administering prescribed medication and/or taking action in the event of an emergency. Every person involved with children who have medical needs should be aware of what is expected of them. Co-operation between schools, parents/guardians and health professionals will help provide a supportive setting for children with health issues.

THE EMPLOYER

The Headteacher is responsible to ensure there is full insurance cover for staff acting within the scope of their employment.

Local authority maintained schools opt into the liability cover arranged via the East Riding of Yorkshire Council's blanket policy. Academy schools are to organise their own insurance. Each individual school opts into the local authority cover and needs to be satisfied that they are protected.

The liability policy operates to cover administration of medicines provided that there is no prescribing of dosage. It is required that the individual establishments will ensure that they have suitably trained employees to carry out the activity and that appropriate care plans are in place as appropriate. A record will also need to be retained of all administrations. It is important that such cover is known to be in place and made explicit to all staff, so that they are reassured about their personal and professional safety. Headteachers should support staff to use their best endeavours at all times, particularly in emergencies. In general, the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.

It is the Headteacher's responsibility to make sure that proper guidance is in place for dealing with medicines in school and that staff have appropriate training to support children with medical needs. Headteachers should also ensure that there are suitable systems for sharing information about children's medical needs in each school for which they are responsible.

Headteachers should satisfy themselves that training has given staff sufficient understanding, confidence and expertise, also that arrangements are in place to up-date training on a regular basis. A health care professional should provide written confirmation of proficiency in any medical procedure (e.g. first aid, use of auto-injector pens).

Under the Health and Safety at Work etc. Act 1974, employers, including local authorities and school governing bodies, must have a health and safety policy. This should incorporate managing the administration of prescribed medicines and supporting children with complex health needs, and assist schools when developing their own operational policies and procedures.

THE GOVERNING BODY

Individual schools should develop policies to cover the needs of their own school. The governing body has general responsibility for all of the school's policies, and will usually take account of the views of the Headteacher, staff and parents/guardians in developing a policy on assisting pupils with medical needs. The policy should be reviewed and updated on a regular basis and should contain clear systems and procedures for the safe administering of prescribed medication to pupils. Where the local authority is the employer, the school's governing body should follow the health and safety policies and procedures produced by the local authority.
If the administration of prescribed medicines requires technical or medical knowledge then the governing body should ensure training is provided to staff from a qualified health professional. Training should be specific to the individual medical needs of the child concerned.

THE HEADTEACHER

The Headteacher is responsible for implementing the governing body's policy on a day-to-day basis. For a child with medical needs, the Headteacher must agree with parents/guardians exactly what support can be provided in school. If parents/guardians expect unreasonable adjustments, the Headteacher should seek advice from the school nurse, the child's Doctor or other appropriate health professional. The Headteacher, or delegated manager, should:

- Ensure that procedures are understood and adhered to
- Ensure that training is provided where necessary
- Ensure that there is appropriate, effective communication and consultation with parents/guardians, children and health professionals concerning pupils with medical needs

In addition all staff (including supply staff) should be notified of the delegated person with responsibility for medical care and informed of a child's medical needs/ allergies, if appropriate.

PARENTS/GUARDIANS

The major role of caring for a child rests with the parents or guardians and it is their responsibility to manage the child's health and to ensure attendance at school (Section 7 of the 1996 Education Act).

It is the responsibility of the parent/guardian to provide the school with full information about their child's medical needs, including:

- Details of their child's medical needs
- Details of the treatment he/she will need at school, including any possible side effects of prescribed medication
- Other special needs or conditions (i.e. dietary requirements, pre activity precautions)
- Details of any allergies
- The name and address of GP/consultants
- Telephone number of surgery
- What to do and who to contact in an emergency

Parents/guardians should also provide any prescribed medication in a clearly labelled container with the following:

- Name and strength of medicine
- Dosage of medication to be given to the child
- When to be given (actual time if possible)
- Expiry date
- Any changes to the medication
- Any other appropriate instructions (e.g. special storage arrangements)
- Collect and dispose of any medicines held in school at appropriate times
- Ensure that medicines have not passed the expiry date

PARENTS AND PARENTAL RESPONSIBILITY

For the purpose of Section 576 of the Education Act 1996 a parent is all natural parents, whether married or not, but includes any person who is not a parent of a child but who has parental responsibility for or care of a child.

Mothers and fathers who are married automatically have parental responsibility for their children.

Having parental responsibility means assuming all the rights, duties, powers, responsibilities and authority that a parent of a child has in relation to the child.

A person other than a child's natural parents can acquire parental responsibility through:

- Being granted a residence order
- Being appointed a guardian
- Adopting a child
- Step-parents by virtue of a Step-Parent Parental Responsibility Agreement or as result of a court order.

In addition, a local authority acquires parental responsibility if it is named in the care order (including emergency protection order and interim care order) for a child.

Where a child's parents are not or have not been married to each order, the child's father will still have parental responsibility if the child was born after 1 December 2003 and is named on the birth certificate. If a father does not have parental responsibility then he can acquire this:

- Through a registered 'parental responsibility agreement' between him and the child's mother
- As a result of a Parental Responsibility Order
- Being granted a Residence Order

DEVELOPING A MANAGING MEDICINES POLICY

A clear policy adopted by staff, parents and children provides a sound basis for ensuring that children with medical needs receive proper care and support in school to enable regular attendance.

Policies and procedures should be developed in consultation with Headteachers, school staff and governing bodies. All policies should be reviewed and updated on a regular basis.

The policy should contain formal systems and procedures in respect of administering medicines, and needs to be clear to all staff, parents/guardians and children. It should be included in the prospectus, or in other information for parents/guardians.

A policy should cover:

- Procedures for managing prescribed medicines which need to be taken during the school day
- Procedures for managing prescribed medicines on trips and outings
- A clear statement on the roles and responsibility of staff managing administration of prescribed medicines, and for administering or supervising the administration of prescribed medicines
- A clear statement on parental responsibilities in respect of their child's medical needs
- The need for prior written agreement from parents/guardians for any prescribed medicines to be given to a child
- How the school assists children with long-term or complex medical needs
- How the school support children carrying and taking their medicines themselves where appropriate
- Staff training in dealing with medical needs
- Record keeping
- Safe storage of prescribed medicines
- Access to the school's emergency procedures
- Risk assessment and management procedures

ADMINISTERING PRESCRIBED MEDICINES

Medicines should only be taken in school when essential; that is where it would be detrimental to a child's health if the medicine were not administered during the school day. Medicines should always be provided by parents in the original container or as dispensed by a pharmacist (include the prescriber's instructions for administration). Any change in a prescription should be supported by new directions on the package of the medication or by a letter from a medical professional.

Schools should never accept medicines that have been taken out of the container as originally dispensed/supplied or make changes to dosages on parental instructions.

Non-prescription medicines should not be administered to a child beyond 48 hours, after which a healthcare professional should be consulted. For example, if a child suffers regularly from frequent or acute pain the parents/guardians should be encouraged to seek medical advice and request prescribed medication from the Pharmacist or an appropriate health care professional. A child under 16 should never be given aspirin or medicines containing ibuprofen unless prescribed by a doctor.

OVER THE COUNTER MEDICINES (NON-PRESCRIPTION)

Over the counter medicines, e.g. hay-fever treatments, sun cream should only be accepted in exceptional circumstances, and be treated in the same way as prescription medication. The parent/carer must clearly label the container with the child's name, dose and time of administration and complete a Consent Form.

Staff should check that the medicine has been administered without adverse effect in the past and that parents have certified that this is the case – a note to this effect should be recorded in the written parental agreement for the school to administer medicine. There is a potential risk of interaction between prescription and over the counter medicines so where children are already taking prescription medicine(s), prior written approval from an appropriate healthcare professional should be considered.

The use of non-prescribed medicines should normally be limited to a 24hr period and in all cases not exceed 48hrs. If symptoms persist medical advice should be sought by the parent. Other remedies, including herbal preparations, should not be accepted for administration in school.

It is expected that parents/guardians will normally administer medication to their children at home. No prescribed medication should be administered in school unless prior written permission has been given by the parent/guardian (a request to administer prescribed medication form should be completed).

Medicines should normally be administered during break and lunch times. If for medical reasons, the prescribed medicine has to be taken at other times of the day, arrangements should be made accordingly. Pupils should be told where their medication is kept and who will administer it. Written permission from parents/guardians will be required for pupils to self-administer medication.

Any member of staff giving medicines to a child should:

- Check the child's name
- Check prescribed dose
- Check expiry date
- Check any written instructions provided on the original medication
- Complete either the long or short term administration sheet
- Check the record sheet to ensure the medication has not already been administered.

If in doubt about any procedure staff, should not administer the medicines but check with the parents/guardians/carer or a health professional before taking further action. If staff have any concerns related to administering prescribed medicine to a particular child, the issue should be discussed with the parents/guardians, if appropriate, or with a health professional attached to the school. Only designated member(s) of staff should administer medication, checking the medication log record to avoid the risk of double dosing; however backup cover should be arranged for when the member of staff responsible is unavailable or absent.

All staff should be familiar with normal precautions for avoiding infection and must follow basic hygiene procedures. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood, other body fluids and disposing of dressings.

The Education (School Premises) Regulations 1999 require every school to have an area appropriate and readily available for medical treatment and the care of sick or injured children.

CONTROLLED DRUGS

The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated documents (*Managing Medicines in Schools (DfE 2015)*) and NICE guidance NG46 (2016). Some may be prescribed as medicine for use by children, e.g. methylphenidate.

Any designated member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber's instructions.

It is permissible for schools and settings to look after a controlled drug, where it is agreed that it will be administered to the child for whom it has been prescribed. Schools and settings should keep controlled drugs in a locked non-portable container and only named staff should have access. A record should be kept for audit and safety purposes.

A controlled drug, as with all medicines, should be returned to the parent/guardian when no longer required.

Misuse of a controlled drug, such as passing it to another child for use, is an offence. Schools should have a policy in place for dealing with drug misuse.

CARRYING MEDICINES

There are regulations regarding Medicines in a School Setting. Only certain medication is allowed to be carried by pupils whilst in school.

By law parents/guardians must give written consent for their child to carry their own prescribed medication and to be given prescribed medication.

Conditions such as allergy causing anaphylaxis, asthma and diabetes mean pupils may need to carry their own prescribed medication whilst at school; however unless it is deemed essential for their condition (e.g. the above and certain migraine medication) the pupil is not allowed to carry their own medication. It is the parent's/guardian's responsibility to ensure that prescribed medication is handed into the main office, preferably to the nurse or first aider. In these circumstances the medication should remain in school and not be returned home at the end of the day.

Medication should be in date, it is NOT the school's responsibility to notify parents/guardians if medication has gone out of date.

Parents/guardians will also be responsible for ensuring there is an adequate supply of prescribed medication for their child whilst at school.

Any out of date medication should be collected by parents/guardians.

REFUSING MEDICATION

If a child refuses to take their prescribed medication, staff should not force them to do so, but should note this in the records and parents/guardians should be informed of the refusal as soon as possible. If a refusal to take prescribed medicines results in an emergency, the school's emergency procedures should be followed.

STORAGE AND ADMINISTRATION OF PARACETAMOL ORAL SUSPENSION SACHETS

The purpose of this guidance is:

- To enable parents to provide over the counter paracetamol for short term use for their child whilst at school without requesting prescribed paracetamol from the GP
- To specify the use of sachets to ensure that pupils receive the correct dosage of paracetamol as directed by the parent
- To alleviate the need to store numerous bottles of paracetamol oral suspension. This reduces the risk of administering from expired, contaminated, poorly labelled or multiple pupils' supplies.

PRIOR TO SUPERVISION OR ADMINISTRATION OF PARACETAMOL ORAL SUSPENSION

The responsibilities of parents and schools are as follows:

Parents must:

- Provide paracetamol oral suspension as a 5ml sachet. Depending on the dose, this may be one or two 5ml sachets (however, if the dose required is 7.5ml, the parent/ guardian must provide an oral syringe or a 2.5ml spoon)
- Bring the medication **only on the day it is required** in a sealed envelope containing the medication with the pupil's name, class, date and time last given clearly marked on the front of the envelope
- Complete consent form 3 (Parental agreement for school to administer medicine) giving permission to administer or supervise their child, stating clearly the dose to be taken. If a dose has been taken before arriving at school, details of the time after which the next dose may be received (**at least four hours**).

Schools must:

- Ensure that the Parental Agreement for School to Administer Medicine form has been fully completed and authorised by the parent
- Ensure medication has not been given within the last four hours
- Check the details on the envelope concur with the pupil's details
- Check that the sachet is not damaged or punctured in any way and if it is, discard it - inform the parent and be advised by the parent what to do
- Check the expiry date on the paracetamol oral suspension sachet
- Massage the contents of the sachet before opening to ensure the medication is fully mixed in the suspension
- Ensure that the pupil has taken the full amount required and that form 6 is completed (Record of short term medicines administered to all children).

RECORD KEEPING

Written records **must** be made each time prescribed medicines are given to a child, signed by the member of staff administering the medication. Good records help demonstrate that staff have exercised a duty of care and should include the following:

- Name of the child and their class/form
- Name of medication and expiry date
- Date and time of administration
- Dose given
- Who administered the medication
- A note of any side effects

A parental consent form must be obtained before the administration of any prescribed medication.

RISK ASSESSMENTS FOR MEDICATION

A model risk assessment and associated safe system of work for the Storage and Administration of Medication has been devised to ensure a consistent procedure is adopted when administering medication – see page 8.22. This does not replace the need for schools to have a policy in place to record roles and responsibilities, but does allow agreed controls and a subsequent protocol by members of staff to be recorded, communicated and implemented.

This risk assessment is a summary of the guidance for administering medication that is contained within the 'Medical Conditions at School' document.

This model risk assessment should be reviewed by schools on an individual basis and adapted, where necessary, to ensure their own procedures and arrangements are recorded.

EDUCATIONAL VISITS

Schools should consider any adjustments they may need to make to enable children with medical needs to participate safely on visits. This might include reviewing and revising the visits policy and procedures, risk assessments and additional safety measures that may need to be taken for outside visits.

Staff supervising excursions should always be aware of any medical needs, including travel sickness and relevant emergency procedures. A copy of any health care plan should be taken on visit in the event of the information being needed in an emergency.

If there are concerns about whether staff can provide for a child's safety or the safety of other children on a visit, they should seek parental views and medical advice from the school health service or the child's GP.

SPORTING ACTIVITIES

Most children with medical conditions can participate in physical activities and extra-curricular sport, in ways appropriate to their own abilities. Any restrictions on a child's ability to participate in PE should be recorded in their individual health care plan. All adults should be aware of issues of privacy and dignity for children with particular needs.

Some children may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their prescribed medicines such as asthma inhalers and spacers. Staff supervising sporting activities should consider whether risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative prescribed medicine that may need to be taken and emergency procedures.

MEDICINE CARE

STORING MEDICINES

Schools should not store large volumes of medication. Where a pupil needs more than one medicine, each should be in original packaging. Staff should never transfer medicines from their original packaging. The Headteacher is responsible for making sure that medicines are stored in a secure place. All staff should know where to obtain the medicine. Medication and the care plan should be stored together ensuring medication is not mistakenly administered to another child that may be on identical medication.

A few prescribed medicines, such as asthma inhalers and spacers, must be readily available to pupils and must not be locked away. If it is appropriate schools may allow pupils to carry their own medication.

Some prescribed medicines need to be refrigerated. These medicines can be kept in a refrigerator containing food but should be in an airtight container and clearly labelled, but the school should restrict access to a refrigerator holding medicines.

School staff should not dispose of medicines. Parents/guardians should collect medicines held at school at the end of each term if the pupil no longer requires them and are responsible for the disposal of date-expired medicines.

Secondary schools should not keep or supply non-prescription medicines such as paracetamol. The potential for damage is high, as staff in school will not know what previous medication may have been taken or what the reaction may be. Schools should never put themselves in the position where they may be seen to be 'prescribing' medication either to their pupils or to their own staff.

DISPOSAL OF MEDICINES

Staff should not dispose of medicines. Parents/guardians are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal. They should also collect medicines held at the end of each term if the pupil no longer requires them. If parents/guardians do not collect medicines, arrangements should be made with the local pharmacy for safe disposal. NICE Guidance NG46 (2016).

Sharps boxes should always be used for the disposal of needles. Sharps boxes can be obtained by parents/guardians on prescription from the child's GP or paediatrician. Collection and disposal of the boxes should be arranged with the local authority's environmental services.

EMERGENCY PROCEDURES

Headteachers should ensure that all staff are aware of the school's planned emergency procedure in event of medical need, and that pupils know what to do in the event of an emergency, such as telling a member of staff. A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent/guardian arrives. Health professionals are responsible for any decisions on medical treatment when parents/guardians are unavailable, not the member of staff.

Wherever possible staff should avoid taking children to hospital in their own car; it is safer to call an ambulance. Individual health care plans should include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency, for example if there is an incident in the playground a lunchtime supervisor would need to be very clear of their role.

Arrangements for dealing with emergency situations should be included in the schools health and safety policy.

INDIVIDUAL HEALTHCARE PLAN

PURPOSE OF A HEALTHCARE PLAN

The main purpose of an individual healthcare plan for a child with medical needs is to identify and clarify the level of support that is needed. Not all children who have medical needs will require an individual plan. An individual healthcare plan clarifies for staff, parents/guardians and the child the help that can be provided.

It is important for staff to be guided by a health professional, the child's GP or paediatrician and the register marked accordingly ensuring consistency of support when a change of staff occurs. Staff should agree with parents/guardians how often they should jointly review the healthcare plan.

It is sensible to do this at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently. Staff should judge each child's needs individually as children and young people vary in their ability to cope with poor health or a particular medical condition.

Developing a healthcare plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child. In addition to input from the school nurse, the child's GP or other health care professionals (depending on the level of support the child needs), those who may need to contribute to a healthcare plan include:

- The Headteacher or head of setting
- The parent/guardian
- The child (if appropriate)
- Early years practitioner/class teacher (primary schools) /form tutor/head of year (secondary schools)
- Care assistant or support staff (if applicable)
- Staff who are trained to administer prescribed medicines
- Staff who are trained in emergency procedures

When the child's Individual Healthcare Plan is being completed, the Emergency Information (see Templates and Forms) should also be completed, printed double sided, placed in a clear wallet file with the child's emergency medication and where possible kept within easy access of staff (and child if appropriate).

STAFF TRAINING

A healthcare plan may reveal the need for some staff to have further information about a medical condition or specific training in administering a particular type of prescribed medicine or in dealing with emergencies. Staff should not give prescribed medicines without appropriate training from health professionals.

When staff voluntarily agrees to assist a child with medical needs, the employer should arrange appropriate training in collaboration with local health services and ensure that training is regularly updated. Local health services/school nurse will also be able to advise on further training needs.

There should be a clear school policy regarding medical procedures with defined roles and responsibilities. This policy should be reviewed, updated and publicised on a regular basis.

CONFIDENTIALITY

The Headteacher and staff should always treat medical information confidentially. The Headteacher should agree with the child where appropriate, or otherwise the parent/guardian, who else should have access to records and other information about a child. If information is withheld from staff they should not generally be held responsible if they act incorrectly in giving medical assistance but otherwise in good faith.

A healthcare plan should be easily accessible in appropriate places but with confidentiality in mind (including break time cover).

Schools are responsible to give relevant information regarding the children in their care to any temporary staff.

LONG TERM MEDICAL NEEDS/ ACCESS TO EDUCATION

Some children with medical needs are protected from discrimination under the Equality Act (2010). The Equality Act defines a person as having a disability if he/she has a physical or mental impairment which has substantial or long term adverse effect on his or her abilities to carry out normal day to day activities.

Under chapter 4 of the Equality Act, responsible bodies for schools (including nursery schools) must not discriminate against disabled pupils in relation to their access to education and associated services – a term that covers all aspects of school life including school trips, clubs and activities. Schools should make reasonable adjustments for disabled children, including those with medical needs at different levels of school life, and for the individual disabled child, in their practises, procedures and policies.

Schools are also under a duty to plan strategically an increase to access, over time, for disabled children, including those with medical needs.

The national curriculum inclusion statement 2000 emphasises the importance of providing effective learning opportunities to all pupils by:

- Setting suitable learning challenges
- Responding to pupil needs
- Overcoming potential barriers to learning

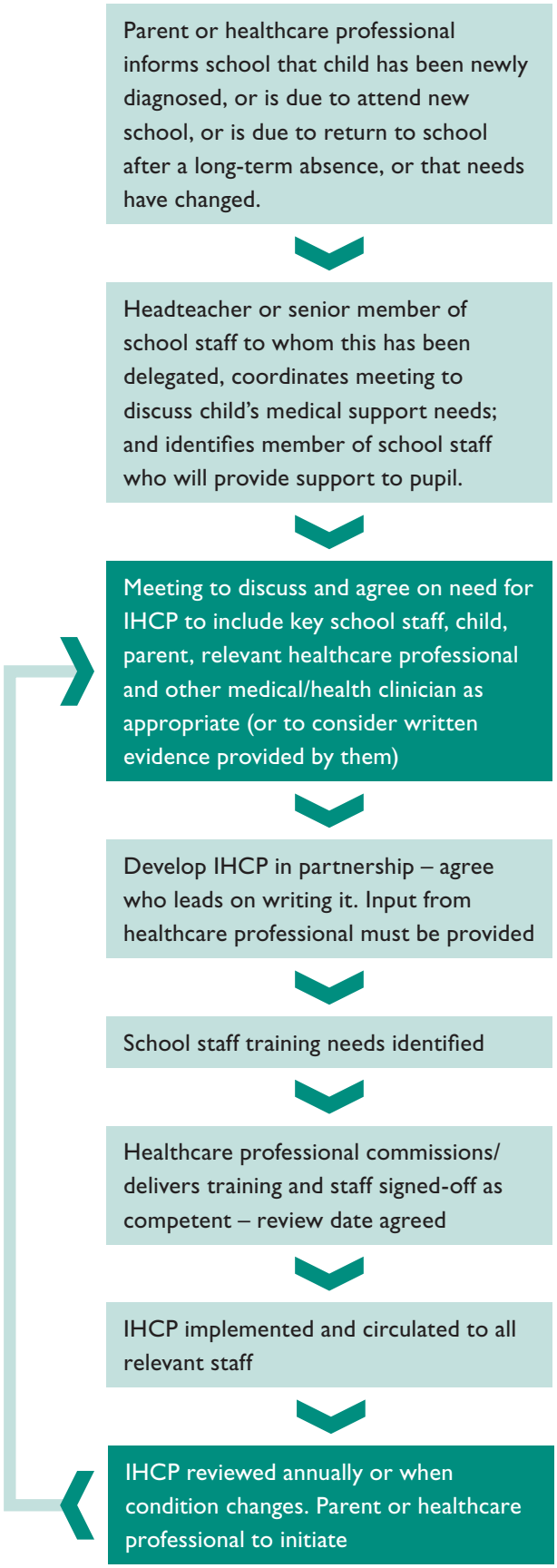
If schools encounter difficulties in making adjustments to accommodate children with medical needs, advice may be sought from the local authority.

SUPPLY / TEMPORARY STAFF

All supply staff should be notified of the delegated person with responsibility for medical care and informed of a child's medical needs/allergies who are in their care throughout the time they are in their care, if appropriate.

If the child's condition may require emergency treatment, the child's Individual Healthcare Plan and Emergency Information sheet must be shared with the staff member to raise their awareness in case medical attention is required.

MODEL PROCESS FOR DEVELOPING INDIVIDUAL HEALTHCARE PLANS



Flow chart taken from *'Supporting Pupils from School with Medical Conditions'* (DfE December 2015)

SCHOOL GUIDANCE FOR FACILITATION OF A MEDICAL CONDITION

AWARENESS OF CONDITION

FURTHER ADVICE RECEIVED FROM PREVIOUS SCHOOL/PARENTS/OTHER HEALTH PROFESSIONALS (WITH PARENTAL CONSENT).

PROVISION CAN BE DELIVERED THROUGH A CURRENT JOB ROLE?

NO

A MEMBER OF STAFF IS RECOGNISED AND WILLING TO TAKE RESPONSIBILITY?

YES

IS TRAINING /UPDATE TRAINING REQUIRED?

NO

Possible conclusions:
(in no specific order)

- Advertise for staff to cover required care
- Renegotiate staff contract (pay increase)
- Appoint new first aider (attracting the First Aid Allowance) and include the pupil's care
- Approach parent/carers to investigate if family members are willing and available
- Contact the Integrated Specialist Public Health Nurse ISPHN to signpost school to similar situation

YES

Signpost to specific training provision:
Integrated Specialist Public Health Nurse (ISPHN).
Contact details are on Local Offer

SOLUTION FOUND

APPROPRIATE TRAINING PROVIDED AND STAFF FEEL SUFFICIENTLY CONFIDENT?

NO

YES

NO

SCHOOL HEALTH CARE PLAN COMPLETED

HEALTH CARE PLAN REVIEWED / TRAINING REQUIRED TERMLY / ANNUALLY OR WHEN ADJUSTMENTS ARE REQUIRED

INSURANCE SERVICES FOR SCHOOLS – INSURANCE COVER FOR ADMINISTERING MEDICATION IN SCHOOLS

CHILDREN AND FAMILIES ACT 2014 SUPPORTING PUPILS AT SCHOOL WITH MEDICAL CONDITIONS

The Department for Education guidance for schools on this legislation contains a section on 'Liability and Indemnity' with the following advice relating to insurance cover:

- Governing bodies should ensure that the appropriate level of insurance is in place. It is important that policies set out the details of the school's insurance.
- Policies should provide liability cover relating to the administration of medication but individual cover may need to be arranged for health care procedures associated with more complex conditions. Any requirements of the insurance such as the need for staff to be trained should be made clear.
- In the event of a claim alleging negligence by a member of staff, civil actions are likely to be brought against the employer, who carries public liability, rather than the employee.

We are pleased to confirm that maintained schools that arrange their insurance through the East Riding of Yorkshire Council, already have Public Liability insurance in place to meet the DfE's requirements.

For further information about the above, please email insurance@eastriding.gov.uk or contact Insurance and Risk Manager on (01482) 393939.

WHAT YOUR INSURANCE COVERS

- The insurance policy includes cover for the **school governing body, teachers, other employees and volunteers** should a claim be made against them by a pupil who alleges that they have sustained an injury or damage to their property as a result of the negligent provision of medical treatment.
- The insurance policy covers the administration or supervision of prescription and non-prescription medication orally, topically, by injection or by tube, the application of appliances or dressings and basic medical treatment, such as re-fitting a gastronomy tube/peg or tracheotomy tube. This applies to both straightforward and complex conditions.
- Teachers, employees and volunteers must have received appropriate training and this must be reviewed on a regular basis. It is important that evidence of training given and received is recorded and retained.
- The insurance policy applies to all school activities including extra-curricular activities and school trips at home and abroad. Cover also applies to any first aid activities carried out by teachers, employees and volunteers.

MEDICATION RETENTION PERIODS

One of the Information Commissioner's Office (ICO) data protection principles states 'you must not keep personal data for longer than you need it'.

This raises the question; how long do we keep information for and what determines the retention period? Information from the Department for Education's Data Protection Toolkit state the following guidance:

- If a child has **short term illness** and requires medication (ie. antibiotics) then keep the permission form for the **duration the child requires medication for, plus an additional month**.
- Additionally when permission slips have been gained for events like school trips these should be kept for the **event plus one month**.
- For medical conditions and ongoing treatments (e.g. allergies and asthma) keep the permission form for the **time the pupil is at school plus one year after they have left**. You may choose to review this on annual basis to ensure medication is still required and a pupils medical needs remain the same.

Medical 'incidents' that have a **behavioural or safeguarding** concerns (including the school duty of care) should refer to the retention periods associated with those school **policies**.

Headteachers and Governors are advised to document retention periods using the DfE guidance as a guide and keep records for recommended short and medium term use of medication.

ADDITIONAL SOURCES OF INFORMATION

ADDITIONAL SOURCES OF INFORMATION

- Equality Act (2010): Advice for Schools (updated 2018)
- Health and Safety at Work Act 1974
- Control of Substances Hazardous to Health Regulations 2002
- Misuse of Drugs Act 1971
- National Standards for under 8's day care and childminding
- Guidance and Infection Control in Schools and Nurseries 1999
- The Education (School Premises) Regulations 1999
- First Aid for Schools – A good Practice Guide 1998
- Special Educational Needs and Disabilities Code of Practice: 0-25 years (January 2015)

RELATED DOCUMENTS

Statutory guidance

- *Supporting pupils at school with medical conditions* (DfE December 2015)
- *Supporting pupils with medical conditions: links to other useful resources* (DfE December 2015)

Schools

Further information and guidance can be found on the Department for Education website:

media.education.gov.uk

- *Guidance on First Aid for Schools* (DfE February 2014)
- *Health and safety: Responsibilities and Duties of School (DfE November 2018)*
- *Home to School Travel and Transport Guidance* (DfES 2007)
- *Exclusion from maintained schools, Academies and pupil referral units* (DfE 2012)
- *School Admissions Code* (DfE 2012)
- *Special Educational Needs Code of Practice* (DfES 2001)
- *Advice on Standards for School Premises* (DfE May 2013)
- *Safeguarding Children and Safer Recruitment in Education* (DfES 2007)
- *Access to Education* (DfES 2001)

Department of Health (including joint publications)

- *Guidance on the use of emergency salbutamol inhalers in schools* (Sept 2014)
- *Guidance on the use of adrenaline auto-injectors in schools* (September 2017)
- *National Service Framework for Children, Young People and Maternity Services: Medicines for Children and Young People* (2004).

www.gov.uk

Ofsted

All documents can be viewed online:

www.ofsted.gov.uk/schools

- *Inspecting schools – Handbook for inspecting* (Sept 2013)
- *The special educational needs and disability review* (Sept 2010)

EAST RIDING OF YORKSHIRE COUNCIL

Safety Services

(01482) 391117

Safety Services Documentation including model health and safety policy, model risk assessments (including infection control) and PEEP template available on InSight: **Safety Services > Schools Model Document and Templates**

Educational Welfare Service

(01482) 393939

USEFUL CONTACTS

Allergy UK
- Allergy Helpline: (01322) 619864
- www.allergyfoundation.com

The Anaphylaxis Campaign
- Helpline: (01252) 542029
- www.anaphylaxis.org.uk and www.allergyinschools.co.uk

Asthma UK (formerly the National Asthma Campaign)
- Adviceline: 08457 01 02 03 (Mon-Fri 9am to 5pm)
- www.asthma.org.uk

Council for Disabled Children (National Children's Bureau)
- (020) 7843 1900
- www.ncb.org.uk/cdc

Contact a Family (Information about caring for disabled and special needs children)
- Helpline: 0808 808 3555
- www.cafamily.org.uk

Cystic Fibrosis Trust
- (020) 8464 7211 (Out of hours: 020 8464 0623)
- www.cftrust.org.uk

Diabetes UK
- Careline: 0845 1202960 (Weekdays 9am to 5pm)
- www.diabetes.org.uk

Disability Rights Commission (DRC)
- DRC helpline: 08457 622633 Textphone: 08457 622 644 Fax: 08457 778878
- www.drc-gb.org

National Eczema Society
- Helpline: 0870 241 3604 (Mon-Fri 8am to 8pm)
- www.eczema.org

Epilepsy Action
- Freephone Helpline: 0808 800 5050 (Mon-Thurs 9am to 4.30pm, Fri 9am to 4pm)
- www.epilepsy.org.uk

National Society for Epilepsy
- Helpline: (01494) 601400 (Mon-Fri 10am to 4pm)
- www.epilepsynse.org.uk

Health and Safety Executive (HSE)
- HSE Infoline: 08701 545500 (Mon-Fri 8am to 6pm)
- www.hse.gov.uk

Health Education Trust
- (01789) 773915
- www.healthedtrust.com

Department of Health
- (020) 7210 4850
- www.dh.gov.uk

MENCAP
- (020) 7454 0454
- www.mencap.org.uk

Psoriasis Association
- 0845 676 0076 (Mon-Thurs 9.15am to 4.45pm / Fri 9.15am to 4.15pm)
- www.psoriasis-association.org.uk

Association for Spina Bifida and Hydrocephalus
- (01733) 555988 (9am to 5pm)
- www.asbah.org

MANAGING CHRONIC HEALTH CONDITIONS AND INFECTION CONTROL

GUIDANCE

EAST RIDING OF YORKSHIRE COUNCIL

NHS

MANAGING CHRONIC HEALTH CONDITIONS AND INFECTION CONTROL

GUIDANCE

CONTENTS

This is an updated version of the 'Managing Chronic Health Conditions and Infection Control in schools' guidance produced in January 2014.

TABLES OF CONDITIONS AND RECOMMENDED ABSENCE FROM SCHOOL

3.1

If a parent is concerned about any aspect of their child's health they should consult a health professional via NHS direct, a local chemist (Minor Ailment Scheme), walk in centre, GP or a referral should be made to the school nurse.

The information listed below and Good Hygiene Practice guidance has been taken from Guidance on Infection Control in Schools and Other Child Care Settings (Public Health England March 2017):
www.publichealth.hscni.net/publications/guidance-infection-control-schools-and-other-childcare-settings-0

Further information:
www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities

Within this section the following acronyms relate – Health Protection Team (HPT) – Public Health England (PHE)

RASHES AND SKIN INFECTIONS

Children with rashes should be considered infectious and assessed by their doctor.

Infection or complaint	Recommended period to be kept away from school, nursery or childminders	Comments
Athlete's foot	None	Athlete's foot is not a serious condition. Treatment is recommended.
Chickenpox	Until all vesicles have crusted over (which may take 5-6 days)	See advice and information for: *Immunocompromised* Pupils and Pregnant Females.
Cold sores (Herpes simplex)	None	Avoid kissing and contact with the sores. Cold sores are generally mild and self-limiting.
German measles (rubella)*	Four days from onset of rash (as per "Green Book")	Preventable by immunisation (MMR x2 doses). See advice and information for: *Immunocompromised* Pupils & Pregnant Females.
Hand, foot and mouth	None	Contact your local HPT if a large number of children are affected. Absence may be considered in some circumstances
Impetigo	Until lesions are crusted and healed, or 48 hours after starting antibiotic treatment	Antibiotic treatment speeds healing and reduces the infectious period. Where possible infected areas should be covered.
Measles*	Four days from onset of rash	Preventable by immunisation (MMR x2 doses). See advice and information for: *Immunocompromised* Pupils and Pregnant Females.
Molluscum contagiosum	None	A self-limiting condition.
Ringworm	Absence not usually required	Treatment is required.
Roseola (infantum)	None	None.
Scabies	Child can return after first treatment	Household and close contacts require treatment.
Scarlet fever*	Child can return 24 hours after starting appropriate antibiotic treatment	Antibiotic treatment is recommended for the affected child.

RASHES AND SKIN INFECTIONS (CONTINUED)

Infection or complaint	Recommended period to be kept away from school, nursery or childminders	Comments
Slapped cheek/fifth disease. Parvovirus B19.	None (once rash has developed)	See advice and information for: *Immunocompromised* Pupils and Pregnant Females.
Shingles*	Absence only if rash is weeping and cannot be covered	Can cause chickenpox in those who are not immune, i.e. have not had chickenpox. It is spread by very close contact and touch. If further information is required, contact your local Public Health England (PHE) centre. See advice and information for: *Immunocompromised* Pupils and Pregnant Females.
Warts and verrucae	None	Verrucae should be covered in swimming pools, gymnasiums and changing rooms.

DIARRHOEA AND VOMITING ILLNESS

Infection or complaint	Recommended period to be kept away from school, nursery or childminders	Comments
Diarrhoea and/or vomiting	48 hours from last episode of diarrhoea or vomiting	Some East Riding schools policy may state 24hrs for **vomiting only**; this is when no other symptoms are present.
E. coli O157 VTEC Typhoid* [and paratyphoid*] (enteric fever) Shigella (dysentery)	Should be absent for 48 hours from the last episode of diarrhoea. Further absence may be required for some children until they are no longer excreting	Further absence is required for children aged five years or younger and those who have difficulty in adhering to hygiene practices. Children in these categories should be absent until there is evidence of microbiological clearance. This guidance may also apply to some contacts who may also require microbiological clearance. Please consult your local PHE centre for further advice.
Crypto-sporidiosis	Absent for 48 hours from the last episode of diarrhoea	Absence from swimming is advisable for two weeks after the diarrhoea has settled.

RESPIRATORY INFECTIONS

Infection or complaint	Recommended period to be kept away from school, nursery or childminders	Comments
Flu (influenza)	Until recovered	See: Vulnerable Children below.
Tuberculosis*	Always consult your local PHE centre	Requires prolonged close contact for spread.
Whooping cough* (pertussis)	Two days from starting antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment	Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks. Your local PHE centre will organise any contact tracing necessary.

OTHER INFECTIONS

Infection or complaint	Recommended period to be kept away from school, nursery or childminders	Comments
Conjunctivitis	None	If an outbreak/cluster occurs, consult your local PHE centre.
Diphtheria*	Absence is essential. Always consult with your local Health Protection Team (HPT)	Family contacts must be absent until cleared to return by your local PHE centre. Preventable by vaccination. Your local PHE centre will organise any contact tracing necessary.
Glandular fever	None	
Head lice	None	Treatment is recommended only in cases where live lice have been seen.
Hepatitis A*	Absent until seven days after onset of jaundice (or seven days after symptom onset if no jaundice)	In an outbreak of hepatitis A, your local PHE centre will advise on control measures.
Hepatitis B*, C*, HIV/AIDS	None	Hepatitis B and C and HIV are bloodborne viruses that are not infectious through casual contact. For cleaning of body fluid spills see: Good Hygiene Practice.
Meningococcal meningitis*/ septicaemia*	Until recovered	Meningitis C is preventable by vaccination. There is no reason for siblings or other close contacts of a case to be absent from school. In case of an outbreak, it may be necessary to provide antibiotics with or without meningococcal vaccination to close school contacts. Your local PHE centre will advise on any action is needed.
Meningitis* due to other bacteria	Until recovered	Hib and pneumococcal meningitis are preventable by vaccination. There is no reason for siblings or other close contacts of a case to be absent from school. Your local PHE centre will give advice on any action needed.
Meningitis viral*	None	Milder illness. There is no reason for siblings or other close contacts of a case to be absent from school. Contact tracing is not required.
MRSA	None	Good hygiene, in particular handwashing and environmental cleaning, are important to minimise any danger of spread. If further information is required, contact your local PHE centre.
Mumps*	Absent child for five days after onset of swelling	Preventable by vaccination (MMR x2 doses).
Threadworms	None	Treatment is recommended for the child and household contacts.
Tonsillitis	None	There are many causes, but most cases are due to viruses and do not need an antibiotic.

*denotes a notifiable disease. It is a statutory requirement that doctors report a notifiable disease to the proper officer of the local authority (usually a consultant in communicable disease control). In addition, organisations may be required via locally agreed arrangements to inform their local PHE centre. Regulating bodies (for example, Office for Standards in Education (OFSTED) /Commission for Social Care Inspection (CSCI)) may wish to be informed – please refer to local policy.

GOOD HYGIENE PRACTICE

Hand washing

Hand washing is one of the most important ways of controlling the spread of infections, especially those that cause diarrhoea and vomiting, and respiratory disease. The recommended method is the use of liquid soap, warm water and paper towels. Always wash hands after using the toilet, before eating or handling food, and after handling animals. Cover all cuts and abrasions with waterproof dressings.

Coughing and sneezing

Coughing and sneezing easily spread infections. Children and adults should be encouraged to cover their mouth and nose with a tissue. Wash hands after using or disposing of tissues. Spitting should be discouraged.

Personal protective equipment (PPE)

Disposable non-powdered vinyl or latex-free CE-marked gloves and disposable plastic aprons must be worn where there is a risk of splashing or contamination with blood/body fluids (for example, nappy or pad changing). Goggles should also be available for use if there is a risk of splashing to the face. Correct PPE should be used when handling cleaning chemicals.

Cleaning of the environment

Cleaning of the environment, including toys and equipment, should be frequent, thorough and follow national guidance. For example, use colour-coded equipment, COSHH and correct decontamination of cleaning equipment. Monitor cleaning contracts and ensure cleaners are appropriately trained with access to PPE.

Cleaning of blood and body fluid spillages

All spillages of blood, faeces, saliva, vomit, nasal and eye discharges should be cleaned up immediately (always wear PPE). When spillages occur, clean using a product that combines both a detergent and a disinfectant. Use as per manufacturer's instructions and ensure it is effective against bacteria and viruses and suitable for use on the affected surface. Never use mops for cleaning up blood and body fluid spillages – use disposable paper towels and discard clinical waste as described below. A spillage kit should be available for blood spills.

Laundry

Laundry should be dealt with in a separate dedicated facility. Soiled linen should be washed separately at the hottest wash the fabric will tolerate. Wear PPE when handling soiled linen. Children's soiled clothing should be bagged to go home, never rinsed by hand.

Clinical waste

Always segregate domestic and clinical waste, in accordance with local policy. Used nappies/pads, gloves, aprons and soiled dressings should be stored in correct clinical waste bags in foot-operated bins.
All clinical waste must ideally be removed by a registered waste contractor or double-bagged in biodegradable bags and placed in an appropriate bin. All clinical waste bags should be less than two-thirds full and stored in a dedicated, secure area while awaiting collection.

Sharps disposal

Sharps should be discarded straight into a sharps bin conforming to BS 7320 and UN 3291 standards. Sharps bins must be kept off the floor (preferably wall-mounted) and out of reach of children and should be less than two-thirds full.

Sharps injuries and bites

If skin is broken, encourage the wound to bleed/ wash thoroughly using soap and water. Contact GP or occupational health or go to A&E immediately. Ensure local policy is in place for staff to follow. Contact your local HPT for advice, if unsure.

Animals

Animals may carry infections, so hands must be washed after handling any animals. Health and Safety Executive (HSE) guidelines for protecting the health and safety of children should be followed.

Animals in school (permanent or visiting)

Ensure animals' living quarters are kept clean and away from food areas. Waste should be disposed of regularly, and litter boxes not accessible to children. Children should not play with animals unsupervised. Veterinary advice should be sought on animal welfare and animal health issues and the suitability of the animal as a pet. Reptiles are not suitable as pets in schools and nurseries, as all species carry salmonella.

Visits to farms

Please contact your local environmental health department, which will provide you with help and advice when you are planning a visit to a farm or similar establishment. A model infection control template is available from Safety Services InSight Page. For further guidance contact the Educational Visits Officer.

Vulnerable children

Some medical conditions make children vulnerable to infections that would rarely be serious in most children, these include those being treated for leukaemia or other cancers, on high doses of steroids and with conditions that seriously reduce immunity. Schools and nurseries and childminders will normally have been made aware of such children. These children are particularly vulnerable to chickenpox, measles or parvovirus B19 and, if exposed to either of these, the parent/carer should be informed promptly and further medical advice sought. It may be advisable for these children to have additional immunisations, for example pneumococcal and influenza.

Female staff – pregnancy

If a pregnant female develops a rash or is in direct contact with someone with a potentially infectious rash, this should be investigated according to PHE guidelines by a doctor. The greatest risk to pregnant women from such infections comes from their own child/children, rather than the workplace. Some specific risks are:

- Chickenpox can affect the pregnancy if a female has not already had the infection. Report exposure to midwife and GP at any stage of exposure. The GP and antenatal carer will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles
- German measles (rubella). If a pregnant female comes into contact with German measles she should inform her GP and antenatal carer immediately to ensure investigation. The infection may affect the developing baby if the female is not immune and is exposed in early pregnancy
- Slapped cheek disease (parvovirus B19) can occasionally affect an unborn child. If exposed early in pregnancy (before 20 weeks), inform whoever is giving antenatal care as this must be investigated promptly
- Measles during pregnancy can result in early delivery or even loss of the baby. If a pregnant female is exposed she should immediately inform whoever is giving antenatal care to ensure investigation

For further information go to:
Immunocompromised Pupils and Pregnant Females

Further information:

www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/

RESPONSE TO NOTIFIABLE DISEASES

Schools do not ordinarily need to report individual cases of influenza or shingles, but if there are 2 or more cases of influenza within a few days in the same class or year group (or other group like those on a school trip, etc.), then this should be reported in other for investigations to be undertaken. The same applies to shingles.

The outbreak plan template for shcools can be found in 8.24.

Please contact your local Public Health England centre for further advice and information:

PHE Yorkshire and Humber Health Protection Team (York Office)

Block 2, National Agri-food Innovation Campus
Sand Hutton
York
YO41 1LZ

(01904) 687 100

www.gov.uk/notifiable-diseases-and-causative-organisms-how-to-report

Infection control checklist can be found in 8.23.

FABRICATED ILLNESS

Schools are asked to be aware that in a very small number of children, there are concerns that reported illnesses may be exaggerated or fabricated.

If you do have concerns about any child, particularly where reported illnesses, absences or disabilities appear inconsistent, unusual or even bizarre, then please follow your safeguarding procedures of the school.

TABLE OF COMMON CONDITIONS AND RECOMMENDED ABSENCE FROM SCHOOL

Remember, if a parent is concerned about any aspect of their child's health they should seek a healthcare professional. Advice can be obtained from the School Nurse, NHS 111, NHS 111 Online, their local pharmacy, Urgent Treatment Centre (UTC) or GP Surgery. Parents are advised not to visit A&E unless it is considered an emergency.

OTHER INFECTIONS

Common Conditions	Recommended period to be kept away from school, nursery or childminders
Acne	None
Allergic contact dermatitis	None
Constipation	None
Coughs and Colds	Coughs, colds. A child with a minor cough or cold may attend school. If the cold is accompanied by a raised temperature, shivers or drowsiness that is not responding to medication the child should stay off school and seek medical advice.
Dandruff	None
Earache	If a child has earache and not responding to medication, they should seek medical advice.
Earwax	None
Eczema / Allergic Dermatitis	None. Children can attend school even when it is being treated. Pupils should only be absent from school if advised by a medical advisor because it is so severe.
Hay fever / Allergic Rhinitis	None
Headache	None. If the headache is more severe and accompanied by other symptoms, they should seek medical advice.
Hives	None
Indigestion / Heartburn	None
Insect Bites / Stings	None
Mouth Ulcers	None
Pain (Period / Soft Tissue)	None
Prickly Heat	None
Sore Throat	If a child has a sore throat with no other symptoms then they are usually well enough to attend school. It is only in severe cases that there may be good reason for them to stay at home.
Temperature	A raised temperature can usually be identified through a child looking or feeling shivery. There are lots of reasons for a raised temperature and if symptoms persist medical attention should be sought. As soon as the child is feeling better they can return to school.
Toothache	School attendance should be maintained until the child can be seen by a dentist.
Travel Sickness	None. Medication should be administered in accordance with the guidance given under 'over the counter medicines (non prescription)' on page 2.4.

HAY FEVER INFORMATION

WHAT IS HAY FEVER?

Hay fever is an allergy to pollen that affects around one in four people and is one of the most common allergic conditions. Hay fever can be a reaction to tree, grass or weed pollen. All these have differing times of pollination.

In the most dangerous cases, they can experience a reaction that is close to anaphylaxis. Hay fever usually begins in childhood or during the teenage years, but it can start at any age. The condition is more common in boys than in girls. In adults, men and women are equally affected and it is more likely if there is a family history of allergies, particularly asthma or eczema.

WHAT ARE THE SYMPTOMS OF HAY FEVER?

The symptoms of hay fever can vary from person to person. Some people only have mild symptoms that tend to come and go. Others can be severely affected with symptoms that are present every day during the pollen season:

- **Common symptoms** - these include a runny and itchy nose, a blocked nose, sneezing, itchy and watery red eyes and an itchy throat. In some cases only nasal symptoms occur and in some cases only eye symptoms occur.
- **Less common symptoms** - these include loss of smell, face pain, sweats and headache.
- **Asthma symptoms** - For those with asthma, hay fever may make symptoms such as wheeze and breathlessness worse. If this is the case it is important to treat their asthma symptoms using their usual medication (see asthma guidance). NB some children and young people may not get asthma symptoms during the hay fever season.

Although symptoms are usually limited to the nose and eyes, some who is severely allergic to grass may also get hives upon contact with its pollen (itchy skin producing a red raised area anywhere on the body). In the most dangerous cases, they can experience a reaction that is close to anaphylaxis.

CONTROL WHILST AT SCHOOL

It is impossible to avoid pollen totally. However, symptoms tend to be less severe if a child reduces their exposure to pollen. The pollen count is the number of pollen grains per cubic metre of air. The pollen count is often given with TV, radio, internet, or newspaper weather forecasts. A high pollen count is a count above 50. A pupil suffering with hay fever could be given the options to help control their symptoms:

- Avoid sitting the pupil next to open windows and doors.
- Offer the pupil the option of staying in the classroom during break times.
- Avoid exposing the pupil to freshly cut grass or large grassy places.
- Encourage the wearing of sunglasses when they are outside.
- Ensure that the school has all the relevant information regarding the child's medical condition.
- Make sure the child takes their medication regularly if required at school.
- If a child is sitting SAT's, tests or examinations and is troubled by hay fever, if possible and relevant inform the relevant boards.
- Schools can check pollen forecasts regularly.
- Suggest the child change their route to school if exposed to specific plants or trees.

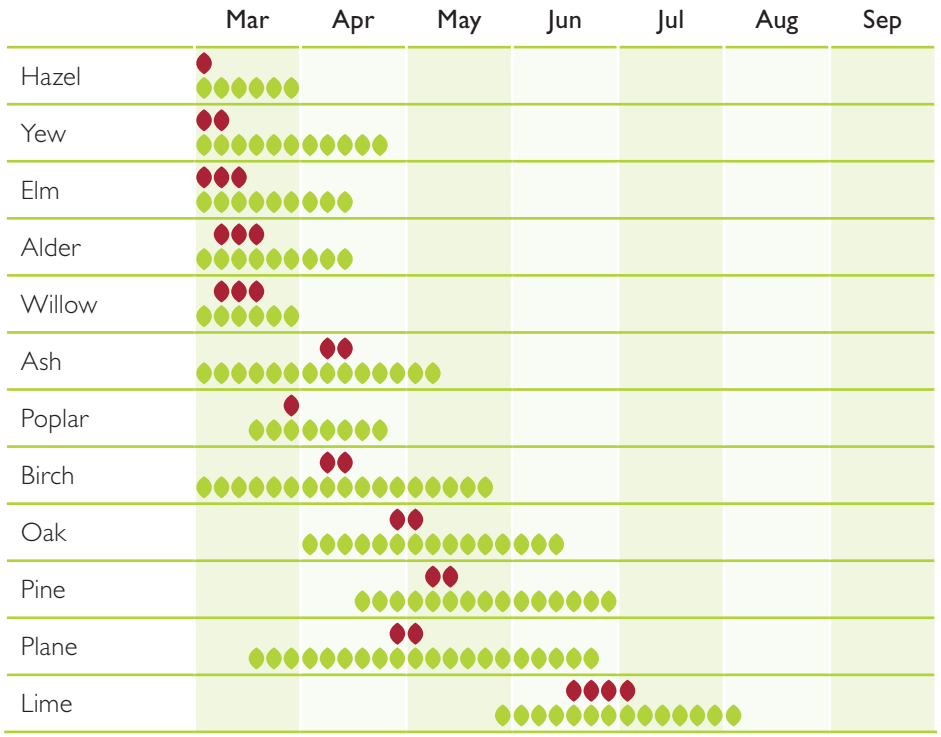
MEDICATION WHILST AT SCHOOL

The commonly used hay fever treatment options are: antihistamine nasal sprays, antihistamine tablets, steroid nasal sprays, and eye drops, which can usually be administered before school. If the child's hay fever symptoms are not controlled on the medication they are taking after 2-4 weeks, they should seek further medical advice.

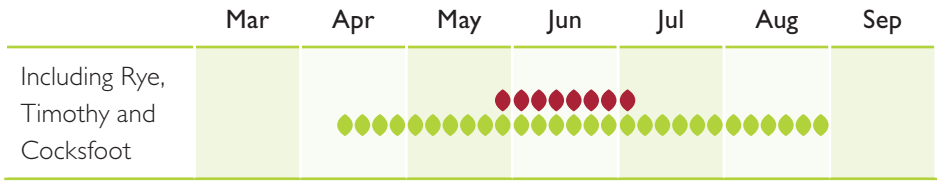
Any medication that may be required whilst the child is at school should be authorised, stored, administered and recorded in line with the current East Riding guidance Managing Medicines in Schools.

POLLEN CALENDAR

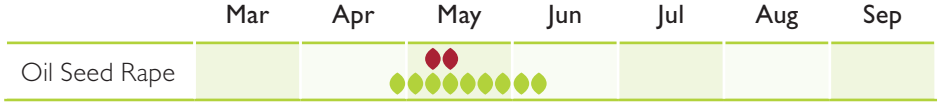
TREE POLLEN



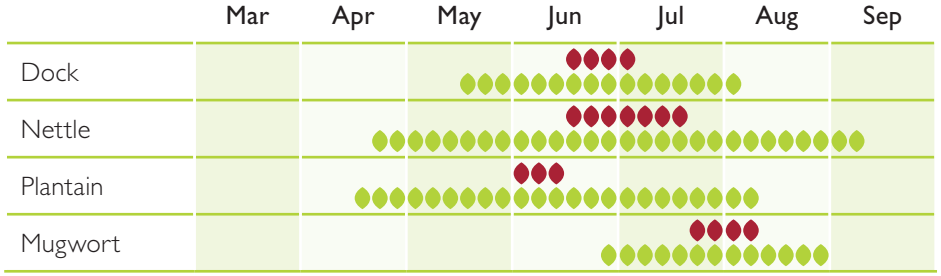
GRASSES



CROPS



WEEDS



Peak period of pollen release

Pollen season

THE PEAK POLLEN MONTHS

March
Alder*, Hazel*, Yew, Willow, Elm and Poplar

April
Ash, Birch and Oak

May
Grass, Oak, Pine, Oil Seed Rape and Plane

June
Grass, Nettle, Dock, Lime and Plantain

July
Mugwort, Nettle and Grass

August
Mugwort

*Alder and Hazel cross react with Birch

Pollen calendar information taken from: www.zirtek.co.uk/hayfever/symptoms

MIGRAINE INFORMATION FOR SCHOOLS

WHAT IS MIGRAINE?

Migraine is more than "just a headache". It is a complex neurological condition, which can affect the whole body and can result in many symptoms, sometimes without a headache at all. It can be easily overlooked or mistaken for other conditions and can affect children in different ways.

THE SIGNS OF MIGRAINE

For most children the main feature of a migraine is a painful headache. However, there are other associated symptoms that can prevent an individual from continuing with daily life, and these can occur with or without the headache. If a child has two or more of the following symptoms during an attack, it is probable they are suffering from migraine:

- Intense throbbing headache, often on one side of the head only;
- Nausea and / or vomiting. You may also experience diarrhoea;
- Increased sensitivity to light, sound, and / or smells;
- Neurological symptoms that include visual disturbances such as blind spots, distorted vision, flashing lights or zigzag patterns;

Other common aura symptoms a child may experience include: dizziness, vertigo, tingling or pins and needles in the limbs, an inability to concentrate, confusion, difficulty in speaking, paralysis or loss of consciousness (in very rare cases).

Children with migraine can often exhibit behavioural changes which is part of the early warning signs of an impending migraine. For instance, they are reported to look very pale, be extremely quiet and inattentive or become very disruptive, boisterous and have inappropriate high levels of energy. As a teacher there are some practical approaches you can take to help a child deal with his/her condition:

- Discuss any concerns that you may have with the parent/guardian of a child you suspect of having migraine.
- It is worth consulting your school nurse if you have any children in your class that have been diagnosed with migraine or if you suspect they are suffering from this condition as she will be able to offer some practical advice for the child's migraine management in class.
- For some children with diagnosed migraine they may have medications to treat an attack. Timing of these medications is crucial; please consult your school's policy on their medication/illness at school guidelines.
- If you feel that the child's performance in class is being affected by migraine, it is advised that you have early contact with the parents/carers before this becomes a genuine problem.
- Flexibility around homework deadlines should be considered to relieve any additional pressure on the child during a period when their abilities could be affected by their migraine.
- Be understanding towards the child during an attack; who in addition to feeling ill, may also be feeling very embarrassed. A full-blown attack may be prevented if a child feels able to ask for help as soon as they begin to feel unwell.
- Work with the parent/carer and child to recognise any possible triggers if attacks frequently occur at school. Could anxiety due to work expectations or bullying be a factor? Would allowing the child to have a snack or drink during lessons help prevent an attack? Is the white board causing problems? Would opening a window help?
- Work with the child and parent/carer to discuss the most appropriate way to help if the child experiences an attack whilst in your care.

A migraine attack in children may last for as little as an hour, but can be as long as three days. Generally they last for between two and four hours (shorter than the average adult attack).

A child can feel 'washed out' for a couple of days after an attack but the symptoms will resolve completely between attacks. The frequency of attacks varies, but the average is one per month. However some children may experience an attack each week, others may go for months before an attack reoccurs.

FURTHER INFORMATION

If you need more advice on how to support pupils whilst in your care, then medical advice should be sought through the school nurse, health visitor, pharmacist or GP.

www.migraine.org.uk

NHS Choices:

www.nhs.uk/conditions/migraine/pages/introduction.aspx

HEAD LICE INFORMATION FOR PARENTS

If your child has head lice, infestation should be treated immediately and again one week later to ensure the lice have all gone.

If live lice are still detected using the wet-combing method or seen on the hair after the second treatment, advice should be sought from your local school nurse, health visitor, pharmacist or GP about alternative treatments on how to use these to best effect. Children do not usually need to be taken out of school for treatment. Some treatments are best done overnight (eight hour contact time).

If you keep your child off school due to them having head lice the absence will not be authorised. If your child has long hair you may be advised to tie their hair back to help prevent infestation.

FACTS

Head lice are small, six-legged wingless insects, pin-head size when they hatch, less than match-head size when fully grown and grey/brown in colour. They are difficult to detect in dry hair even when the head is closely inspected. They very often cause itching, but this is not always the case, particularly when recently arrived on the head. Itching is a delayed hypersensitivity reaction to louse saliva. Sometimes puncture marks can be found on the scalp and sometimes black louse faeces can be seen on collars and pillows.

Head lice cannot fly, jump or swim, but spread by climbing swiftly long hairs during close head-to-head contact. Anyone with hair can catch them, but children who have head to head contact, either at school or during play, are most commonly affected.

Head lice feed by biting and sucking blood through the scalp of their host. The female louse lays eggs which are very small, dull in colour, and well camouflaged. These are securely glued to hairs where the warmth of the scalp will hatch them out in 7-10 days. Empty egg sacs (nits) are white and shiny and may be found further along the hair shaft as the hair grows out.
Many people mistake the empty egg sacs or nits for head lice when they are actually evidence of a previous infection of head lice. Lice take 6-14 days to become fully grown, after which they are capable of reproduction.
Head lice are not fussy about hair length or condition. Clean hair is therefore no protection, although weekly wet-combing (bug busting) sessions offer a good opportunity to detect head lice, and arrange treatment if detected.

Head lice are unlikely to be passed from person to person through shared combs, brushes, towels, clothing or bedding. There is no need to wash or fumigate clothing or bedding that comes into contact with head lice.

DETECTION

Head lice are well camouflaged and hide when disturbed by combing. They do not always cause itching, particularly when recently arrived on the head. They may also be few in number and a quick inspection is unlikely to detect them.

Wet-combing is an effective method of detection (also known as "bug busting") as it removes lice and baby lice (nymphs) without using chemicals.

Wet-combing involves washing and rinsing the hair as usual, applying plenty of conditioner, combing through with a normal comb to get rid of tangles, then combing with a fine-toothed detection comb. The teeth of the detection comb should be slotted into the detangled hair at the roots (touching the scalp) and drawn though to the tips of the hair. The detection comb should be checked for lice after each stroke and cleaned.

For maximum effect, the time taken for wet-combing ranges from two minutes for short straight hair to thirty minutes for long curly hair ideally repeated every third or fourth day over a two-week period. Conditioner is washed out at the end of combing. The aim is to detect and remove any live lice and newly hatched nymphs until none are left.

If you find lice, then there are two options, wet-combing as described above and/or chemical treatment. Whichever option(s) you choose it is important to recognise that neither will protect against re-infestation if head to head contact is made with someone with head lice at a later date. You may therefore wish to undertake occasional checks during hair washing sessions.

TREATMENT AND PREVENTION OF RE-INFESTATION

Wet-combing is more effective than insecticides at curing head lice infestations. A Bug Busting Kit or individual combs are available from pharmacies, supermarkets or online. Wet-combing can be undertaken on a regular basis e.g. at routine hair washing sessions - to detect the presence of lice before they can spread and especially if head lice are prevalent in a school (minimum weekly wet-combing is recommended). Egg detection combs are readily available to purchase.

Do not use chemical treatments unless you find a living, moving louse. Close family/friends and staff should use the wet-combing method, as described above, and treat anyone who is found to have lice at the same time, to prevent re-infection. None of the treatments for head lice is 100 per cent effective after a single application, all depend on careful and correct use, and treatment should be repeated after seven days.

Ensure there is enough lotion/spray/wash to treat all those affected and follow the instructions on the packet carefully and correctly with close attention to how long the treatment must remain on the hair to be effective, how often you may apply the product etc. The product may be capable of killing eggs, as well as lice, but there is no certainty of this. Check for baby lice (nymphs) hatching out from eggs 3-5 days after you use it, and again at 10-12 days.

If the lice appear to be unaffected by the product (some lice may have developed resistance to a particular insecticide) or if the problem persists then you should take advice from your local school nurse, health visitor, pharmacist or GP, who will be able to advise you on alternative treatments and explain how to use these to best effect. You should seek advice where whoever is being treated is either under 1 year of age, suffers from asthma or allergies, or is pregnant or breast feeding. Schools may wish to place reminder information on newsletters and on their school website.

FURTHER INFORMATION

If a child has a frequent and/or prolonged infestation, the Schools Safeguarding Procedures should be followed. Ask to see your school nurse, health visitor, pharmacist or family doctor.

NHS Choices:
www.nhs.uk/conditions/migraine/pages/introduction.aspx
Exemplar letter to parents can be found within Templates.

CONTROLLING HEAD LICE – ADVICE FOR TEACHERS

HEAD LICE INFESTATION SUSPECTED

LIVE LOUSE

Seen or:

- Child with severely itchy scalp and/or
- Black spots (louse faeces) on white collar and/or
- Empty egg sacs (nits) close to hair root.

ALERT THE PARENT/CARER

- Where possible, issue the child with a head lice detection comb.
- Provide the 'Head Lice Information for Parents' sheet (3.10) to parents of infected child with letter 8.17.
- Signpost the parent to their local pharmacy for further advice.
- Advise to check all close family and friends using the wet combing method.

SEND LETTER OUT TO PARENTS

TREATMENT FAILURE QUESTIONS TO ASK

- Was the treatment repeated after 7 days?
- Have live lice been detected? Empty egg sacs will remain for some time glued to the hair after treatment.
- Were the instructions for treatment followed carefully?
- Have family/close friends been checked and treated?

REFER BACK TO THE PHARMACISTS, TO THE SCHOOL NURSE OR HEALTH VISITOR AND FOLLOW SAFEGUARDING PROCEDURES IF NECESSARY.

Nicki Bush: Pharmaceuticals and Medicines Manager 8/10/2015 v1

IMPETIGO INFORMATION

WHAT IS IMPETIGO?

Impetigo is a contagious skin infection usually caused by either Staphylococcus or Streptococcus bacteria. It is most commonly found in children although it may also occur in adults.

Impetigo may affect skin anywhere on the body but commonly occurs in the area around the nose and mouth. It first appears as a small itchy, inflamed area of skin which blisters. The blisters rupture, release a yellow fluid and develop honey-coloured crusts and form scabs. New blisters develop in the same area or in different parts of the body and may ooze fluid which is highly contagious.

Impetigo is easily diagnosed by the doctor. Occasionally a skin swab may be taken to identify the bacteria responsible for the infection.

HOW IS IMPETIGO SPREAD?

Impetigo is extremely contagious. It can be spread from one person to another through touch or shared items such as clothes and towels. However, a person can also spread it to another part of their own body through scratching or picking at the blisters and scabs.

WHO IS MOST AT RISK OF DEVELOPING IMPETIGO?

Children are most at risk of developing impetigo. Children and adolescents may be more likely to develop impetigo if the skin has already been irritated or injured by other skin problems such as eczema, insect bites, skin allergy or recent cuts or abrasions.

HOW LONG DOES IT TAKE UNTIL SYMPTOMS START?

The incubation period will vary depending on the particular bacteria. It is usually 1–3 days for streptococcal and 4–10 days for staphylococcal infections.

HOW IS IMPETIGO TREATED?

- Impetigo is most often treated with antibiotics, either orally or with bactericidal ointment. It is important to follow the recommended treatment and complete the course of antibiotics.
- Treatment involves washing the sores and crusts every 12 hours or as directed with the prescribed soap or lotion. After each wash pat dry using the child's own facecloth and towel. Encourage children to wash their hands regularly.
- Healing should begin within 3 days and the infection eliminated in 7–10 days.
- If the sores spread and get worse despite treatment or the child becomes unwell with fever, see your doctor.
- Advise parents to keep the child's nails short and encourage them not to scratch scabs or pick their nose.
- Keep infected areas of skin clean and covered to minimise the chance of any bacterial infection.
- Always wash your hands after touching sores or scabs and use gloves if possible when treating infected children or care of infected clothing (e.g. PE activities or assistance with washing).

Keep children with impetigo away from other children for the period of absence until lesions are crusted and healed, or 48hrs after starting antibiotic treatment.

HOW LONG DOES IMPETIGO REMAIN INFECTIOUS?

If untreated, oozing sores remain infectious for as long as they persist.

WHEN CAN CHILDREN RETURN TO SCHOOL OR CHILD CARE?

Children can return to school or child care after treatment has started and the sores are completely covered with a watertight dressing.

FURTHER INFORMATION

If you need more advice on how to support pupils whilst in your care, then medical advice should be sought through the school nurse, health visitor, pharmacist or GP.

NHS Choices:

www.nhs.uk/conditions/impetigo/pages/introduction.aspx

SLAPPED CHEEK DISEASE INFORMATION

WHAT IS SLAPPED CHEEK DISEASE?

Slapped cheek disease is an infectious disease that mainly affects children between the ages of six and ten years old. It is also called Fifth Disease because it used to be the fifth most common childhood infection.

Slapped cheek disease is caused by a virus and often occurs in outbreaks at nursery and school. It is spread by droplets, which are released into the air by coughing and sneezing.

The incubation period between catching the virus and showing any symptoms is one to two weeks. Slapped cheek disease often occurs in outbreaks because children can be infectious for up to two weeks before any signs appear. It is no longer infectious once the rash has appeared. Once a child has had slapped cheek disease, he or she will not catch it again.

WHAT ARE THE SYMPTOMS OF SLAPPED CHEEK DISEASE?

A child may have a runny nose, rash, aches and pains and a high temperature. To begin with, the rash appears on the cheeks making them look red - which is why it is called slapped cheek disease. A few days later, the rash will appear on a child's chest, arms and legs. The rash may fade a bit and then come back if a child gets hot after a bath, is in direct sunlight or runs about.

Some people can have slapped cheek disease and not have any symptoms, but they will still be able to pass the virus on to other people. If a child has a chronic illness, particularly affecting his or her blood, they should see their GP if symptoms occur.

HOW IS IT TREATED?

In most children, slapped cheek disease is a mild illness, which gets better in a few days without any treatment. As a virus causes slapped cheek disease, antibiotics won't help to treat it.

If the child has aches and pains, they can be given paracetamol according to the instructions on the bottle. Aspirin, or medications containing aspirin, should not be given to children under sixteen years old. Whilst at school, staff should encourage the child to drink plenty of fluids to reduce the chance of dehydration due to the high temperature.

The spread of slapped cheek disease can be reduced by frequent hand washing, putting their hand over their mouth when coughing and sneezing into a handkerchief or tissue.

WHAT IS THE OUTLOOK FOR CHILDREN WITH SLAPPED CHEEK DISEASE?

The vast majority of children recover completely within a few days, with no lasting effects.

NOTE TO SCHOOLS

If a pregnant female comes into contact with or develops slapped cheek disease, she should see her GP as the disease can cause miscarriage. Therefore:

- Appropriate staff must seek medical advice immediately to ascertain whether it would be suitable for her to return to work/school. If absence is recommended, the school must provide staff to cover her duties. See advice and information for: Immunocompromised Pupils and Pregnant Females (3.16)
- Clear notification must be placed on access points used by parents alerting them to the infection.
- If the school feel it necessary a text should be sent to all parents and if possible information placed in the school newsletter.

Compiled by: the Infectious Diseases Department / Child and Family Information Group

www.nhs.uk/Conditions/slapped-cheek-syndrome/Pages/introduction.aspx

INFORMATION FOR TEACHERS: CHILDREN WHO WET AND SOIL

This information is to support schools with providing care for children who wet and/or soils whilst at school. If this has not been diagnosed by a medical professional it would be advisable to speak to the parents and encourage them to see their GP or speak to the school nurse.

This is not a policy but suggestions for good practice as schools will need to agree individual care plans for each child.

The first few years of school are the years when the child is making friends, and when peer pressure begins to be felt. Faecal soiling at this age can be detrimental to the child's self-esteem, confidence and progress at school.

Faecal soiling at school is clearly a most embarrassing and socially unacceptable problem. For the children concerned it can create isolation, low self-esteem and a situation where they are the 'butt of jokes'. With careful planning and a "circle" of support (parents, child, teacher, and other staff) school can be a successful and happy time. The most important thing is to be prepared, establish good strategies, enlist support and work together.

WHAT CAN YOU SUGGEST TO PARENTS?

- Be kept informed about the child's condition and how often he or she soils. Find out the routine and method of management at home, and continue this as closely as possible. As a teacher you need to understand whether the child's faecal soiling is a disability or behaviour problems, both require patience and understanding. Maintain regular contact with the parent to check the child's progress.
- Ask parents to send spare clothes and "clean-up" equipment such as wet wipes, a plastic bag or airtight container for soiled underwear, soap and a hand towel. The school will need to provide a lidded bin or pad disposal unit if pads are used.
- Parents whose children are under the care of a stomal therapy nurse may want to discuss the possibility of a suppository or small enema before school as this may clear out the child's rectum enough to prevent accidents during the day.
- Encourage parents to remain patient, understanding and hopeful. Children spend most of their time in school; creating a warm, friendly and easy environment encourages a better quality of life for the child and their academic performance.

WHAT CAN YOU DO AS A TEACHER?

- Get to know the family. Discuss with them the particular needs of the child - what equipment of appliances are needed? Such as, spare clothes, flushable wipes, plastic bags for disposal, a lidded bin, soap and a hand towel. How frequently do they soil? What are the parent's fears or apprehensions about their child starting school?
- Talk with the child as early as possible – the year before starting in your class is ideal but not always possible. It is vital to establish a good rapport with the child so that they have developed a level of trust in you before classes begin. Strategies and special arrangements can be decided so they are ready to be implemented when the year begins.
- It is also valuable if you can have time to discuss strategies etc. with the current or previous teacher of the child. This is particularly helpful if the child or parents speak highly of that teacher.
- Remain in contact frequently. A notebook or communication diary is worthwhile.
- Discuss with the parents the advisability of having the school nurse or specialist person talk to the class and staff about the child's disability. This should not be the only disability discussed. There will be other children in the class with asthma, diabetes, sight or hearing loss and many more. The child should not be singled out.
- Provide security and consistency in the approach to the child and the problem. The teacher needs to set up a 'no fuss' signal to let the child know that they need to go to the toilet. The child may not be able to avoid suddenly becoming smelly, but must not be allowed to remain so. It is rare for the child to be able to smell its own faeces. A child who is frequently soiled cannot tell when their pants or pad are dirty, even if there is full skin sensation, they have become unaware of the area, just as adults we become unaware of the feeling of rings, watches, earrings and other things.

- Rethink some classroom strategies such as insisting that students sit cross-legged on the floor, how to ask to leave the room, "toilet times" (some teachers are reluctant to allow students to leave the classroom soon after breaktime or lunchtime) – this may need to be re-assessed.
- Provide a toilet that is private, where other children can't look over or under the partitions to see what they are doing. Sometimes it's easiest to choose a staff toilet, a disabled toilet (provided that the wheelchair sign is removed) or simply close in one of the main toilets. Make sure that you discuss these arrangements with the child and parents before making a decision. It is really important to understand that what you may think is a great solution may not work for the child. There is no way to determine this from an adult's perspective – give the child the final decision!
- All young children will require some supervision in the toilet. This is often just to ensure that the task is actually carried out. Children will often go to the toilet, sit there for a while, then return to the classroom and still be able to say quite honestly that they 'have been to the toilet'. Check on the child if they have been absent for a longer than "normal" time.
- Provide the 'perfect teacher': One who never shows impatience, can take the smell of faeces in closed, warm classrooms, can see through the back of his/her head to know when the child has left/returned to the classroom, has a discrete, private signal to tell the child that they have soiled, even though they think they haven't, then to remember what part of the lesson they have missed and have the time to go over it with the child later.

Exemplar Policy and Practice Guidelines can be found within Templates.

Information adapted from Vicki Ratcliff, Eunice Gribbin and Helen Athanasakos:
www.bgk.org.au (School link).

IMMUNOCOMPROMISED PUPILS AND PREGNANT FEMALES

If an immunocompromised pupil or pregnant female develops a rash or is in direct contact with someone with a potentially infectious rash, this should be investigated by a doctor. The greatest risk from such infections comes from their own family members, rather than the workplace.

CHICKENPOX

Chickenpox can affect the pregnancy if a female has not already had the infection. Report of exposure needs to be made to the midwife and GP at any stage of exposure. The GP and antenatal carer will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.

GERMAN MEASLES

German measles (rubella). If a pregnant female comes into contact with german measles she should inform her GP and antenatal carer immediately to ensure investigation. The infection may affect the developing baby if the female is not immune and is exposed in early pregnancy. Rubella immunity status is checked routinely in antenatal checks. Those already immune are not at risk.

SLAPPED CHEEK DISEASE

Slapped cheek disease (parvovirus B19) can occasionally affect an unborn child. If exposed early in pregnancy (before 20 weeks), inform whoever is giving antenatal care as this must be investigated promptly requesting a blood test to clarify her immunity against the disease. Should she be immune, she must seek advice from the medical person whether it would be suitable for her to return to work/school.

MEASLES

Measles during pregnancy can result in early delivery or even loss of the baby. If a pregnant female is exposed she should immediately inform whoever is giving antenatal care to ensure investigation.

IN ALL THESE CASES

In all these cases the school must arrange cover (if staff member) or education (if pupil) should the pregnant female require to be absent at any time until it is safe for them to return.

If it is a pupil, the school must ensure their educational needs are being met either through attendance at a neighbouring school (providing transport if required) or work being sent home.

STAFF IMMUNISATIONS

All staff should undergo a full occupational health check prior to employment; this includes ensuring they are up to date with immunisations. All females aged 16–25 should be advised to check they have had two doses of MMR. Ref: www.phe.org.uk

A notice should be placed on all school entrances and if possible a text message sent informing visitors of the infection present at the school and the proposed risk to pregnant women.

Information provided by Health Protection Agency 2010.

For further information visit:

www.dh.gov.uk/health

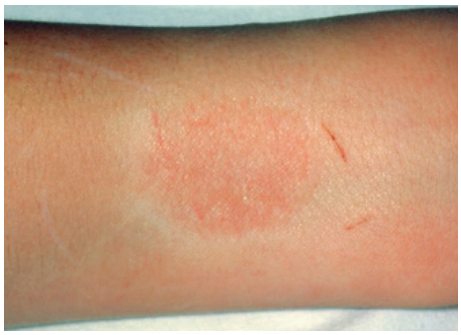
STAFF HEALTH

www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities

Health protection in schools and other childcare facilities (updated March 2019)

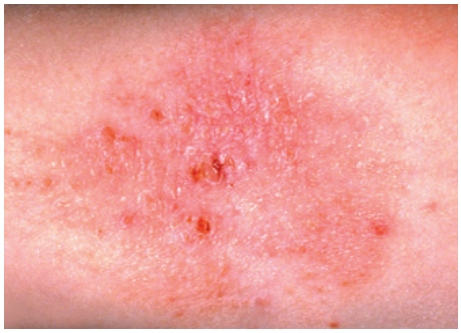
CHILDHOOD CONDITIONS

This is a basic guide to help recognise some of the most common childhood conditions.



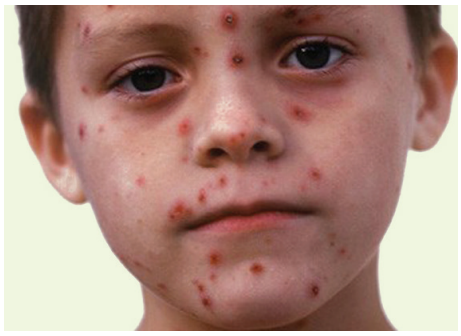
ALLERGIC CONTACT DERMATITIS

Contact dermatitis occurs when the skin comes into contact with a substance to which they have an allergy. This causes the skin to become inflamed, red, blistered, dry, thickened or cracked. It may take many hours or several days for symptoms to appear after coming into contact with the allergen.



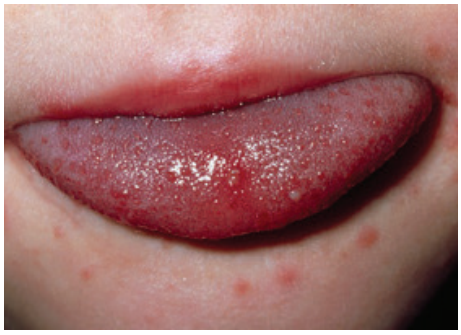
ATOPIC ECZEMA

Most commonly, eczema develops in the creases of your skin, such as inside your elbow, behind your knees, at the front of your ankles, round your neck or around your eyes. During a flare-up, atopic eczema can cause the skin to become extremely itchy, red, dry and cracked. It may also be weeping and swollen if it has become infected.



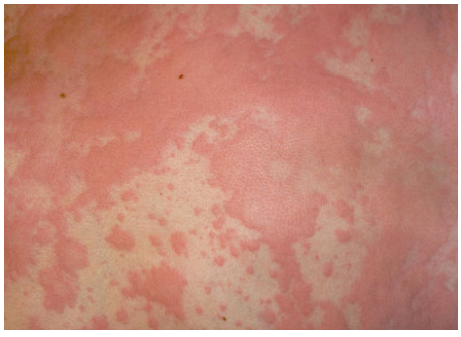
CHICKENPOX

Chickenpox causes a rash of red, itchy spots that turn into fluid-filled blisters after about 12 hours. A few days later, the blisters will crust over to form scabs that fall off after a week or two. The rash normally appears in clusters behind the ears, on the face, scalp, under arms, on chest and belly, and arms and legs. Return to school only when all vesicles have crusted over.



HAND, FOOT & MOUTH DISEASE

Early symptoms of hand, foot and mouth disease include a fever, loss of appetite, a cough and a sore throat. After a day or two spots and blisters may appear on the hands, feet (more commonly seen on the upper surfaces and often between the fingers and toes) and in the mouth (on the tongue and inner surface of the cheeks). They could also have a temperature which can be treated with paracetamol. However, children affected by this condition aren't usually particularly ill with it.

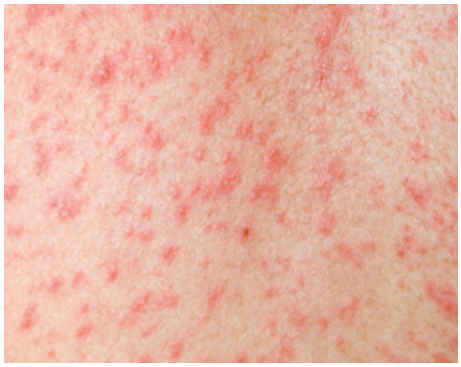


HIVES

Swollen, pale red bump appear suddenly due to an adverse reaction to certain allergens. Hives usually cause itching, but may also burn or sting. They can appear anywhere on the body and vary in size, joining together to form larger areas known as plaques. They can last for hours, or up to one day before fading.

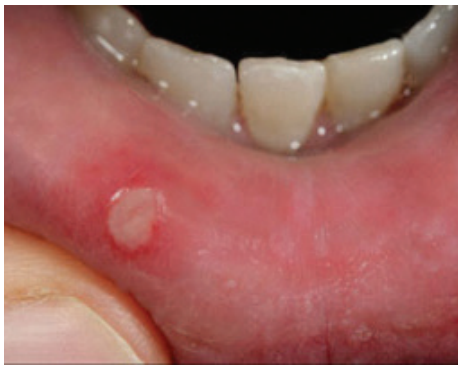
HEAD LICE

Head lice are tiny (pinhead sized) grey-brown, wingless insects that can live in hair by sucking blood from the scalp. Their eggs, which look like tiny white specks, are known as nits. They can make the scalp very itchy and you can spot them in the hair using a special fine-toothed comb that's available from pharmacies.



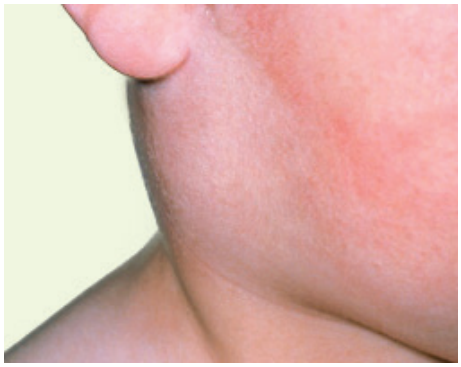
MEASLES

Early symptoms of measles can include a runny nose, red eyes, swollen eyelids, sneezing, and a fever. A few days later, a red-brown spotty rash appears, and lasts for about a week. It starts behind the ears, before spreading around the head and neck, and eventually to the legs and the rest of the body.



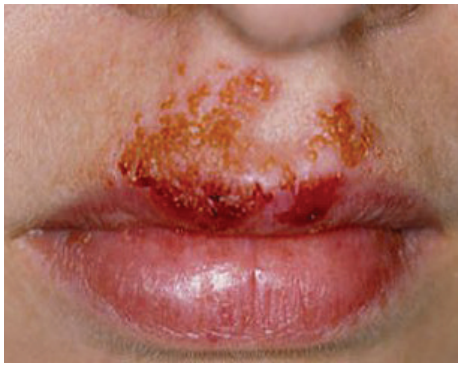
MOUTH ULCER

Mouth ulcers are painful round or oval sores that form in the mouth, most often on the inside of the cheeks or lips. They are usually white, red, yellow or grey in colour and are inflamed (red and swollen) around the edge. They can be uncomfortable, particularly when eating, drinking or brushing your teeth, but usually pass in a week or two.



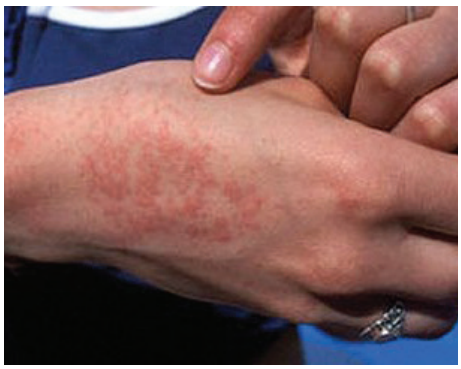
MUMPS

In mumps, one or both of the salivary glands located under the ears on each side of the face swell up and become painful, giving the person a characteristic 'hamster' appearance. Other symptoms can include a fever, feeling tired, loss of appetite, tummy pain, a dry mouth and a headache.



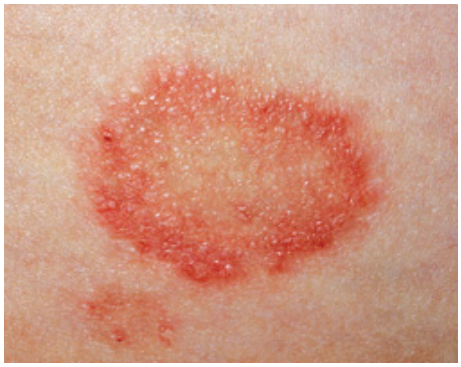
IMPETIGO

Impetigo begins with the appearance of red sores, usually on the area around the nose and mouth. The sores quickly burst, leaving thick, yellow-brown golden crusts. The sores aren't painful, but they may be itchy. Other symptoms of infection, such as fever and swollen glands, are rare but may occur in more severe cases.



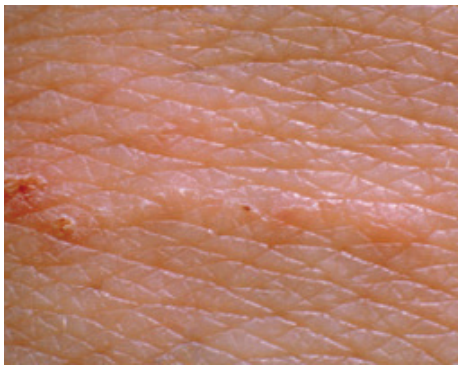
PRICKLY HEAT

Prickly heat causes a rash made up of tiny spots or bumps, surrounded by a patch of red skin. Sometimes, the spots look like tiny blisters. The rash may cause mild swelling, itching, and a stinging or a prickling sensation. It can affect any part of your body, but most commonly appears on the face, back, neck, chest and thighs.



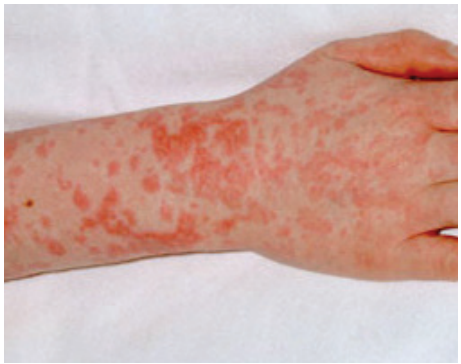
RINGWORM

Ringworm is a fungal infection that causes a red or silvery ring-like rash on the skin. Sometimes the rings may multiply and grow, and rings can also merge together. The rings may feel slightly raised to the touch, and the skin may feel itchy.



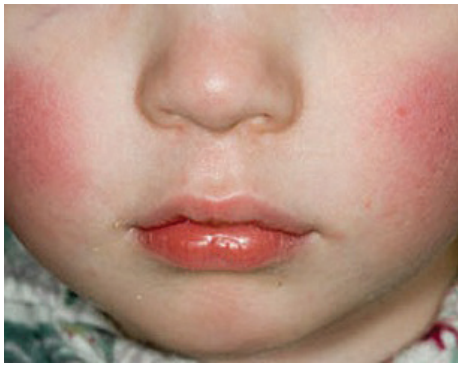
SCABIES

Scabies is caused by tiny mites that burrow into the skin. It causes your skin to feel intensely itchy and there may be small red blotches and lines on your skin. Burrow marks can be found anywhere including the face, head, neck, scalp, palms of the hands and soles of the feet.



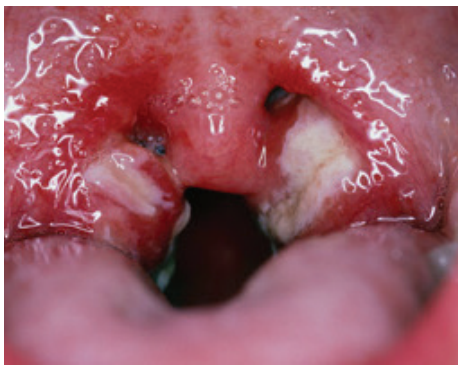
SCARLET FEVER

Scarlet fever often starts with a sore throat, headache and fever. A rash appears 12-48 hours later. This starts as red blotches, but turns into a pinkish-red rash that feels like sandpaper. The rash spreads to other areas, commonly ears, neck, elbows, thighs and groin. The rash will turn white if you press a glass on it



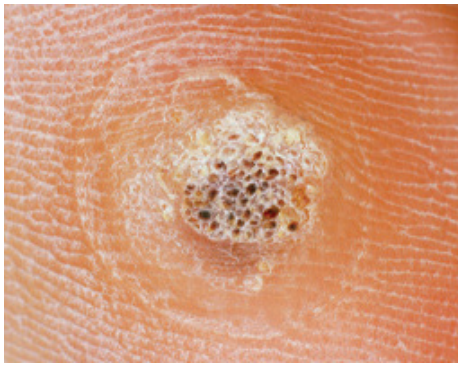
SLAPPED CHEEK SYNDROME

Slapped check syndrome causes a distinctive bright red rash on the cheeks, which can make it look like they've been slapped. The rash may become itchy and spread to the body and limbs and can take between one and three weeks to clear.



TONSILLITIS

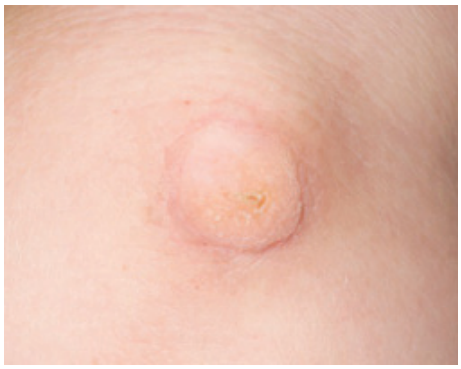
The main symptom of tonsillitis is a sore throat with red swollen tonsils. Other common symptoms include white pus-filled spots on your tonsils, pain on swallowing, a fever, coughing, a headache, tiredness, pain in the ears or neck, and swollen glands in your neck.



VERRUCA

Verrucas are warts on the soles of your feet, heels and toes. They don't usually stick up from the surface of the skin and often have a black dot in the centre, surrounded by a hard, white area. They can be painful when standing up or walking.

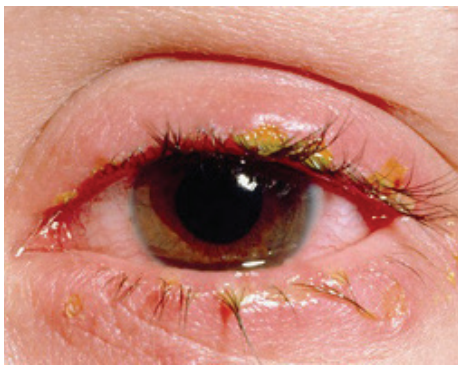
Verrucas are only passed in a wet environment.



WARTS

Common warts (verruca vulgaris) are firm and raised, with a rough surface that can look a bit like a cauliflower.

They can occur anywhere, but are most common on knuckles, fingers and knees. The size of a wart can range from 1mm to more than 1cm.



CONJUNCTIVITIS

Conjunctivitis is redness and inflammation of the thin layer of tissue that covers the front of the eye (conjunctiva). It is very common.

People often refer to conjunctivitis as red eye.

Other symptoms of conjunctivitis include itchiness and watering of the eyes, and sometimes a sticky coating on the eyelashes (if it's caused by an allergy).

Information provided by NHS Choices 2015:
www.nhs.uk/Tools/Pages/Childhoodillness.aspx

For advice and procedures for reporting cases or suspected cases of infectious disease in schools and other educational establishments contact Public Health England:

www.gov.uk/government/organisations/public-health-england
(01904) 687100

USEFUL WEBSITES AND DOCUMENTS

DEPARTMENT FOR EDUCATION

www.gov.uk/government/organisations/department-for-education

Department for Education
Piccadilly Gate
Store Street
Manchester
M1 2WD

0370 000 2288
Fax: 0161 600 1332

GOV.UK PUBLICATIONS

- Supporting pupils at school with medical conditions
- Supporting pupils with medical conditions: templates
- Supporting pupils with medical conditions: links to other useful resources:
  goo.gl/VK2ylw
- School Attendance October 2014: Last updated September 2018
  www.gov.uk/government/publications/school-attendance
- Statutory framework for the early years foundation stage
- Ensuring a good education for children who cannot attend school because of health needs Statutory guidance for local authorities May 2013:
  goo.gl/h01lWm
- Safeguarding Children in whom illness is fabricated or induced. A publication outlining what is known about and the ways in which it can be caused and addressed:
  goo.gl/Lf8Zbv

STATUTORY GUIDANCE ON PROMOTING THE HEALTH AND WELL-BEING OF LOOKED AFTER CHILDREN

media.education.gov.uk/assets/files/pdf/s/promotinghealth.pdf

EQUALITY AND HUMAN RIGHTS COMMISSION (DISABILITY RIGHTS COMMISSION)

www.equalityhumanrights.com

NHS CHOICES

NHS Choices is the online 'front door' to the NHS. It is the country's biggest health website and gives valid up to date information.

www.nhs.uk/111

111

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (NICE)

www.nice.org.uk

PUBLIC HEALTH ENGLAND

www.gov.uk/government/organisations/public-health-england

(01904) 687100

INSIGHT SAFETY SERVICES PAGE

- Schools Model Documents and Templates – Infection Control Model Risk Assessment

ANAPHYLAXIS

GUIDANCE

EAST RIDING
OF YORKSHIRE COUNCIL

NHS

ANAPHYLAXIS
GUIDANCE

CONTENTS

WHAT IS ANAPHYLAXIS?

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance, but on rare occasions may happen after a few hours.

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwifruit, and also penicillin, latex and the venom of stinging insects (such as bees, wasps or hornets).

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.

MEDICINE AND CONTROL

If antihistamines have been prescribed and provided by parents to the school, this should be given at the first sign of an allergic reaction and the child closely observed. Antihistamine dose may need to be repeated if the patient vomits.

For a child who is known to have asthma, if there is any sign of breathing difficulty then their reliever inhaler (usually blue) should be administered or the school's emergency inhaler.

MINOR REACTIONS (NEEDING ORAL ANTIHISTAMINE)

Any, or all, of the following symptoms and signs may be present in an acute allergic reaction.

- Feeling hot/flushing
- Itching
- 'Nettle sting like' rash/welts/hives (urticaria)
- Red, itchy watery eyes
- Itchy, runny or congested nose or sneezing
- Swelling: face, lips, eyes, hands
- Tummy pain
- Vomiting or diarrhoea
- Metallic (funny) taste in the mouth

Even where mild symptoms are present the child should be watched carefully as they may be heralding the start of a more serious reaction.

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription (auto-injector). The devices are available in two strengths - adult and junior.

EMERGENCY PROCEDURES

A flow chart is issued with this policy outlining the action to be taken in an emergency and should be printed on the reverse of the child's anaphylaxis care plan. Good practice suggests that a copy is kept with the child's emergency medication near the child at any given time. Further copies may be printed and displayed in the school office, staff room and relevant locations including classrooms where a pupil is known to have anaphylaxis.

Call an AMBULANCE IMMEDIATELY if the reaction continues to progress despite antihistamine and any of the symptoms/signs listed below are seen. Administer the auto-injector into the muscle of the upper outer thigh also at this stage.

SEVERE REACTIONS (NEEDING AUTO-INJECTOR)

- Difficult/noisy breathing, wheeze, breathlessness, chest tightness, persistent cough
- Difficulty talking, change in voice, hoarseness
- Swelling, tightness, itchiness of the throat (feeling of 'lump in throat')
- Impaired circulation - pale clammy skin, blue around the lips and mouth, decreased level of consciousness
- Sense of impending doom ("I feel like I am going to die")
- Becoming pale/floppy
- Collapse

If an auto-injector is administered, the child should be kept lying down, with feet raised (e.g. on a chair) to assist circulation.

They should transfer to hospital in this 'head-down' position.

Raising the child's head or assisting them to sit or stand up can result in an acute severe deterioration of the allergic reaction.

Occasionally, a second auto injector may be required if there has been no improvement in the child's condition 5 to 10 minutes after administering the first auto-injectors.

Staff that volunteer to be trained in the use of auto-injectors can be reassured that they are simple to administer. Auto-injectors, given in accordance with the manufacturer's instructions, are a well understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child's leg. In cases of doubt it is better to give the injection than to hold back.

The decision on how many auto-injectors the school or setting should hold, and where to store them, has to be decided on an individual basis between the Headteacher, the child's parents and medical/school staff involved.

Where children are considered to be sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away and is accessible to all staff. In large schools or split sites, it is often quicker for staff to use an auto-injector that is with the child rather than taking time to collect one from a central location.

Studies have shown that the risks for allergic children are reduced where an individual medication plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the child's parents, the school and the specialist/ school nurse.

Important issues specific to anaphylaxis to be covered include:

- anaphylaxis - what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be sought by the school from the specialist nursing team.

Staff should have the opportunity to practice with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school. When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' could be put in place.

Parents often ask for the Headteacher to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect except that if they come into contact with a certain food or substance, they may become very unwell. It is important that these children are not stigmatised or made to feel different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school life may continue as normal for all concerned.

The Anaphylaxis Campaign website contains guidance for schools, which discusses anaphylaxis, treatment, setting up a protocol, and support for pupils and staff. It also includes a sample protocol. The Anaphylaxis Campaign Helpline is 01252 542029. The Anaphylaxis Campaign has also published the Allergy in Schools website which has specific advice for pre-schools, schools, school caterers, parents and pupils.

MORE INFORMATION

Anaphylaxis Campaign

www.anaphylaxis.org.uk/schools/help-for-schools

Department of Health, Social Services and public safety

www.dhsspsni.gov.uk

Hull and East Yorkshire Hospitals NHS Trust

The Craven Building
Hull Royal Infirmary
Anlaby Road, Hull
HU3 2JZ

(01482) 461403

APPENDIX 1

GOOD PRACTICE

4.3

When the child's Individual Healthcare Plan is being completed, the Emergency Information exampled below (see Templates and Forms for user friendly version) should also be completed, printed double sided, placed in a clear wallet file with the child's emergency medication and where possible kept within easy access of staff (and child if appropriate).

EAST RIDING OF YORKSHIRE COUNCIL

Hull and East Yorkshire Hospitals NHS Trust

ANAPHYLAXIS EMERGENCY INFORMATION

8.4

This information should be completed by parents, school and the specialist/school nurse and if necessary a copy sent to the child's GP.

Child's Name		Child's Photo
Class/form		
Date of Birth		
School Year		
Parent/Carer Name(s)		
Home Contact Number		
Mobile Contact Number		
GP/Medical Centre Number		
School Nurse Number		

Known triggers	
Location of medication in school	
Designated school health official	

Instructions for adrenaline auto-injector use (please tick the appropriate statement)
☐ My child does **not** understand the proper use of his/her adrenaline auto-injector and requires help to administer it. ☐ My child understands the proper use of his/her adrenaline auto-injector, and in my opinion, can advise its use at school.

I give permission for school personnel to share this information with all school staff and appropriate trained staff to administer medication. In the case of an emergency, this information may be passed to medical professionals and if necessary, I also give permission for the school to contact our GP/School Nurse.

I assume full responsibility for providing the school with an adequate supply of adrenaline auto-injectors and if necessary I give permission for the school to use the emergency auto-injector if required. I approve this anaphylaxis care plan for my child.

Parent/s Signature	Date
Health Care Practitioner Signature	Date
Headteacher's Signature	Review Date

ANAPHYLAXIS EMERGENCY INFORMATION TEMPLATE

Page 8.4

D EMERGENCY CARE

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'anaphylaxis', even if the child starts to feel better.

- **Inject outer thigh through child's clothes**
- **Lie the child flat with their legs up to keep their blood flowing.**
- Stay with the child while waiting for the ambulance.
- If the child still feels unwell after the first injection, use your second injector 5 to 15 minutes after the first.

An adrenaline auto-injector is for emergency, on the spot treatment of an anaphylactic reaction. The child should always go to hospital after using the auto-injector.

Two adrenaline auto-injectors should be available in school for the child at all times.

Check the expiry date on the adrenaline auto-injectors and ask parents to ask their doctor or nurse to prescribe new ones before they expire. Out-of-date injectors may not work.

A NOTE ON BRANDS

Make sure that appropriate school staff have been trained to use the brand of auto-injector prescribed because injection technique may vary between brands. Order and practice using a trainer device (available for free from the manufactures' websites). The brand names of adrenaline auto-injectors currently available in the UK are Emerade, EpiPen, and Jext. See manufacturers' websites for further details.

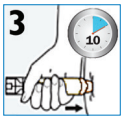
MORE INFORMATION

Anaphylaxis Campaign
www.anaphylaxis.org.uk/schools

Department of Health, Social Services and public safety
www.dhsspsni.gov.uk.

Form fist around auto-injector (dominant hand). **PULL OFF SAFETY CAP**

SWING AND PUSH TIP at a 90° angle against outer thigh (with or without clothing) until a click is heard.



HOLD FIRMLY in place for 10 seconds.

REMOVE auto-injector. Massage injection site for 10 seconds.

Exemplar letter for Pharmacy requesting emergency adrenaline auto-injectors can be found within Templates and Forms – See page 8.20a

APPENDIX 2

EXEMPLAR LETTER

Example wording for signed order:

[Add name and address of school]

(if not on headed paper or if address isn't included in the header)

[Insert date]

To *[add name and address of supplier]*

Please supply ***[write the number of auto-injectors required]*** auto-injectors to ***[add the name of school]*** to be used for the purpose of supplying the medicinal product to pupils at the school in an emergency in accordance with the regulations.

[Signature of the Principal or Headteacher of the school]
[Print name of Principal or Headteacher]

This request complies with the statutory guidance laid out in the document: *Guidance on the use of auto-injectors in schools* (DoH September 2017).

ASTHMA

- GUIDANCE
- EMERGENCY SALBUTAMOL INHALERS GUIDANCE

EAST RIDING OF YORKSHIRE COUNCIL

NHS

ASTHMA
GUIDANCE

CONTENTS

EMERGENCY SALBUTAMOL INHALERS GUIDANCE

Page 5.10

WHAT IS ASTHMA?

INTRODUCTION

This guidance is for schools to consider following and is based on good practice. An exemplar school asthma policy can be found as appendix 1.

WHAT IS ASTHMA?

Asthma is a common condition which affects the airways in the lungs. Symptoms occur in response to exposure to a trigger e.g. pollen, dust, smoke, exercise etc. These symptoms include cough, wheeze, chest tightness and breathlessness. Symptoms are usually easily reversible by use of a reliever inhaler but all staff must be aware that sufferers may experience an acute episode which will require rapid medical or hospital treatment.

MEDICATION IN SCHOOL

Only reliever inhalers should be kept in school. Usually these are blue in colour. **Immediate access to reliever inhaler is vital.** As a guideline schools should consider that:

Key Stage 1
Inhalers and spacers will be kept by the teacher in the classroom in a designated place, of which pupils will be made aware. However, if the child or class moves to another area within the school, the inhaler will be taken too. Good practice indicates that a spare inhaler is kept in school for staff to use if the original runs out or is lost.

Key Stage 2
Children aged 7 years and over who are considered sufficiently mature are encouraged to carry their own inhaler with them, at the discretion of the parent/carer and teacher. Otherwise the inhaler must be kept wherever the child is at any time e.g. class, hall, playground etc.

Key Stage 3 and 4
Pupils will carry their own inhalers with them at all times. Good practice indicates that a spare inhaler is kept in school by the teacher for use if the original runs out or is lost (see 5.10).

Children, who are able to identify the need to use their medication, should be allowed to do so, as and when they feel it is necessary.

STORAGE OF INHALERS

The following good practice guidelines for the storage of inhalers should be followed:

All children with asthma must have rapid access to their inhalers as soon as they need them. For this reason a child's inhaler should **NEVER** be locked away or kept in the school office.

Devices should always be taken with the child when moving out of the classroom for lessons, trips or activities.

N.B. – In the unlikely event of another pupil using someone else's blue inhaler there is little chance of harm. The drug in reliever inhalers is very safe and overdose is very unlikely.

RECORD KEEPING

When a child with asthma joins this school, parents/carers will be advised to complete an asthma care plan (appendix 2), giving details of the condition and the treatment required. Information from this form will be used to compile an "Asthma Register" which is available for all school staff. This register should be updated at least annually or more frequently if required using the information supplied by the parent/carer.

PHYSICAL EDUCATION

Taking part in sports is an essential part of school life and important for health and well being and children with asthma are encouraged to participate fully. Symptoms of asthma are often brought on by exercise and therefore, each child's labelled inhaler should be available at the site of the lesson.

Certain types of exercise are potent triggers for asthma e.g. cross country running and field activities. Any child who knows that an activity will induce symptoms should be encouraged to use their reliever inhaler prior to exercise, carry it with them and be encouraged to warm up prior to participating and cool down after.

SCHOOL TRIPS/RESIDENTIAL VISITS

No child should be denied the opportunity to take part in school trips/residential visits because of asthma, unless so advised by their GP or consultant.

The child's reliever inhaler should be readily available to them throughout the trip, being carried either by the child themselves or by the supervising adult in the case of Key Stage 1 children.

For residential visits, staff should be trained in the use of regular controller treatments, as well as emergency management. It is the responsibility of the parent/carer that they should to provide written information about all asthma medication required by their child for the duration of the trip. Parents should be responsible for ensuring an adequate supply of medication is provided. Group leaders should have appropriate contact numbers with them.

COLDS/VIRUSES

When a child has a cold it is sometimes necessary for him/her to use their regular reliever inhaler for a few days. Therefore a parent/carer may ask you to administer the blue inhaler every lunchtime for approximately 1 week. The number of puffs will be advised by the parent/carer but may be anything between 4 and 8 puffs. This does not replace using the inhaler as and when needed – it is in addition to this.

Children should not be taking their reliever inhaler every break/lunch time 'just in case' of symptoms. This is not a recommended practice. However, if a parent requests this, the school should administer the dose as requested and ask the parent to seek written clarification from their GP/Practice Nurse regarding this.

ASTHMA EDUCATION FOR PUPILS

It is recommended that all pupils should be educated about asthma. This could be through PSHE, drugs education, assemblies etc. Support for this may be available from your school nurse or the paediatric asthma specialist nurse.

TRAINING

All staff who have contact with these pupils should be given the opportunity to receive training on signs and symptoms of asthma and how to treat it from the school nursing team/specialist nurses. Updates for training are offered at regular intervals and this school will encourage attendance by staff.

This should take place at least every two years and more often if there are pupils within the school who have significant asthma symptoms or there are significant changes to the management of asthma in children.

Where possible, any new staff should receive appropriate training on their appointment.

CONCERNS

If a member of staff has concerns about the progress of a child with asthma, which they feel may be related to poor symptom control, they will be encouraged to discuss this with the parent/carer and/or school nurse.

EMERGENCY PROCEDURES

A flow chart is issued with this guidance outlining the action to be taken in an emergency and should be printed on the reverse of the child's asthma emergency information (8.5). Good practice suggests that a copy is kept with the child's emergency medication near the child at an given time. Further copies may be printed and displayed in the school office, staff room and relevant locations including classrooms where a pupil is known to have severe asthma.

In an emergency, where a child, who is a **known asthmatic and on the school asthma register is experiencing significant symptoms** and has not got their own blue inhaler with them or it is found to be empty, broken or out of date, it is acceptable to use the schools emergency inhaler and spacer as per the guidance in 5.10 (if one is available within the school). Emergency inhalers will be kept in appropriate locations on the school site, where staff can access one with ease and will be used as per the asthma flow chart.

This should then be recorded in the child's records and parent/carer informed.

To obtain an emergency inhaler and spacer the school should write a letter to a local pharmacy (appendix 3), on headed notepaper requesting the purchase of a Salbutamol Metered Dose Inhaler and spacer (with mask). This letter should be signed by the Headteacher.

EMERGENCY INHALERS

There are two ways to obtain emergency inhalers for the school.

Inhalers and spacers can be purchased by the school for emergency use as recommended in *Guidance on the use of emergency salbutamol inhalers in schools* (DoH March 2015). In Hull and East Yorkshire schools, the local charity (Reg charity No. 1164031) Breathe for Cameron

raise funds to supply, free of charge, inhalers and spacers for emergency use in schools. These can be obtained by emailing the charity at info@breathecharity.org.uk

If the school has not subscribed to having an emergency inhaler, then, in a situation where a child who is on the asthma register, is having severe symptoms, it is acceptable to borrow a reliever inhaler and spacer from another child.

This should then be recorded in the child's records and parent/carer informed.

RESPONSIBILITIES

Parents/Carers:

- To tell the school that their child has asthma.
- Ensure the school has complete and up to date information regarding their child's condition.
- Inform the school about the medicines their child requires during school hours.
- Inform the school of any medicines their child requires while taking part in visits, outings or field trips and other out of school activities.
- Inform the school of any changes to their child's medication.
- Inform the school if their child is or has been unwell which may affect the symptoms e.g. symptoms worsening or sleep disturbances due to symptoms.
- Ensure their child's inhaler (and spacer where relevant) is labelled with their child's name.
- Provide the school with a spare inhaler labelled with their child's name.
- Regularly check the inhalers kept in school to ensure there is an adequate amount of medicine available and that it is in date.

All school staff (teaching and non-teaching):

- Understand the school asthma policy.
- Know which pupils they come into contact with have asthma.
- Know what to do in an asthma attack.
- Allow pupils with asthma immediate access to their reliever inhaler.
- Inform parents/carers if a child has had an asthma attack.
- Inform parents if they become aware of a child using more reliever inhaler than usual.
- Ensure inhalers are taken on external trips/outings.
- Be aware that a child may be more tired due to night time symptoms.
- Liaise with parents/carers, school nurse, SENCO, etc. if a child is falling behind with their work because of asthma

FURTHER READING

This free online resource is a public access site with content developed by expert health professionals in consultation with teachers, sports coaches and children's activity leaders. Anyone who uses the resource will gain the knowledge and confidence to support children with asthma, deal with emergency situations and could help save lives.

www.educationforhealth.org/child-asthma

APPENDIX 1

This draft school asthma policy has been developed based on best practice. Schools and governors should consider whether it fits their practice and amend if and as necessary.

EXEMPLAR SCHOOL ASTHMA POLICY

Name of School	
Name of Coordinator	
Role of Coordinator	
School Nurse	
Contact details	
Date of Policy	
Policy Review date	

POLICY STATEMENT

This policy is based on guidance from Asthma UK and local healthcare and education professionals. It is based on the following documents: *Supporting pupils at school with medical conditions* (DfE December 2015) and *Guidance on the use of emergency salbutamol inhalers in schools* (DoH March 2015).

This school recognises that asthma and recurrent wheezing are important conditions affecting increasing numbers of school age children. This school welcomes pupils with asthma.

This school encourages all pupils to achieve their full potential in all aspects of life by having a clear policy and procedures that are understood by school staff, parents / carers and pupils.

Developing and implementing this asthma policy is important to our school.

TRAINING

Staff should be given the opportunity to receive training on signs and symptoms of asthma and how to treat it from the school nursing team/specialist nurses biannually. Where possible, any new staff will receive appropriate training on their appointment.

INDEMNITY

School staff are not required to administer asthma medication to pupils except in an emergency. However many staff may be happy to give routine medication on the advice of an appropriate healthcare professional. School staff who agree to administer asthma medication are insured by relevant authorities when acting in agreement with this policy.

All school staff will allow pupils **immediate** access to their own asthma medication when they need it.

RECORD KEEPING

When a child with asthma joins this school, parents/carers will be asked to complete an asthma care plan, giving details of the condition and the treatment required. Information from this form will be given to the school nurse for review and used to compile an "Asthma Register" which is available for all school staff. This register will be updated at least annually or more frequently if required using the information supplied by the parent/carer.

SCHOOL TRIPS/RESIDENTIAL VISITS

No child will be denied the opportunity to take part in school trips/residential visits because of asthma, unless so advised by their GP or consultant.

The pupil's reliever inhaler will be readily available to them throughout the trip, being carried either by the child themselves or by the supervising adult in the case of Key Stage 1/2 children.

For residential visits, staff will be advised in the use of regular controller treatments, as well as emergency management. It is the responsibility of the parent/carer to provide written information about all asthma medication required by their child for the duration of the trip. Parents must be responsible for ensuring an adequate supply of medication with the pharmacist instructions is provided.

Group leaders will have appropriate contact numbers with them.

CONFIDENTIALITY

All staff should treat medical information confidentially.

The school will agree with the pupil where appropriate or otherwise the parent, who else should have access to medical information.

Date of Policy	
Date of Review	
Responsibility of	

COMPLIANCE

This policy complies with the statutory requirements laid out in the document: *Supporting Pupils at School with Medical Conditions December 2015* (DfE) and the School Partnership and local authority guidance: *Medical Conditions at School* – Management Resource Pack 2017.

APPENDIX 2

GOOD PRACTICE

When the child's Individual Healthcare Plan is being completed, the Emergency Information exampled below (see Templates and Forms for user friendly version) should also be completed, printed double sided, placed in a clear wallet file with the child's emergency medication and where possible kept within easy access of staff (and child if appropriate).

ASTHMA EMERGENCY INFORMATION TEMPLATE

Page 8.5

EAST RIDING OF YORKSHIRE COUNCIL

Hull and East Yorkshire Hospitals NHS Trust

ASTHMA EMERGENCY INFORMATION

8.5

This plan should be produced by parents, school and the specialist/school nurse and if necessary a copy sent to the child's GP.

Child's Name		Child's Photo
Class/form		
Date of Birth		
School Year		
Parent/Carer Name(s)		
Home Contact Number		
Mobile Contact Number		
GP/Medical Centre Number		
School Nurse Number		

Known triggers	
Location of medication in school	
Designated school health official	

Instructions for reliever inhaler use (please tick the appropriate statement)
☐ My child does **not** understand the proper use of his/her inhaler and requires help to administer them.
☐ My child understands the proper use of his/her asthma medications and, in my opinion, can carry and use their inhaler at school independently; notifying the designated school health official after using their inhaler..

I give permission for school personnel to share this information with all school staff, follow this plan and administer medication.

If necessary, I also give permission for the school to contact our GP/School Nurse and in the case of an emergency, this plan may be passed to medical professionals.

I assume full responsibility for providing the school with prescribed medication and delivery devices and if necessary I give permission for the school to use the emergency inhaler if required. I approve this Asthma Care Plan for my child.

Parent/s Signature	Date
Health Care Practitioner Signature	Date
Headteacher's Signature	Review Date

ATTACK

est (when at rest)
breathing fast and with effort, using all accessory muscles in the upper body)

– some children will go very quiet
ls tight' (younger children may express this as tummy ache)

nt for a child to be having an asthma attack

TELY AND COMMENCE THE
VITHOUT DELAY IF THE CHILD

HE EVENT OF AN ASTHMA ATTACK

ly forward
ilable, use the emergency inhaler
and spacer are brought to them

TO TAKE TWO SEPARATE PUFFS OF SALBUTAMOL VIA THE SPACER

If there is no immediate improvement, continue to give
TWO PUFFS AT A TIME EVERY TWO MINUTES, UP TO A MAXIMUM OF 10 PUFFS

IMPROVEMENT
Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better.
Document medication given. Dose may be repeated if symptoms return. However, if this is within four hours, contact parent(s) as medical review is recommended.

NO IMPROVEMENT
If the child does not feel better or you are worried at **ANYTIME** before you have reached 10 puffs, **CALL 999 FOR AN AMBULANCE**

If an ambulance does not arrive in 10 minutes
GIVE ANOTHER 10 PUFFS
IN THE SAME WAY

The information in this flowchart is taken from the Department of Health – *Guidance on the use of emergency salbutamol inhalers in schools* (March 2015)

www.gov.uk/government/publications/emergency-asthma-inhalers-for-use-in-schools

APPENDIX 3

EXEMPLAR LETTER

Example wording for signed order:

5.7

[Add name and address of school]

(if not on headed paper or if address isn't included in the header)

[Insert date]

To *[add name and address of supplier]*

Please supply ***[write the number of inhalers required]*** salbutamol inhalers to ***[add the name of school]*** to be used for the purpose of supplying the medicinal product to pupils at the school in an emergency in accordance with the regulations.

[Signature of the Principal or Headteacher of the school]
[Print name of Principal or Headteacher]

This request complies with the statutory guidance laid out in the document: *Guidance on the use of emergency salbutamol inhalers in schools* (DoH March 2015).

FURTHER INFORMATION

Department for Education

www.education.gov.uk

Castle View House
East Lane, Runcorn
Cheshire
WA7 2GJ

0370 000 2288

Asthma UK

www.asthma.org.uk

Hull and East Yorkshire Hospitals NHS Trust

Paediatric Respiratory Specialist Nurse
The Craven Building
Hull Royal Infirmary
Anlaby Road, Hull
HU3 2JZ

(01482) 645544

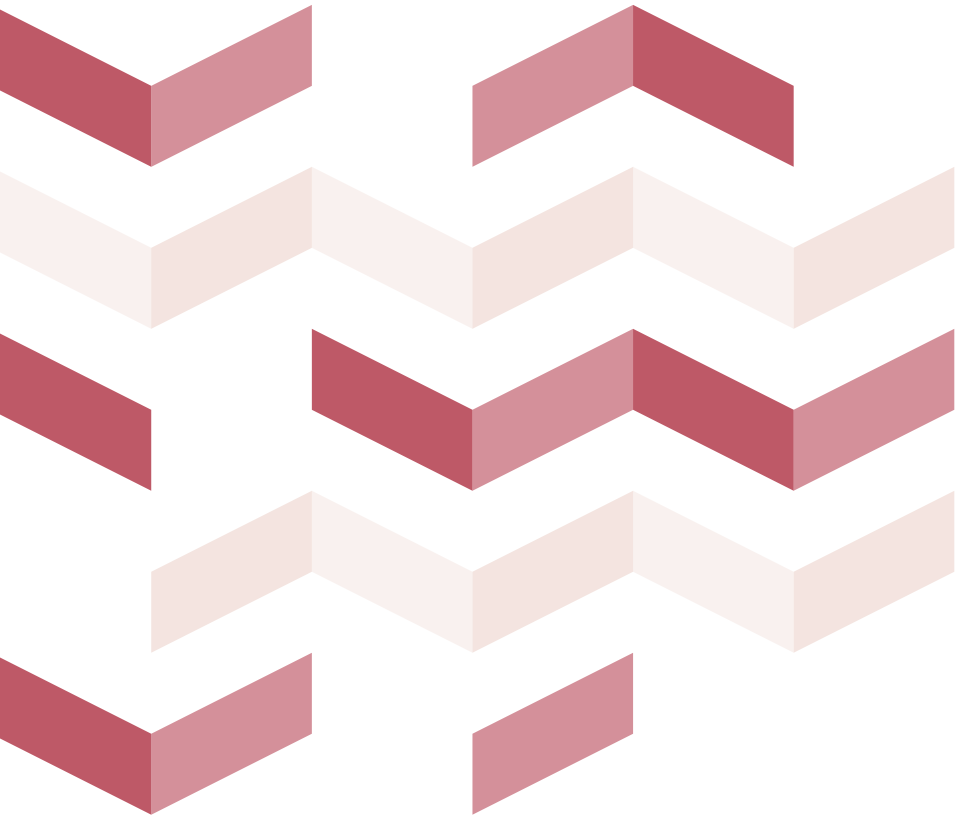
REFERENCES

Supporting pupils at school with medical conditions
Statutory guidance for governing bodies of maintained schools and proprietors of academies in England.
www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3
(DfE December 2015)

Managing Chronic Health Conditions and Infection Control in Schools
(East Riding local authority and schools Partnership Guidance January 2014)

Managing Medicines in Schools
(East Riding local authority and schools Partnership Guidance January 2014)

Guidance on the use of emergency salbutamol inhalers in schools
www.gov.uk/government/publications/emergency-asthma-inhalers-for-use-in-schools
(DoH March 2015)



ASTHMA

EMERGENCY SALBUTAMOL INHALERS GUIDANCE

LEGAL BACKGROUND

From the 1st October 2014 Schools have been able to purchase and keep emergency salbutamol inhalers for use for with pupils with asthma who do not have access to their own inhaler. The relevant regulations can be found in The Human Medicines (Amendment)(Number 2) Regulations 2014.

This does not mean schools must keep emergency salbutamol inhalers it simply allows them to do so if wished.

The Department of Health has produced Guidance on the use of emergency salbutamol inhalers in schools:

- www.gov.uk/government/publications/emergency-asthma-inhalers-for-use-in-schools

This information sheet is intended as a supplement to the Department of Health guidance.

ISSUES TO CONSIDER

Schools must be confident before they decide to keep emergency inhalers that they have in place the following

- Sufficient trained staff who are able and willing to administer the medication when necessary.
- A robust policy which covers the management and use of the inhalers – details of what should be included in the policy are included in the Department of Health guidance.
- Appropriate insurance cover.

PURCHASING INHALERS

To purchase inhalers from a pharmaceutical supplier schools must give the supplier a signed order completed by the Principal or Head Teacher preferably on the school's letter headed paper. An example of the possible wording for the signed order is given in Templates and Forms.

Schools must only obtain inhalers from reputable suppliers such as the local community pharmacy or licensed pharmaceutical wholesale dealer. Internet purchases are not advised.

TYPE OF INHALER TO PURCHASE

Schools should purchase standard aerosol (MDI) salbutamol inhalers.

They should not purchase breath actuated or dry powder type inhalers. Not only will these inhalers be more costly to purchase, they cannot be used via a spacer device.

OBTAINING SPACERS

Spacers are medical devices which allow for the use of standard aerosol inhalers without having to coordinate breathing with activation of the inhaler. The DH guidance recommends a spacer device is used to when the emergency inhaler is used.

There are several different types of spacer that vary in size and compatibility with different inhalers. The cost will vary depending on the type of spacer used.

The pharmacist will also be able to show you how to use the spacer if necessary. The spacer should be left in its packaging until use so that it is easy to see that the spacer is ready for use.

ESTABLISHING THE CORRECT NUMBER OF INHALERS AND SPACERS TO KEEP

Schools should ensure that they have sufficient inhalers and spacers to allow rapid access to the inhaler in an emergency. Larger schools may wish to have several inhalers in various sites around the school, including in a central location and in the sports area of the school.

Schools may also wish to consider having a pack which can be taken out on school trips, where these are accompanied by a teacher who is able to administer the emergency inhaler.

The DH guidance suggests that a typical school may require around 5 inhalers.

Each inhaler should be accompanied by at least two compatible spacer devices.

The school should also take into account the number of children recorded as having asthma and needing a reliever inhaler when assessing the number of inhalers needed.

DOCUMENTING USE

The inhalers can only be used where the child has previously been prescribed an emergency reliever inhaler and where there is a record of parental consent to the use (Asthma Emergency Information: 8.5). It is recommended that a list is kept with each inhaler of the names of pupils for who parental consent has been obtained.

The school must keep a record of inhalers purchased including the batch number and expiry date. (The batch number is a number provided by the manufacturer to identify inhalers made at the same time during the manufacturing process. The expiry date or "use by" date is the date after which the inhaler must not be used. Both of these numbers can be found on the inhaler packaging and usually also on the aerosol canister).

A record must also be made each time the inhaler is used including which pupil it was used for, when it was used, where it was used, how much was given and who administered the inhaler.

It is suggested that a separate form is kept for each inhaler on which all the relevant information is recorded along with a running balance of doses left in the inhaler. Most standard aerosol inhalers do not contain a dose counter so having a running balance will allow staff to monitor that there are sufficient doses available in each inhaler. A template form can be found in Templates and Forms 8.21 (Emergency Salbutamol Inhaler Record) and a exemplar record is given in 8.21a.

It is essential that the child's parents or guardians are informed when the child has used the emergency inhaler. An example form for this is given in Annex B of the DH guidance.

STORING THE INHALERS

Inhalers should be stored in at room temperature in dry conditions. Rooms which become very moist such as shower rooms and kitchens are not suitable places. The inhalers should be easily accessible to staff and not locked away but must be out of the sight and reach of children.

The school's emergency inhalers must be kept separately from inhalers belonging to specific children.

Inhalers awaiting disposal must be stored separately from inhalers which are still in use.

CARE OF INHALERS

The school must have a regular schedule to check the inhalers and the inhaler kit to ensure that all is present and in working order. Inhalers should be tested routinely on a monthly basis by depressing the canister and ensuring that doses spray into the air. The wastage of these doses should be recorded on the inhaler record sheet. Staff should always ensure that when they test the inhaler they do this in a well-ventilated space with the mouthpiece turned away from their face and not pointing at any other person to prevent inadvertent inhalation of doses.

The plastic housing of the inhaler should be cleaned after use by removing the canister and the cap from the mouthpiece. The plastic housing and mouthpiece cap can be rinsed with warm water and left to air dry in a safe, warm and dry place. Do not wash the metal canister. Once dry the inhaler should be reassembled and returned to its in use storage space.

Schools should also be aware of any safety alerts involving salbutamol inhalers. Schools can sign up to the Central Alerting System (CAS) by emailing:
@ safetyalerts@dh.gsi.gov.uk

There is a helpsheet available on the CAS website help page:
www.cas.dh.gov.uk/Help/Help.aspx

LABELLING INHALERS

Emergency inhalers belonging to the school must not be confused with inhalers belonging to specific children which are held by the school.

The school should attach a label to the inhaler which clearly identifies it as the school's emergency inhaler. See example label right.

Emergency salbutamol inhaler

Property of ***[name of school]***

Always use with a spacer

Inhaler number ***[add number]***

DISPOSING OF INHALERS

Inhalers will need to be disposed of when they reach the expiry date or if they have been used without a spacer or if they may have become contaminated in any way.

The inhalers are business waste, as they belong to the school not an individual pupil, and it is the school's responsibility to dispose of them safely. A waste transfer note is required when they are disposed of. The correct completion of a waste transfer note is the responsibility of the school. A duty of care waste transfer note form can be obtained from the gov.uk website:

www.gov.uk/government/publications/duty-of-care-waste-transfer-note-template

Guidance on completing the form is available by clicking on the icon below. Waste transfer notes must be retained for 2 years.

Schools are advised to discuss with their local pharmacy whether they will accept back the inhalers for safe disposal and are willing to complete their section of the waste transfer note. Not all pharmacies will accept back business waste.

If the school is to take the inhalers to the local pharmacy for disposal then you must be registered as a waste carrier. The DH guidance recommends registering as a lower tier waste carrier. This is done on the Gov.UK register as a waste carrier, broker or dealer website:

www.gov.uk/waste-carrier-or-broker-registration

If the waste cannot be returned to a local pharmacy then it must be disposed of via a licensed waste disposal company. If you already have a waste carrier collecting waste from the school it is sensible to ask them if they can transport and safely dispose of pharmaceutical waste. Alternatively, the Gov.uk website provides a means to find a registered waste carrier to move your waste:

www.gov.uk/find-registered-waste-carrier

TRAINING OF STAFF

It is essential that staff are properly trained and competent to administer the emergency inhaler. They will need to know what symptoms to look out for, how to use the inhaler and spacer device, what response to expect and when to call the emergency services. The training should be documented along with any updates or refresher training undertaken.

Staff do not have to administer emergency salbutamol inhalers and should be able to state that they do not feel competent to do so. Their agreement to administer the inhalers must be documented. It would be sensible to have a list of suitably trained staff in the inhaler kits for other staff to reference if necessary.

Asthma UK produces videos on using your inhalers which staff may find useful to supplement their training. Education for Health is also developing online training on asthma. Further information can be obtained from their website:

www.educationforhealth.org/pages/children-and-young-people-asthma.html

Exemplar letter to Pharmacy and Emergency salbutamol inhaler record template can be found within Templates and Forms.

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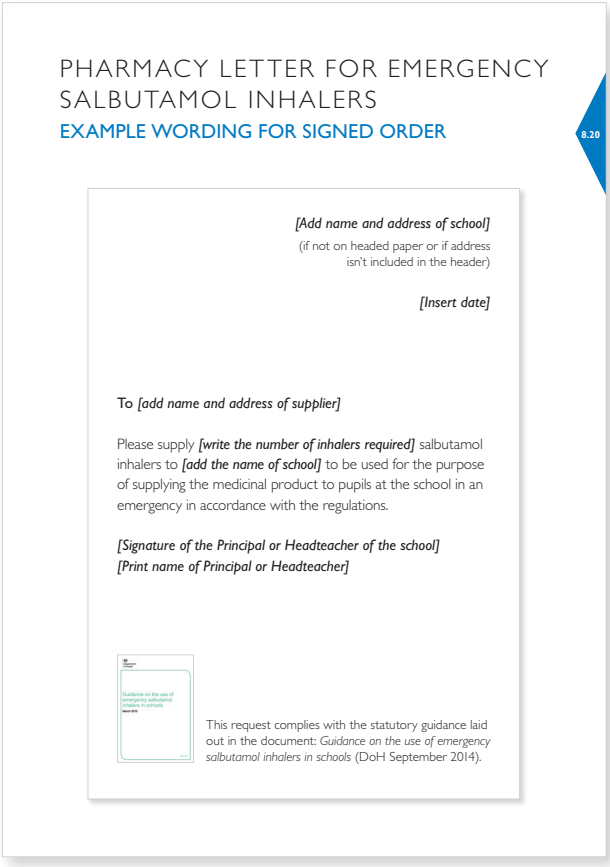

PHARMACY LETTER FOR EMERGENCY SALBUTAMOL INHALERS

EXAMPLE WORDING FOR SIGNED ORDER

8.20

[Add name and address of school]
(if not on headed paper or if address isn't included in the header)

[Insert date]

To *[add name and address of supplier]*

Please supply ***[write the number of inhalers required]*** salbutamol inhalers to ***[add the name of school]*** to be used for the purpose of supplying the medicinal product to pupils at the school in an emergency in accordance with the regulations.

[Signature of the Principal or Headteacher of the school]
[Print name of Principal or Headteacher]

This request complies with the statutory guidance laid out in the document: *Guidance on the use of emergency salbutamol inhalers in schools* (DoH September 2014).

DIABETES

GUIDANCE

EAST RIDING
OF YORKSHIRE COUNCIL

NHS

DIABETES
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CONTENTS

DIABETES INFORMATION FOR PARENTS AND SCHOOLS

Parents of children with diabetes should make their condition known and their treatment plan available to the school. All staff in the school should be made aware of what to do if the pupil shows signs of becoming unwell.

GENERAL INFORMATION

There are several types of diabetes:

- Type 1 diabetes - due to the lack of insulin
- Type 2 diabetes - the insulin is not working properly
- Rare genetic causes

The majority of children with diabetes have Type 1 diabetes. They normally require blood glucose monitoring, regular insulin injections and eat a healthy normal diet.

Each child may experience different symptoms and this should be discussed when drawing up the health care plan. A greater need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff should draw any such signs to the parents' attention. All Pupil Care plans should include the roles and responsibilities of the following:

- Parents' responsibility
- Early years/school responsibility

MEDICINE AND CONTROL FOR CHILDREN

Diabetes for the majority of children is controlled by injections of insulin each day and therefore those who do require injection it may be necessary for an adult to administer it. Children may require multiple injections and others may be controlled by an insulin pump. Most children will manage their own injections with supervision if doses are required whilst at school. A suitable, private place to carry out the injections should be made available.

Most (not all) children are taught to count carbohydrate intake and adjust their insulin accordingly. This means they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten.

They need to test blood glucose prior to the meal in order to decide how much insulin to give.

Children with diabetes need to ensure their blood glucose levels regularly by taking a small sample of blood and using a meter. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Older children should be able to do this themselves and will simply need a suitable place to do so. However younger children will need adult supervision to carry out the test and/or interpret their blood glucose test results.

All members of staff need adequate training by the diabetes specialist nursing team.

Children with diabetes need to be allowed to eat regularly during the day. This could include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if they have staggered lunchtimes.

If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a bottle of Original Lucozade* to hand (*only use **Original** Lucozade).

Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar – a **hypoglycaemic episode** below 4m/mols on their meter (hypo) in a child with diabetes:

- Hunger
- Sweating
- Drowsiness
- Lethargy
- Pallor
- Glazed eyes
- Shaking or trembling
- Lack of concentration
- Irritability
- Headache
- Mood changes, especially angry or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

Some children may experience **hyperglycaemia** (high glucose level) and may need to take a correction dose of insulin and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention. If the child is unwell, vomiting or has diarrhoea this can lead to dehydration. If there is a smell of pear drops or acetone on their breath, this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

Any illness, even a cough or a cold can affect a child's diabetes control and extra attention should be paid to a child with diabetes if they are unwell.

As information and photographs of children with diabetes are required to be placed on staff information boards throughout the school these should be where they cannot be seen by the general public. The child's health care plan must be accessible at all times to staff caring for the child, giving details of the child's insulin regime and pump regime.

An ambulance should be called if:
Blood glucose does not improve within 30 minutes after treatment or if the person becomes unconscious

CONTACT DETAILS

Diabetes Nurses

Trudy Tapson	☎ 07801 192809
Joanne Cater	☎ 07557 322731
Nikki Hall	☎ 07557 322736
Joanne Marrow	☎ 07798 581680

IMPORTANT ADDITIONAL CARE INFORMATION

Hyperglycaemia – high blood glucose
Things that may cause a hyper: Not enough insulin / Too much food / Common illness / Stress
If a blood glucose reading is high, usually above 14 mmols, the pupil may need to be given more insulin as a correction dose.

If pump regulated and blood sugars continue to run high the cannula site should be checked and changed if required. Pen devices and syringes should always be available in case of pump failure.

Hypoglycaemia – low blood glucose
Things that may cause a hypo: Exercise or prolonged activity / Heat or hot weather / Excitement
Anxiety / Stress / Hormones / Late snacks or meals / Missed snacks or meals / Too much insulin
During exercise the pupil should always have hypo treatment available and near. Staff should consider if the pupil requires a snack before or/and after exercise, as per health care plan.

If a child has a hypo, **it is very important that the child is not left alone** and that a fast acting sugar, such as: glucose tablets, a glucose rich gel, or a sugary drink is administered to the child immediately. Slower acting starchy food, such a digestive biscuit can be given once BG levels are above 4mmols. Always re-test 15 minutes after giving hypo treatment.

Symptoms	Treatment
STAGE 1 – Low Blood Sugar (Hypo) ■ Pallor ■ Sweating ■ Dizziness ■ Hunger ■ Headaches ■ Trembling/Shakiness ■ Anxiety/irritability ■ Fast pulse/palpitations ■ Glazed eyes/lack in concentration ■ Change in mood	■ Can he/she eat and drink independently? ■ Do NOT leave alone and treat in situ. ■ Take blood sugar reading-finger prick test after washing hands. ■ If below 4mmols give 1 Glucogel tablet OR 120-180mls of Original Lucozade. ■ Allow 15mins recovery. ■ Remeasure blood glucose. ■ If not fully recovered, or if blood glucose is still below 4mmols, treatment may be repeated. ■ This must be followed with a snack (1 digestive biscuit) or lunch. ■ Inform parents as requested.
Stage 2 (In addition to the above) ■ Drowsiness ■ Staggers ■ Slurred speech ■ Aggressive	■ Do NOT leave alone and treat in situ. ■ Give 3 glucose tablets immediately or 120-180mls of Original Lucozade. ■ Or if unable to swallow administer glucose gel – squeeze 1 tube between gum and cheek and massage (½ on each side). ■ Monitor for 15mins. ■ If not fully recovered treatment should be repeated ■ Follow with a snack or lunch once blood glucose is above 4mmols. ■ Inform parents as requested
Stage 3 ■ Unconsciousness	■ IN THIS UNLIKELY EVENT DO NOT PANIC ■ Do NOT give anything by mouth. ■ Place the child in the recovery position and dial 999 for ambulance – ensure medical staff informed of all treatment given prior to calling them. ■ Disconnect pump (if using). ■ Ring parents to inform.

APPENDIX 1

GOOD PRACTICE

When the child's Individual Healthcare Plan is being completed, the Emergency Information exampled below (see Templates and Forms for user friendly version) should also be completed, printed double sided, placed in a clear wallet file with the child's emergency medication and where possible kept within easy access of staff (and child if appropriate).

EAST RIDING OF YORKSHIRE COUNCIL

Hull and East Yorkshire Hospitals NHS Trust

DIABETIC EMERGENCY INFORMATION

8.6

This plan should be produced by parents, school and the specialist/school nurse and if necessary a copy sent to the child's GP.

Child's Name		Child's Photo
Class/form		
Date of Birth		
School Year		
Parent/Carer Name(s)		
Home Contact Number		
Mobile Contact Number		
GP/Medical Centre Number		
School Nurse Number		

Known triggers	
Location of medication in school	
Designated school health official	

Regime

☐ **Insulin Regime**

. . . . . is on a multi-dose insulin regime of 4 or more injections a day.

They will have an injection of insulin at breakfast, lunch, evening meal and another before bed.

A toilet is not considered a suitable place to carry out this clean procedure. Some children / young people will require supervision for this lunchtime injection.

☐ **Pump Regime**

. . . . . is given insulin via a pump device. The pump delivers a small amount of background insulin constantly throughout the day (basal).

Insulin is also administered each time carbohydrate food is consumed (bolus). This is carried out by manually instructing the pump.

An insulin bolus may also be required to correct blood glucose levels as recorded in pupils individual Health Care Plan.

DIABETIC EMERGENCY INFORMATION TEMPLATE

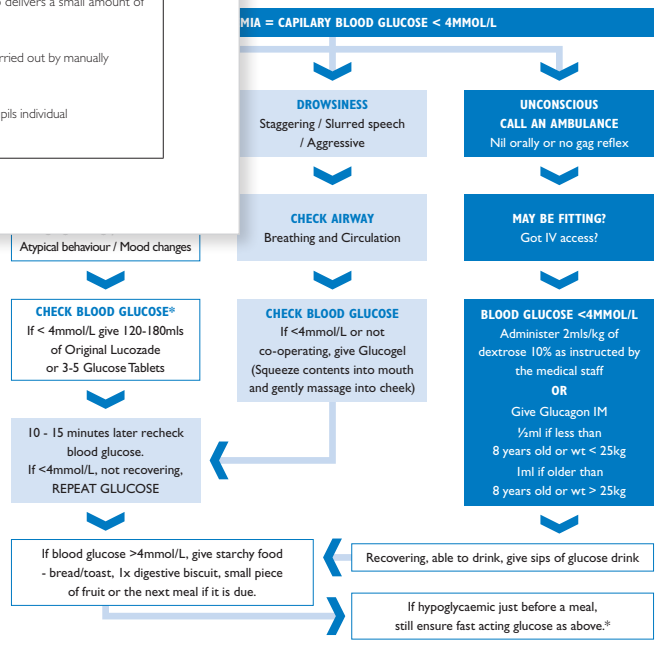
Page 8.6

share this information with all school staff, follow this plan and give permission for the school to contact our GP or specialist/school his plan may be passed to medical professionals.

nent plan for my child. I assume full responsibility for providing the school s, including delivery devices and hypoglycaemia treatment. I will keep the alth care plan as directed.

Date
Date
Review Date

EMIA IN CHILDREN WITH DIABETES



FURTHER INFORMATION

ADDITIONAL ADVICE FOR SCHOOLS

- The needs of children and young people with diabetes are paramount.
- Treatment regimens should be advised by clinical need, rather than the level of support available in schools and early years settings.
- Children and young people with diabetes should have equitable access to all curricular and extracurricular activities.
- Where support is required, training should be provided to identified personnel by appropriately trained health care professionals.
- A child or young person with diabetes should have good diabetes management and have sufficient support to ensure optimal glycaemic control within the school environment, enabling them to meet their full academic capability.

USEFUL WEBSITES AND SOURCES OF FURTHER INFORMATION

Department for Education

www.education.gov.uk
0370 000 2288

Diabetes UK

www.diabetes.org.uk
Care line: 0845 120 2960

Disability Rights Commission merged into the newly created Equality and Human Rights Commission in 2007

www.equalityhumanrights.com

Medical Conditions at School

www.medicalconditionsatschool.org.uk
A partnership of organisations – including Diabetes UK – working collaboratively to support schools to provide a safe environment for children and young people with medical conditions. A policy resource pack is available.

Juvenile Diabetes Research Foundation

www.jdrf.org.uk
020 7713 2030

National Institute for Health and Clinical Excellence (NICE)

www.nice.org.uk

NHS Choices

www.nhs.uk/Conditions/Diabetes/Pages/Diabetes.aspx

EPILEPSY

GUIDANCE

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NHS

EPILEPSY
GUIDANCE

CONTENTS

EPILEPSY GUIDANCE FOR SCHOOLS

For some children, epilepsy can have an effect on how easy or difficult it is for them to learn and affect their behaviour. There could be many possible reasons for this, including:

- The condition itself
- The cause of the epilepsy
- The effects of the seizures
- Side-effects from the epilepsy medicines
- Absences from school

THE CONDITION ITSELF

The Cause

For most children who have epilepsy there is no identifiable cause for the seizures, they have an idiopathic epilepsy, but a small percentage of children, difficulties with learning can be caused by damage to the brain, which also causes their epilepsy. This damage could have happened before, during or after their birth.

The Effects

Epileptic seizures can disrupt normal brain activity and this can stop memory from working properly. The confusion that can occur after seizures may also cause memory loss.

Depending on the type of seizures a child has, they may feel very tired or confused after a seizure. They may also have interrupted sleep which will make them tired. Feeling tired or confused can affect how well a child can learn.

Some children may behave differently in the time before, during and after a seizure.
In the hours or even a few days before a seizure, a child's mood or behavior may also change. This is called prodrome.

During a focal seizure, it's quite usual for a child to appear to be behaving differently. These behaviours may include gagging, lip smacking, running, screaming, crying, and/or laughing. They may not be conscious of what they are doing but have altered awareness so will understand language but may not respond appropriately, but they are in fact having a seizure.

After a seizure, it's quite usual for a child to be confused, have a headache, feel sleepy or have problems with vision or speech.

Very rarely, a child might have a condition called post-ictal psychosis. This can be very frightening and can change a child's behaviour. It can cause them to have a strong belief that something unreal is true, or hear or see things that are not there.

Treatment of epilepsy

The first line of treatment for children with epilepsy is medication using antiepileptic drugs or AEDs. Most medication is taken twice daily and it is important that the medication is taken in the way that the doctor has prescribed. AEDs are not a cure for epilepsy, but they can reduce the amount of seizures a person is having.

Some people experience side effects from taking medication, but these often subside after a while. It is important to keep a record of any side effects so that these can be reported to the doctor.

There are other treatments for epilepsy and these include the use of implanted devices (like a cardiac pacemaker) such as a Vagus Nerve Stimulator (VNS) and dietary treatments such as the ketogenic diet. In some cases neurosurgery may be a treatment option.

Side-effects from epilepsy medicines

Some children may have side-effects that affect their behaviour. These could include hyperactivity, irritability, sleepiness, mood changes, aggression and confusion, problems concentrating and mood swings.

What triggers a seizure?

We often do not know why a seizure occurs at one time and not another, but there are certain factors that may increase the likelihood of a seizure and these are known as triggers.

Common seizure triggers include:

- Tiredness
- Illness (raised temperature)
- Dehydration
- Stress
- Menstruation
- Alcohol
- Changes in medication
- Flashing lights (although photosensitive epilepsy is quite rare, affecting only around 5% of those with epilepsy)

Absences from school

Some children miss parts of their education because they need time off school to go to appointments with the specialist epilepsy nurse or specialist who manages their conditions. They may also be absent as a result of seizures, recovery after a seizure or injuries from a seizure.

Support for the child and parents

If parents feel that their child is finding it difficult to learn, or is having problems with their behaviour, they may need extra support. Schools should always make availability to parents and pupils to discuss these issues with the school, and what kind of support might help when you are developing/updating the child's individual health care plan (IHP).

Epilepsy Action

www.epilepsy.org.uk
New Anstey House
Gate Way Drive, Yeadon
Leeds
LS19 7XY
0113 210 8800
Helpline: 0808 800 5050
epilepsy@epilepsy.org.uk

Department for Education

www.education.gov.uk
Castle View House
East Lane, Runcorn
Cheshire
WA7 2GJ
0370 000 2288

Paediatric Specialist Nurse

(01482) 674151

Why schools need an epilepsy policy

It is essential for schools to have an epilepsy policy. Epilepsy Action believes that all children with epilepsy should be given the same opportunities to achieve their full potential. They should be able to enjoy the same level of participation in school life as their friends and classmates.

The Disability Discrimination Act (DDA) requires schools and education settings to ensure that all children with disabilities (which include epilepsy) are not treated 'less favourably' than their classmates.

To help achieve this, and fulfil legal requirements, every school or education setting should have a school epilepsy policy. Schools can use an epilepsy policy on its own or as part of another policy, for example the school's health and safety policy, its first aid policy or as part of its accessible schools plan.

Some children with epilepsy are prevented from attending school due to prolonged or recurrent absence as a result of their epilepsy. Schools should be prepared to incorporate provision for this in their epilepsy policy. Statutory guidance for educating children with health needs: 'Ensuring a good education for children who cannot attend school because of health needs' January 2013 is available from
www.education.gov.uk

School Policy Requirements

Schools should use the information below to develop an epilepsy policy. Each school's policy will be different, but every policy should incorporate the following principles.

1. This school recognises that epilepsy is a common condition affecting many children and young people, and welcomes all students with epilepsy.
2. This school believes that every child with epilepsy has a right to participate fully in the curriculum and life of the school, including all outdoor activities and residential trips.
3. This school keeps a record of all the medical details of children with epilepsy and keeps parents updated with any issues it feels may affect the child.
4. This school ensures that all children and staff in the school understand epilepsy and do not discriminate against any children with the condition.
5. This school ensures that all staff fully understands epilepsy and seizure first aid, and that there is at least one member of staff trained to administer emergency medicines in school at all times.
6. This school will work together with children, parents, staff, governors, educational psychologists and health professionals to ensure this policy is successfully implemented and maintained.

Online training

www.epilepsy.org.uk/training/for-schools

EPILEPSY POLICY FOR SCHOOLS

IMPLEMENTATION

An epilepsy policy should include all of the above points and explain how they are to be implemented. The following is a typical sample policy for a school. The sample forms should help to gather information to implement this policy.

This document contains three approaches that schools can take towards ensuring the needs of any pupil with epilepsy are met within the policy framework of the school.

This document is a guide. You may simply to adopt one of the models, or you may wish to adapt it to meet your schools individual needs.

EXAMPLE SCHOOL EPILEPSY POLICY 1 – EXAMPLE PARAGRAPH

To include in your schools Inclusion Policy

Supporting Children with Epilepsy

[Add name of school] is committed to fully meeting the needs of pupils who have epilepsy, keeping them safe, ensuring they achieve to their full potential, and are fully included in school life. We will do this by:

- Keeping careful records of changes in behaviour and levels of achievement to identify pupils who are not achieving to their full potential.
- Tackling any problems early.
- Ensuring that all pupils with epilepsy are fully included in school life, activities and outings (day and residential) and are not isolated or stigmatised.
- Giving voice to the views of pupils with epilepsy, for example regarding feeling safe, respect from other pupils, teasing and bullying, what should happen during and following a seizure, adjustments to support them in learning, adjustments to enable full participation in school life and raising epilepsy awareness in school.
- Making necessary adjustments e.g. exam timings, coursework deadlines, timetables.
- Liaising fully with parents and health professionals (with the parent's permission) to share information about the pupil's education, healthcare, medication and any affects this has on their school life (for example epilepsy medication and seizures can affect a person's ability to concentrate). This will be an ongoing process.
- Ensure that staff are epilepsy aware and know what to do if a pupil has a seizure.
- If needed, there will be a trained member of staff available at all times to deliver emergency medication.
- Every student with epilepsy will have an Individual Health Care Plan in place which will include information on the pupil's seizures, medication, and emergency protocols. A template is available from Young Epilepsy.
- Raising awareness of epilepsy across the whole school community, including pupils, staff and parents.

EXAMPLE SCHOOL EPILEPSY POLICY 2

This policy is intended to ensure that ***[Add name of school]*** fully meets the needs of pupils who have epilepsy and that all pupils who have epilepsy achieve to their full potential. It has been prepared with reference to information available from Young Epilepsy.

[Add name of school] will ensure at least one member of staff has training in epilepsy and supporting children who have epilepsy in school medically, socially and academically. That person will lead on ensuring that the epilepsy policy is followed.

[Add name of school] will ensure that all pupils who have epilepsy achieve to their full potential by:

- Keeping careful and appropriate records of students who have epilepsy
- Recording any changes in behaviour or levels / rates of achievement, as these could be due to the pupil's epilepsy or medication
- Closely monitoring whether the pupil is achieving to their full potential
- Tackling any problems early

[Add name of school] will ensure that all pupils with epilepsy are fully included in school life, and are not isolated or stigmatised. We will do this by:

- Offering support in school with a mentoring or 'buddying' system to help broaden understanding of epilepsy
- Supporting pupils to take a full part in all activities and outings (day and residential)
- Making necessary adjustments e.g. exam timings, coursework deadlines, timetables
- Giving voice to the views of pupils with epilepsy, for example regarding feeling safe, respect from other pupils, teasing and bullying, what should happen during and following a seizure, adjustments to support them in learning, adjustments to enable full participation in school life and raising epilepsy awareness in school.
- Raising awareness of epilepsy across the whole school community, including pupils, staff and parents.

[Add name of school] will liaise fully with parents and health professionals by:

- Letting parents know what is going on in school
- Asking for information about a pupil's healthcare, so that we can fully meet their medical needs
- Asking for information about if or how the pupil's epilepsy and medication affect their concentration and ability to learn
- Informing parents and health professionals (with the parent's permission) of changes to the pupil's achievement, concentration, behaviour and seizure patterns.

We will ensure that staff are epilepsy aware and know what to do if a pupil has a seizure.
If needed, there will be an appropriately trained member of staff available at all times to deliver emergency medication.

EXAMPLE SCHOOL EPILEPSY POLICY 3

Including the role of School Epilepsy Champion

This policy is intended to ensure that appropriate processes are in place to fully support and safeguard pupils at ***[Add name of school]*** who have epilepsy. It has been prepared with reference to information available from Young Epilepsy.

School Epilepsy Champion

Our School Epilepsy Champion is ***[Insert name]***

[Add name of school] will maintain the informal post of a School Epilepsy Champion, who has received training in epilepsy and supporting children who have epilepsy in school. The School Epilepsy Champion will take a leading role ensuring that the following epilepsy policy is adhered to, raising awareness of epilepsy within the school, identifying further training needs within the school as they arise and maintaining links with Young Epilepsy. The School Epilepsy Champion will also become a resource for colleagues in school, by sharing both their knowledge of epilepsy and classroom strategies. Prior to our School Epilepsy Champion leaving the school the [head teacher] will ensure that a new Champion is appointed and trained.

Communication with parents

When a pupil who has epilepsy joins ***[Add name of school]*** or an existing student is diagnosed with epilepsy, a meeting will be arranged with the parents (and pupil where appropriate) to:

- Discuss the pupil's medical needs, including the type of epilepsy he or she has.
- Discuss if and how the pupil's epilepsy and medication affect his or her ability to concentrate and learn, and how the pupil can be supported with this.
- Discuss any potential barriers to the pupil taking part in all activities and school life, including day and residential trips, and how these barriers can be overcome.
- Advise parents and the pupil of the school's epilepsy policy and the presence of the School Epilepsy Champion.
- Discuss with parents and the pupil the arrangements for ensuring that all relevant staff are trained and other pupils are epilepsy aware.
- Ensure that both medical prescription and parental consent are in place for staff to administer any necessary medication.
- Initiate the completion of an Individual Heathcare Plan, including types of seizures, symptoms, possible triggers, procedures before and after a seizure and medicines to be administered.
- Initiate the completion of an Individual Education Plan for the pupil.
- Discuss how the school, parents and pupil can best share information about the pupil's progress in school and any changes to his or her epilepsy and medication.

A record of what was discussed and agreed at this meeting will be kept by the school.

After the initial meeting, the school will continue to share information with the pupil's parents and to involve the parents in any decision making process. Where appropriate the pupil will also be involved in this process.

With Health Professionals

[Add name of school] recognises that information held by the school, such as changes to the pupil's seizure patterns and changes to the pupil's behaviour, may be extremely useful to the pupil's healthcare team. Where appropriate and with the parents' permission ***[Add name of school]*** will share this information, either via the parents, or directly, with the pupil's healthcare team. ***[Add name of school]*** will also encourage information sharing between health and education, for example changes in medication or seizure patterns.

With School staff

All appropriate staff, including teachers and office staff will be told which children in the school have epilepsy, and what type of epilepsy they have. All staff (teaching and support) who are responsible for a child with epilepsy, will receive basic epilepsy awareness training, including what to do if a child has a seizure. New staff will be given this information as part of their induction. Supply staff, who will be responsible for a child with epilepsy, will be given

(Cont.)

information about epilepsy, including what to do if a child has a seizure, before they begin working in the school.

At the beginning of the academic year or immediately following the pupil's diagnosis, a meeting will be arranged to discuss the pupils support needs. At this meeting all attendees will be given a copy of the pupils Individual Education Plan and Individual Health Plan.

One named member of staff will take responsibility for sharing any changes to the pupil's Individual Healthcare Plan and Individual Education Plan, with appropriate members of staff.

With the pupils who have epilepsy
The school will give voice to the views of pupils with epilepsy, for example regarding feeling safe, respect from other pupils, teasing and bullying, what should happen during and following a seizure, adjustments to support them in learning, adjustments to enable full participation in school life and raising epilepsy awareness in school.

SCHOOL LIFE

An inclusive environment
Pupils with epilepsy will not be isolated or stigmatised and will be allowed to take a full part in the school curriculum and school life, including activities and school trips (day and residential). Parents and staff will discuss any special requirements prior to such events.
Staff will consider the adjustments necessary to enable the pupil to participate fully in school life and to reach their full potential. This might include changes to timetables, exam timings and coursework deadlines. These adjustments will be recorded and shared with other appropriate members of staff.

Raised Awareness
The School Epilepsy Champion will ensure that awareness of epilepsy is raised across the whole school community. Particular attention will be given to the pupil's peer group so that they know what to expect, are not scared by a seizure and know what to do if a pupil has a seizure.

Mentor / Buddy The school will offer support by providing a mentor or buddy for the pupil.

Education
All pupils who have epilepsy will have an Individual Education Plan. The pupil's teachers will keep records detailing the pupil's achievement, behaviour, memory, concentration and energy levels.

For primary school children: the pupil's teacher will review his or her progress termly. If any problems are identified the teacher will meet with the SENCO / the School Nurse / the Epilepsy Champion, to discuss and agree strategies for supporting the pupil.

For pupils at secondary school students: once a term the pupil's teachers will review the pupil's progress in their subject, and inform the form tutor if the child is not achieving to their full potential or is experiencing problems with concentration etc. If any problems are identified the form tutor will meet with the pupil's teachers / the SENCO / the School Nurse / the Epilepsy Champion, to discuss and agree strategies for supporting the pupil.

The pupil will also be encouraged to reflect upon his or her achievements and whether he or she feels that his or her education is being affected by his or her epilepsy.

Any changes or problems identified, as well as strategies for supporting the pupil, will be discussed with the pupil's parents and, when appropriate, with the pupil. It may be appropriate to share information about these changes with the pupil's healthcare providers. If appropriate the pupil may undergo an assessment by an educational or neuropsychologist. Any changes to the pupil's Individual Education Plan will be shared with the appropriate members of staff.

Medical Needs
The pupil's Individual Healthcare Plan will be kept in the ***[Add location]***. The pupil's form teacher will be responsible for reviewing the plan at least once a term and will advise other appropriate staff of any changes.

All staff (including support staff) will be trained in first aid appropriate for the pupil's seizure type. The first aid procedure will be prominently displayed in all classrooms.

If appropriate, a record will be kept of the pupil's seizures, so that any changes to seizure patterns

(Cont.)

can be identified and so that this information can be shared with the pupil's parents and healthcare team.

The pupil's Individual Healthcare Plan will include the names and contact details of the staff trained to administer medication. There will be a trained member of staff available at all times to deliver emergency medication. Details of who that member of staff is and how to contact them will be kept with the pupil's Individual Healthcare Plan.

We will ensure that enough staff are trained and available, so that even if the person who usually administers emergency medication is unexpectedly absent, there will still be a trained member of staff available to administer the emergency medication.

A record of staff trained in administering emergency medication will be kept with the Individual Healthcare Plan.

A medical room with a bed will be kept available, so that if needed, the pupil will be able to rest following a seizure, in a safe supervised place.

The following can be downloaded from the Young Epilepsy website:

www.youngepilepsy.org.uk

- Individual Healthcare Plan
- Record of the Use of Emergency Medication
- Seizure Record Chart
- Seizure Description Chart

The following information is taken from the DfE document *Supporting pupils at school with medical conditions* (September 2014)

LIABILITY AND INDEMNITY

44. Governing bodies of maintained schools and management committees of PRUs should ensure that the appropriate level of insurance is in place and appropriately reflects the level of risk. Proprietors of academies should ensure that either the appropriate level of insurance is in place or that the academy is a member of the Department for Education's Risk Protection Arrangements (RPA), a scheme provided specifically for academies. It is important that the school policy sets out the details of the school's insurance arrangements which cover staff providing support to pupils with medical conditions. Insurance policies should be accessible to staff providing such support.

45. Insurance policies should provide liability cover relating to the administration of medication, but individual cover may need to be arranged for any healthcare procedures. The level and ambit of cover required must be ascertained directly from the relevant insurers. Any requirements of the insurance, such as the need for staff to be trained, should be made clear and complied with.

46. In the event of a claim alleging negligence by a member of staff, civil actions are likely to be brought against the employer.

www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions

PARENTAL QUESTIONNAIRE FOR PUPILS WITH EPILEPSY

This questionnaire should be completed by the child's parents, Headteacher, specialist epilepsy nurse/school nurse and, wherever possible, the child.

Name	
Date of birth	
Class/form teacher	
What type of seizure/s does your child have? (if you know what they are called)	
How long do they last?	
What first aid is appropriate?	
How long will your child need to rest following a seizure?	
Are there any factors that you have noted might trigger a seizure?	
Does your child have any warning before a seizure occurs?	
What is the name of your child's medicine and how much is each dosage?	
How many times a day does your child take medicine?	
Are there any activities that you feel may require particular precautions?	
Does your child have any other medical conditions?	
Is there any other relevant information you feel the school should be aware of?	

APPENDIX I

GOOD PRACTICE

When the child's Individual Healthcare Plan is being completed, the Emergency Information exampled below (see Templates and Forms for user friendly version) should also be completed, printed double sided, placed in a clear wallet file with the child's emergency medication and where possible kept within easy access of staff (and child if appropriate).

EAST RIDING OF YORKSHIRE COUNCIL

Hull and East Yorkshire Hospitals NHS Trust

EPILEPSY EMERGENCY INFORMATION

8.7

This plan should be produced by parents, school and the specialist/school nurse and if necessary a copy sent to the child's GP.

Child's Name		Child's Photo
Class/form		
Date of Birth		
School Year		
Parent/Carer Name(s)		
Home Contact Number		
Mobile Contact Number		
GP/Medical Centre Number		
School Nurse Number		

Known triggers	
Location of medication in school	
Designated school health official	

I give permission for school personnel to share this information with all school staff, follow this plan and administer medication.

If necessary, I also give permission for the school to contact our GP specialist/school Nurse and in the case of an emergency, this plan may be passed to medical professionals.

I assume full responsibility for providing the school with an adequate supply of the prescribed medication with the pharmacist instructions and required delivery devices. I approve this Epilepsy Care Plan for my child.

Parent/s Signature	Date
Health Care Practitioner Signature	Date
Headteacher's Signature	Review Date

EPILEPSY EMERGENCY INFORMATION TEMPLATE

Page 8.7

replenishment	
	i)
	ii)
	iii)
School liaison	

lowing reasons:

t pupil / lasting over 5 minutes but not recovering.

more than . . . . . minutes.
position checking airway is clear.
to ensure safety.
udents if staff think this is necessary.
n (overleaf) the named trained member of staff will give rectal diazepam/
e sex present (if possible).
ulance Service, give name of student, address and phone number of school.

7. Stay with the pupil until ambulance arrives.
8. If parents have not arrived by this time a member of staff will accompany the pupil to the hospital in the ambulance.
9. Fill in seizure record form for the student file and send copy to parents/GP.

Service	Name	Contact Details
Emergency contact		
Epilepsy Consultant/specialist		
Family GP		
Epilepsy/paediatric/ community support nurse		
Other		

PARENTAL CONSENT

I give consent for . . . . . to be given rectal diazepam or Buccal Midazolam by trained staff in the circumstances described in this document. I will undertake to inform the school of any changes in the nature of his/her seizures or medication.

Signed	Date
Please Print Name	Review Date

TEMPLATES AND FORMS

EAST RIDING OF YORKSHIRE COUNCIL

NHS

MEDICAL CONDITIONS TEMPLATES AND FORMS

These forms and templates can be used for paracetamol oral suspension as well as the pupil's medication prescribed by a medical practitioner.

CONTENTS

Unless otherwise stated, these templates have been taken from the Department for Education guidance: *Templates. Supporting pupils with medical conditions* (May 2014). This was developed from the Department for Education guidance: *Supporting pupils at school with medical conditions* (December 2015).

All templates and forms are examples that schools may wish to use or adapt according to their particular policies on administering prescribed medicines.

MANAGING PRESCRIBED MEDICINES IN SCHOOL

CHECKLIST

This can be used as part of an annual self-check perhaps by a Headteacher and/or Governor.

Checklist		Yes	No	Details
1	Does the school have a written policy for the administration of prescribed medicines in school?	☐	☐	Date/Location
2	Has the school nominated responsible persons to administer prescribed medicines?	☐	☐	List nominated staff
3	Is there a clear statement on the roles, responsibilities and supervision of staff managing and /or administering prescribed medication?	☐	☐	Location/Staff informed
4	Has nominated staff received appropriate information, instruction and training on the schools policy and procedures?	☐	☐	List staff/Date/ Training Provider
5	Does the school have procedures for managing prescribed medicines on school trips and outings?	☐	☐	Risk assessments/ Consent forms
6	Has the school received a written agreement from parents/ guardians for prescribed medication to be given?	☐	☐	Form/Location
7	Has the school agreed to administer prescribed medication?	☐	☐	Form/Location
8	If health care plans are required where are they kept?	☐	☐	Form/Location
9	Is there guidance for children carrying and taking their own prescribed medication? (Asthma only)	☐	☐	Policy/Location
10	Does the school maintain records for the administration of prescribed medication?	☐	☐	Form/Location
11	Does staff have access to the schools emergency procedures?	☐	☐	Policy/Location
12	Does the school have appropriate and secure storage facilities?	☐	☐	Specify
13	Are emergency prescribed medicines, such as inhalers readily available?	☐	☐	Specify
14	Has the risk assessment for the storage and administration of medication been adapted and issued to all relevant staff? Have they signed to confirm receipt and understanding?	☐	☐	

Date checklist completed	
Date due for review	

FORM 1
CONTACTING EMERGENCY SERVICES
PROMPT SHEET

REQUEST FOR AN AMBULANCE

- Dial 999.
- Ask for ambulance.
- Be ready with the following information.
- Speak clearly and slowly and be ready to repeat information if asked.

1	Your name	
2	Your telephone number	
3	Give your location (insert school address)	
4	State that the postcode is	
5	Give exact location in the school (insert brief description)	
6	Give name and age of child	
7	Give a brief description of child's symptoms	
8	Inform Ambulance Control of the best entrance and state that the crew will be met and taken to (locality of incident)	

Signature	Date
Job Title	Time

FORM 2
HEALTH CARE PLAN AND EMERGENCY INFORMATION

THIS TEMPLATE FORM SHOULD BE KEPT BY A TELEPHONE

Name of school		Child's Photo
Name of Child		
Group/class/form		
Date of birth		
Child's address		
Medical diagnosis or condition		
Date		
Review date		

FAMILY CONTACT INFORMATION

Name and relationship to child	
Telephone - work	
Telephone - home	
Telephone - mobile	

FURTHER CONTACT INFORMATION

Name and relationship to child	
Telephone - work	
Telephone - home	
Telephone - mobile	

CLINIC/HOSPITAL CONTACT/HEALTH CARE PROFESSIONAL

Name	
Telephone number	

GP

Name	
Telephone number	

Describe medical needs and give details of child's symptoms

List all medications the child is prescribed (listing the dose and time if required at school)

Daily care requirements (e.g. before sport/at lunchtime)

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

Follow up care

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

If required, has a Personal Emergency Evacuation Plan (PEEP) been completed and shared with all staff?

Any other information

In an emergency I give permission for this plan to be passed to medical professionals.

Form copied to	
Parent/s Signature	Date
Headteacher's Signature	Date

ANAPHYLAXIS EMERGENCY INFORMATION

This information should be completed by parents, school and the specialist/school nurse and if necessary a copy sent to the child's GP.

Child's Name		Child's Photo
Class/form		
Date of Birth		
School Year		
Parent/Carer Name(s)		
Home Contact Number		
Mobile Contact Number		
GP/Medical Centre Number		
School Nurse Number		

Known triggers	

Location of medication in school	

Designated school health official	

Instructions for adrenaline auto-injector use (please tick the appropriate statement)
☐ My child does **not** understand the proper use of his/her adrenaline auto-injector and requires help to administer it.
☐ My child understands the proper use of his/her adrenaline auto-injector, and in my opinion, can advise its use at school.

I give permission for school personnel to share this information with all school staff and appropriate trained staff to administer medication. In the case of an emergency, this information may be passed to medical professionals and if necessary, I also give permission for the school to contact our GP/School Nurse.

I assume full responsibility for providing the school with an adequate supply of adrenaline auto-injectors and if necessary I give permission for the school to use the emergency auto-injector if required. I approve this anaphylaxis care plan for my child.

Parent/s Signature	Date
Health Care Practitioner Signature	Date
Headteacher's Signature	Review Date

INFORMATION AND EMERGENCY CARE

WHAT IS AN ANAPHYLACTIC REACTION?

An anaphylactic reaction is a life-threatening allergic reaction which can happen very quickly. It can be set off by various triggers. The most common triggers are certain foods, medicines, and wasp and bee stings. An adrenaline auto-injector is an injection device filled with adrenaline.

THE FIRST SIGNS OF A SEVERE ALLERGIC REACTION:

- swelling in the throat
- change in voice
- difficulty swallowing or breathing
- wheezing
- dizziness feeling faint
- sudden tiredness

If there is doubt about whether the child's Reactions are severe or not, use the auto-injector.

HOW SHOULD AN AUTO-INJECTOR BE USED?

At the first signs of a severe allergic reaction:

- **Call 999, ask for an ambulance and state 'anaphylaxis', even if the child starts to feel better.**
- **Inject outer thigh through child's clothes**
- **Lie the child flat with their legs up to keep their blood flowing.**
- Stay with the child while waiting for the ambulance.
- If the child still feels unwell after the first injection, use your second injector 5 to 15 minutes after the first.

An adrenaline auto-injector is for emergency, on the spot treatment of an anaphylactic reaction. The child should always go to hospital after using the auto-injector.

Two adrenaline auto-injectors should be available in school for the child at all times.

Check the expiry date on the adrenaline auto-injectors and ask parents to ask their doctor or nurse to prescribe new ones before they expire. Out-of-date injectors may not work.

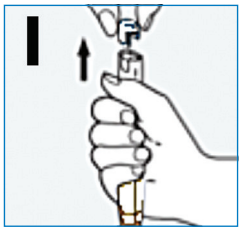
A NOTE ON BRANDS

Make sure that appropriate school staff have been trained to use the brand of auto-injector prescribed because injection technique may vary between brands. Order and practice using a trainer device (available for free from the manufactures' websites). The brand names of adrenaline auto-injectors currently available in the UK are Emerade, EpiPen, and Jext. See manufacturers' websites for further details.

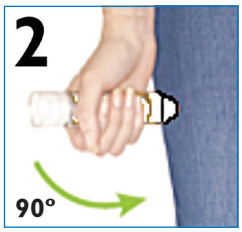
MORE INFORMATION

Anaphylaxis Campaign
www.anaphylaxis.org.uk/schools

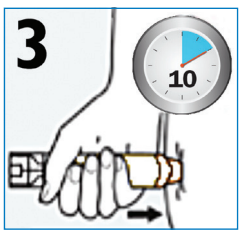
Department of Health, Social Services and public safety
www.dhsspsni.gov.uk.



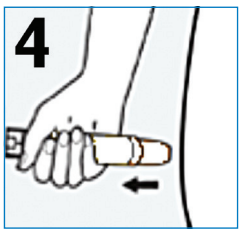
Form fist around auto-injector (dominant hand).
PULL OFF SAFETY CAP



SWING AND PUSH TIP
at a 90° angle against outer thigh (with or without clothing) until a click is heard.



HOLD FIRMLY
in place for 10 seconds.



REMOVE auto-injector. Massage injection site for 10 seconds.

ASTHMA EMERGENCY INFORMATION

This plan should be produced by parents, school and the specialist/school nurse and if necessary a copy sent to the child's GP.

Child's Name		Child's Photo
Class/form		
Date of Birth		
School Year		
Parent/Carer Name(s)		
Home Contact Number		
Mobile Contact Number		
GP/Medical Centre Number		
School Nurse Number		

Known triggers	

Location of medication in school	

Designated school health official	

Instructions for reliever inhaler use (please tick the appropriate statement)
☐ My child does **not** understand the proper use of his/her inhaler and requires help to administer them.
☐ My child understands the proper use of his/her asthma medications and, in my opinion, can carry and use their inhaler at school independently; notifying the designated school health official after using their inhaler..

I give permission for school personnel to share this information with all school staff, follow this plan and administer medication.

If necessary, I also give permission for the school to contact our GP/School Nurse and in the case of an emergency, this plan may be passed to medical professionals.

I assume full responsibility for providing the school with prescribed medication and delivery devices and if necessary I give permission for the school to use the emergency inhaler if required. I approve this Asthma Care Plan for my child.

Parent/s Signature	Date
Health Care Practitioner Signature	Date
Headteacher's Signature	Review Date

SIGNS OF ASTHMA ATTACK

- Persistent cough (when at rest)
- A wheezing sound coming from the chest (when at rest)
- Difficulty breathing (the child could be breathing fast and with effort, using all accessory muscles in the upper body)
- Nasal flaring
- Unable to talk or complete sentences – some children will go very quiet
- May try to tell you that their chest 'feels tight' (younger children may express this as tummy ache)

N.B: Not all symptoms need to be present for a child to be having an asthma attack

CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD

- Appears exhausted
- Has a blue/white tinge around lips
- Is going blue
- Has collapsed

WHAT TO DO IN THE EVENT OF AN ASTHMA ATTACK

- Keep calm and reassure the child
- Encourage the child to sit up and slightly forward
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with the child while the inhaler and spacer are brought to them

IMMEDIATELY HELP THE CHILD TO TAKE TWO SEPARATE PUFFS OF SALBUTAMOL VIA THE SPACER

If there is no immediate improvement, continue to give
TWO PUFFS AT A TIME EVERY TWO MINUTES, UP TO A MAXIMUM OF 10 PUFFS

IMPROVEMENT
Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better.
Document medication given. Dose may be repeated if symptoms return. However, if this is within four hours, contact parent(s) as medical review is recommended.

NO IMPROVEMENT
If the child does not feel better or you are worried at **ANYTIME** before you have reached 10 puffs,
CALL 999 FOR AN AMBULANCE

If an ambulance does not arrive in 10 minutes
GIVE ANOTHER 10 PUFFS IN THE SAME WAY

The information in this flowchart is taken from the Department of Health – *Guidance on the use of emergency salbutamol inhalers in schools* (March 2015)

www.gov.uk/government/publications/emergency-asthma-inhalers-for-use-in-schools

DIABETIC EMERGENCY INFORMATION

This plan should be produced by parents, school and the specialist/school nurse and if necessary a copy sent to the child's GP.

Child's Name		Child's Photo
Class/form		
Date of Birth		
School Year		
Parent/Carer Name(s)		
Home Contact Number		
Mobile Contact Number		
GP/Medical Centre Number		
School Nurse Number		

Known triggers	

Location of medication in school	

Designated school health official	

Regime

☐ **Insulin Regime**

. . . . . is on a multi-dose insulin regime of 4 or more injections a day.

They will have an injection of insulin at breakfast, lunch, evening meal and another before bed.

A toilet is not considered a suitable place to carry out this clean procedure. Some children / young people will require supervision for this lunchtime injection.

☐ **Pump Regime**

. . . . . is given insulin via a pump device. The pump delivers a small amount of background insulin constantly throughout the day (basal).

Insulin is also administered each time carbohydrate food is consumed (bolus). This is carried out by manually instructing the pump.

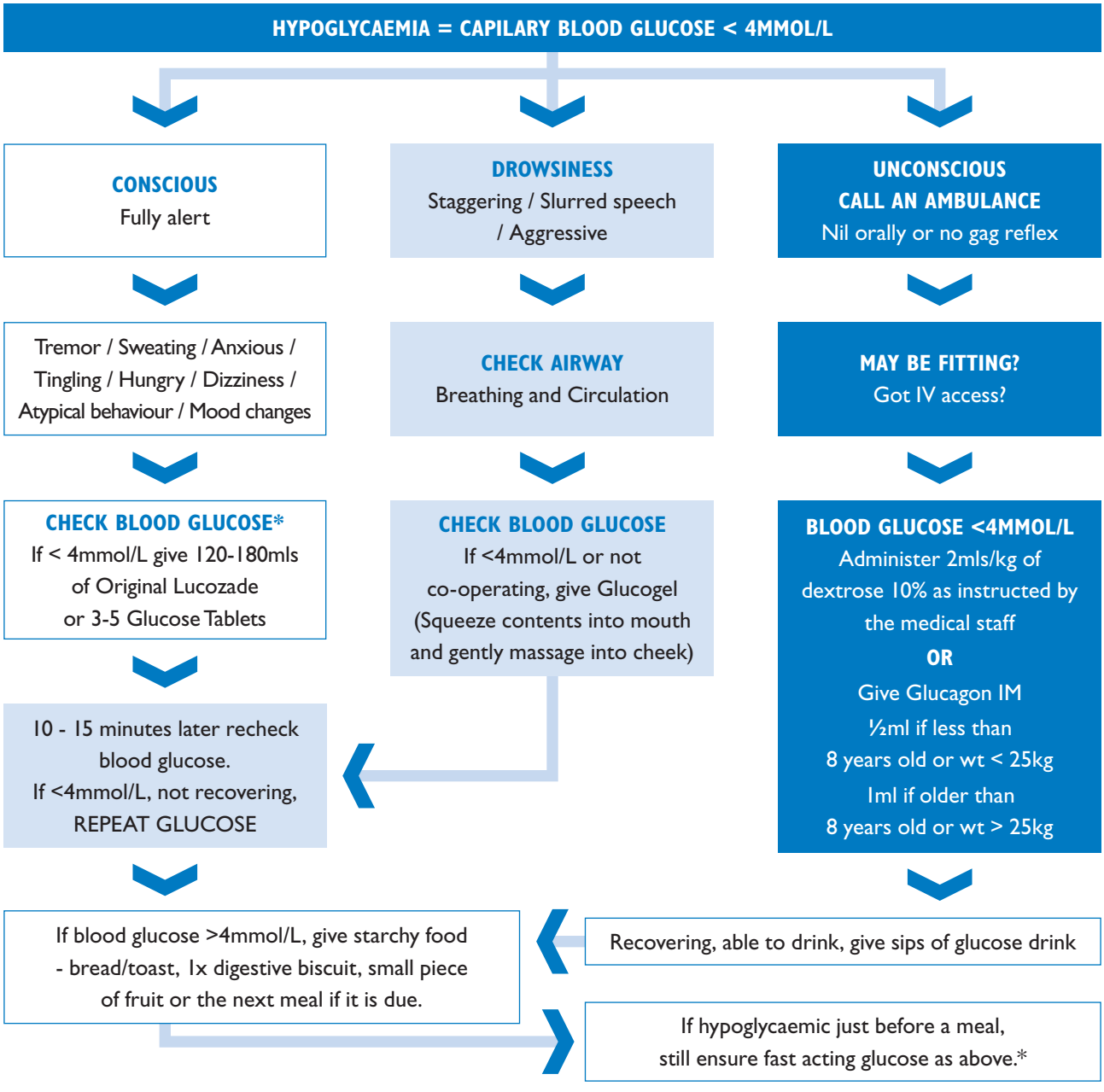
An insulin bolus may also be required to correct blood glucose levels as recorded in pupils individual Health Care Plan.

I give permission for school personnel to share this information with all school staff, follow this plan and administer medication. If necessary, I also give permission for the school to contact our GP or specialist/school nurse and in the case of an emergency, this plan may be passed to medical professionals.

I approve this diabetes emergency treatment plan for my child. I assume full responsibility for providing the school with all supplies of prescribed medications, including delivery devices and hypoglycaemia treatment. I will keep the school informed of any changes to the health care plan as directed.

Parent/s Signature	Date
Health Care Practitioner Signature	Date
Headteacher's Signature	Review Date

MANAGEMENT OF HYPOGLYCAEMIA IN CHILDREN WITH DIABETES



EPILEPSY EMERGENCY INFORMATION

This plan should be produced by parents, school and the specialist/school nurse and if necessary a copy sent to the child's GP.

Child's Name		Child's Photo
Class/form		
Date of Birth		
School Year		
Parent/Carer Name(s)		
Home Contact Number		
Mobile Contact Number		
GP/Medical Centre Number		
School Nurse Number		

Known triggers	

Location of medication in school	

Designated school health official	

I give permission for school personnel to share this information with all school staff, follow this plan and administer medication.

If necessary, I also give permission for the school to contact our GP specialist/school Nurse and in the case of an emergency, this plan may be passed to medical professionals.

I assume full responsibility for providing the school with an adequate supply of the prescribed medication with the pharmacist instructions and required delivery devices. I approve this Epilepsy Care Plan for my child.

Parent/s Signature	Date
Health Care Practitioner Signature	Date
Headteacher's Signature	Review Date

Seizure/s experienced	
Symptoms	
Usual procedure following seizure	
Prescribed anti-epileptic medication	
Where medication is stored	
Staff member responsible for medication replenishment	
Staff trained to give medication	i)
	ii)
	iii)
Member of staff responsible for Home/School liaison	

An ambulance should be called for the following reasons:

- First seizure
- Serious injury occurred
- Poor breathing
- Seizure lasting longer than usual for that pupil / lasting over 5 minutes but not recovering.

Emergency procedure if seizure lasts for more than . . . . . minutes.

Turn the child on their side in the recovery position checking airway is clear.

1. Member of staff to stay with the pupil to ensure safety.
2. Quietly clear the classroom/area of students if staff think this is necessary.
3. If stated on the emergency information (overleaf) the named trained member of staff will give rectal diazepam/ buccal midazolam with witness of same sex present (if possible).
4. If needed, telephone 999, ask for Ambulance Service, give name of student, address and phone number of school.
5. Telephone parents.
6. Inform Headteacher
7. Stay with the pupil until ambulance arrives.
8. If parents have not arrived by this time a member of staff will accompany the pupil to the hospital in the ambulance.
9. Fill in seizure record form for the student file and send copy to parents/GP.

Service	Name	Contact Details
Emergency contact		
Epilepsy Consultant/specialist		
Family GP		
Epilepsy/paediatric/ community support nurse		
Other		

PARENTAL CONSENT

I give consent for . . . . . to be given rectal diazepam or Buccal Midazolam by trained staff in the circumstances described in this document. I will undertake to inform the school of any changes in the nature of his/her seizures or medication.

Signed	Date
Please Print Name	Review Date

FORM 3
PARENTAL AGREEMENT FOR SCHOOL TO ADMINISTER MEDICINE

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

Name of Child	
Group/class/form	
Date of birth	
Medical diagnosis or condition	

MEDICATION INFORMATION

Names and types of medications (as described on the container)

Name of medication			
Type			
Dosage			
Any other instructions			
Expiry date of medication			

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

Agreed review date to be initiated by (name of member of staff)	
Special precautions	
Are there any side effects that the school needs to know about?	
Self-administration (Asthma only)	☐ Yes ☐ No
Procedures to take in an emergency	
Name and telephone number of GP	

CONTACT DETAILS

Contact name	
Daytime telephone/mobile	
Relationship to child	
Address	
Any other information?	

I give consent for school staff to administer the above mentioned prescribed medication(s) to my child. I understand that I must deliver the medicine(s) personally to . . . . . (agreed member of staff).

I accept that this is a service that the school is not obliged to undertake.

I understand that I must notify the school in writing of any changes in my child's condition/medication.

Parent/guardian signature	Date

FORM 4
HEADTEACHER AGREEMENT TO ADMINISTER PRESCRIBED MEDICINE

EXAMPLE LETTER

[Name of school/setting]

It is agreed that ***[name of child]*** will receive ***[quantity and name of medicine]*** every day at ***[time medicine to be administered e.g. lunchtime or afternoon break]***.

[Name of child] will be given/supervised whilst he/she takes their medication by ***[name of member of staff]***.

This arrangement will continue until the end date of course of medicine/until instructed by parents/guardians.

[Date]

[Signature Headteacher/named member of staff]

FORM 5
RECORD OF LONG TERM PRESCRIBED MEDICINE ADMINISTERED TO AN INDIVIDUAL CHILD

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

Quantity and date returned (School's use only)	

. . . . . will be given/supervised whilst he/she takes their medication by . . . . . and/or . . . . . (names of two members of staff).

This arrangement will continue until the end date of course of medicine/until instructed by parents/guardians.

Parent/guardian signature	Date	
Relationship to child		
Staff signatures	Date	Date
Role		

	Week commencing:									
	Monday		Tuesday		Wednesday		Thursday		Friday	
Time given										
Dose given										
Two staff initials										

	Week commencing:									
	Monday		Tuesday		Wednesday		Thursday		Friday	
Time given										
Dose given										
Two staff initials										

	Week commencing:									
	Monday		Tuesday		Wednesday		Thursday		Friday	
Time given										
Dose given										
Two staff initials										

	Week commencing:									
	Monday		Tuesday		Wednesday		Thursday		Friday	
Time given										
Dose given										
Two staff initials										

	Week commencing:									
	Monday		Tuesday		Wednesday		Thursday		Friday	
Time given										
Dose given										
Two staff initials										

FORM 6
RECORD OF SHORT TERM MEDICINES ADMINISTERED TO ALL CHILDREN

This form may also be used to record the administration of emergency adrenaline auto-injectors.

Name of school/setting

Date	Child's name	Time	Name of medicine	Dose given	Any reactions	Initials of staff	Print name	Date / Time / How were parents Informed?

FORM 7
PARENTAL CONSENT FOR CHILD TO CARRY HIS/HER OWN PRESCRIBED MEDICINE
(OPTIONAL FOR SECONDARY SCHOOL USE)

THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN

If staff has concerns, they should discuss this request with healthcare professionals

Name of school/setting	
Name of child	
Group/class/form	
Address	
Name and strength of medicine	

Procedures to be taken in an emergency

CONTACT INFORMATION

Name	
Daytime phone no.	
Relationship to child	

I would like my son/daughter to keep his/her prescribed medicine on him/her for use as necessary.

Parent/guardian signature	Date
Relationship to child	

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

FORM 8
ADMINISTRATION OF PRESCRIBED MEDICINES
STAFF TRAINING RECORD

Name of school/setting	
Name of staff member	
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/reviewed . . . . . (please state how often).

Trainer's signature	Date

I confirm that I have received the training detailed above.

Staff signature	Date

ADMINISTRATION OF MEDICINES POLICY

EXEMPLAR

The purpose of this policy is to put into place effective management systems and arrangements to support children and young people with medical needs in the school and to provide clear guidance for staff and parents/guardians on the administration of medicines. This document, where appropriate, must be considered in conjunction with all other relevant policies, for example, health and safety.

All staff in schools and early year's settings have a duty to maintain professional standards of care and to ensure that children and young people are safe. It is expected good practice that schools and settings will review cases individually and administer medicines in order to meet the all-round needs of the child. However, there is no legal duty requiring staff to administer medication or to supervise a child when taking medicines. This is a voluntary role.

ROLES AND RESPONSIBILITIES

Under the Disability Discrimination Act (DDA) 1995, schools and settings should be making reasonable adjustments for disabled children, including those with medical needs, and are under a duty to plan strategically to increase access over time. Schools and settings should consider what reasonable adjustments they need to make to enable children with medical needs to participate fully in all areas of school life, including educational visits and sporting activities.

The Headteacher/Manager, in consultation with the Governing body, staff, parents/guardians, health professionals and the local authority, is responsible for deciding whether the school or setting can assist a child with medical needs. The Headteacher/Manager is responsible for:

- implementing the policy on a daily basis
- ensuring that the procedures are understood and implemented
- ensuring appropriate training is provided
- making sure there is effective communication with parents/guardians, children and young people, school/settings staff and all relevant health professionals concerning the pupil's health needs.

It is good practice that staff, including supply staff should always be informed of a child's medical needs where this is relevant and of any changes to their needs as and when they might arise. All staff will be informed of the designated person with responsibility for medical care. A list of medical needs must be clearly known and accessible in order to support the child's day to day care.

PARENTS/GUARDIANS

It is the responsibility of parents/guardians to:

a) inform the school of their child's medical needs
b) provide any medication to the (schools designated area) in a container clearly labelled with the following:

   - THE CHILD'S NAME
   - NAME OF MEDICINE
   - DOSE AND FREQUENCY OF MEDICATION
   - SPECIAL STORAGE ARRANGEMENTS

c) collect and dispose of any medicines held in school at the end of each term
d) ensure that medicines have not passed the expiry date

PUPIL INFORMATION

Parents/guardians should be required to give the following information about their child's long term medical needs and to update it at the start of each school year or update school when changes arise:

- Details of pupil's medical needs
- Medication, including any side effects
- Allergies
- Name of GP/consultants
- Special requirements e.g. dietary needs, pre-activity precautions. Parents/guardians may be required to provide evidence in this case.
- What to do and who to contact in an emergency
- Cultural and religious views regarding medical care

ADMINISTERING MEDICATION

Staff are not legally required to administer medicines or to supervise a child when taking medicine. Any employee may volunteer to undertake this task but it is not a contractual requirement and appropriate training should be given before an individual takes on a role which may require administering first aid or medication.

All schools should ensure that they have sufficient members of support staff who are appropriately trained to manage medicines as part of their duties. Within their Health and Safety Policy it should incorporate managing the administration of medicines and supporting children with complex health needs. For staff following documented procedures, they will be fully covered by their local authority's insurance cover should a parent/guardian complain. Staff should also be aware when a child may need extra attention due to changes to their medical requirements as agreed with parents/guardians and their care plan altered as necessary. In the likelihood of an emergency arising, all staff should be aware of what action to take and back up cover should be arranged if the staff member normally responsible for the child's care is absent. See page 2.11 'Insurance Services for Schools'.

It is expected that parents/guardians will normally administer medication to their children at home. No medication will be administered without prior written permission from the parents/guardians. A 'Parental agreement for school to administer prescribed medicine' form must be completed. These staff are:(named staff or their roles to be entered here).

Over the counter/un-prescribed medication will only be administered by school staff in exceptional circumstances. This may be discussed with a senior member of staff who may need clarification from your family G.P.

The Headteacher/Manager will decide whether any medication will be administered in school/early years setting and following consultation with staff, who will be responsible. All medicine will normally be administered during breaks and lunchtime. If, for medical reasons, medicine has to be taken at other times during the day, arrangements will be made for the medicine to be administered at other prescribed times. Where appropriate, pupils will be told where their medication is kept.

Any member of staff, on each occasion, giving medicine to a pupil should check:

a) Name of pupil
b) Written instructions provided by the parents/guardians or doctor
c) Prescribed dose
d) Expiry date

Written permission from the parents/guardians will be required for pupils to self-administer medicine(s). A Parental Consent for child to carry and administer his/her own medicine Form must be completed (optional for secondary use).

Form 7: Parental Consent for child to carry his/her own prescribed medicine (optional for secondary school use) – See page 8.12.

STORAGE

Where appropriate all medicine will be safely stored appropriate to the access to the child. All medicine will be logged on the school's medical file. Class teachers in Foundation Stage and KS1 will store children's' inhalers, which must be labelled with the pupil's name. Pupils in KS2 and above may keep their inhalers ..... (to be agreed by school).

RECORDS

Staff will complete and sign a Record of medicine administered to an individual child each time medication is given to a child and these will be kept in the administration office. The sheets will record the following:

a) Name of pupil
b) Date and time of administration
c) Who supervised the administration
d) Name of medication
e) Dosage
f) A note of any side effects

Form 5: Record of long term prescribed medicine administered to an individual child –See page 8.10.

Form 6: Record of short term prescribed medicines administered to all children – See page 8.11.

REFUSING MEDICATION

If a child refuses to take their medication, staff will not force them to do so. Parents/guardians will be informed as soon as possible. Refusal to take medication will be recorded and dated on the child's record sheet. Reasons for refusal to take medications must also be recorded as well as the action then taken by the teacher.

TRAINING

Training may be required as part of a pupils individual care plan specific to the pupils requirements. This will be provided on a range of medical needs, including any resultant learning needs, as and when appropriate.

The Headteacher/Manager will ensure there are trained and named individuals to undertake first aid responsibilities, ensuring training is regularly monitored* and updated. Advice on the treatment of Asthma will be available from either the school nurse or the school first aiders who will also brief all staff with any updates/ changes on a yearly basis.

Form 8: Administration of prescribed medicines – See page 8.13.

HEALTH CARE PLAN

Where appropriate, a personal Health Care Plan will be drawn up in consultation with the school/setting, parents/guardians/carers and health professionals. The Health Care Plan will outline the child's needs and the level of support required in school. Health Care Plans will be reviewed annually.

The Headteacher/Manager will ensure that all staff are aware of the school's planned emergency procedures in the event of medical needs.

Form 2: Health Care Plan – See page 8.3.

INTIMATE OR INVASIVE TREATMENT

This will only take place at the discretion of the Headteacher/Manager and Governors, with written permission from the parents/guardians and only under exceptional circumstances. Two adults, where possible, one of the same gender as the child, must be present for the administration of such treatment. Cases will be agreed and reviewed on an individual basis. Training will be given to members of staff involved where necessary and all such treatment will be recorded.

SCHOOL TRIPS

To ensure that as far as possible, all children have access to all activities and areas of school life, a thorough risk assessment will be undertaken to ensure the safety of all children and staff. No decision about a child with medical needs attending/not attending a school trip will be taken without prior consultation with the parents/guardians.

Residential trips and visits off site:

a) Sufficient essential medicines and appropriate Health Care Plans will be taken and controlled by the member of staff supervising the trip;
b) If it is felt that additional supervision is required during activities e.g. swimming, school/setting may request the assistance of the parent/guardian/carer.

POLICY STATEMENT

This school is an inclusive community that welcomes and supports pupils with medical conditions.
This school provides all pupils with any medical condition the same opportunities as others at school.
We will help to ensure they can:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic wellbeing once they leave school.

The school makes sure all staff understand their duty of care to children and young people in the event of an emergency.

All staff feel confident in knowing what to do in an emergency.

This school understands that certain medical conditions are debilitating and potentially life threatening, particularly if poorly managed or misunderstood.

This school understands the importance of medication and care being taken as directed by healthcare professionals and parents.

All staff understand the medical conditions that affect pupils at this school. Staff receive training on the impact medical conditions can have on pupils.
The named member of school staff responsible for this medical conditions policy and its implementation is:
.....

POLICY FRAMEWORK

The policy framework describes the essential criteria for how the school can meet the needs of children and young people with long-term medical conditions.

1. **This school is an inclusive community that supports and welcomes pupils with medical conditions.**

This school is welcoming and supportive of pupils with medical conditions. It provides children with medical conditions with the same opportunities and access to activities (both school based and out-of-school) as other pupils. No child will be denied admission or prevented from taking up a place in this school because arrangements for their medical condition have not been made.

This school will listen to the views of pupils and parents.

Pupils and parents feel confident in the care they receive from this school and the level of that care meets their needs.

Staff understand the medical conditions of pupils at this school and that they may be serious, adversely affect a child's quality of life and impact on their ability to learn.

All staff understand their duty of care to children and young people and know what to do in the event of an emergency.

The whole school and local health community understand and support the medical conditions policy.

This school understands that all children with the same medical condition will not have the same needs.

The school recognises that duties in the Children and Families Act (England only), the Equality Act (England, Wales and Scotland) and the Disability Discrimination Act (Northern Ireland only) relate to children with disability or medical conditions and are anticipatory.

2. **This school's medical conditions policy is drawn up in consultation with a wide range of local key stakeholders within both the school and health settings.**

   Stakeholders should include pupils, parents, school nurse, school staff, governors, the school employer, relevant local health services and relevant supporter organisations.

3. **The medical conditions policy is supported by a clear communication plan for staff, parents* and other key stakeholders to ensure its full implementation.**

   Pupils, parents, relevant local healthcare staff, and other external stakeholders are informed of and reminded about the medical conditions policy through clear communication channels.

4. **All children with a medical condition should have an individual healthcare plan (IHP).**

   An IHP details exactly what care a child needs in school, when they need it and who is going to give it.

   It should also include information on the impact any health condition may have on a child's learning, behaviour or classroom performance.

   This should be drawn up with input from the child (if appropriate) their parent/carer, relevant school staff and healthcare professionals, ideally a specialist if the child has one.

5. **All staff understand and are trained in what to do in an emergency for children with medical conditions at this school.**

   All school staff, including temporary or supply staff, are aware of the medical conditions at this school and understand their duty of care to pupils in an emergency.

   All staff receive training in what to do in an emergency and this is refreshed at least once a year.

   A child's IHP should, explain what help they need in an emergency. The IHP will accompany a pupil should they need to attend hospital. Parental permission will be sought and recorded in the IHP for sharing the IHP within emergency care settings.

6. **All staff understand and are trained in the school's general emergency procedures.**

   All staff, including temporary or supply staff, know what action to take in an emergency and receive updates at least yearly.

If a pupil needs to attend hospital, a member of staff (preferably known to the pupil) will stay with them until a parent arrives, or accompany a child taken to hospital by ambulance. They will not take pupils to hospital in their own car.

7. **This school has clear guidance on providing care and support and administering medication at school.**

   This school understands the importance of medication being taken and care received as detailed in the pupil's IHP.

   This school will make sure that there are more than one members of staff who have been trained to administer the medication and meet the care needs of an individual child. This includes escort staff for home to school transport if necessary. This school will ensure that there are sufficient numbers of staff trained to cover any absences, staff turnover and other contingencies. This school's governing body has made sure that there is the appropriate level of insurance and liability cover in place.

   This school will not give medication (prescription or non-prescription) to a child under 16 without a parent's written consent except in exceptional circumstances, and every effort will be made to encourage the pupil to involve their parent, while respecting their confidentiality.

   When administering medication, for example pain relief, this school will check the maximum dosage and when the previous dose was given. Parents will be informed. This school will not give a pupil under 16 aspirin unless prescribed by a doctor.

   This school will make sure that a trained member of staff is available to accompany a pupil with a medical condition on an off-site visit, including overnight stays.

   Parents at this school understand that they should let the school know immediately if their child's needs change.

   If a pupil misuses their medication, or anyone else's, their parent is informed as soon as possible and the school's disciplinary procedures are followed.

8. **This school has clear guidance on the storage of medication and equipment at school.**

   This school makes sure that all staff understand what constitutes an emergency for an individual child and makes sure that emergency medication/ equipment is readily available wherever the child is in the school and on off-site activities, and is not locked away. Pupils may carry their emergency medication with them if they wish/this is appropriate.

   Pupils may carry their own medication/equipment, or they should know exactly where to access it.

   Pupils can carry controlled drugs if they are competent, otherwise this school will keep controlled drugs stored securely, but accessibly, with only named staff having access. Staff at this school can administer a controlled drug to a pupil once they have had specialist training.

   This school will make sure that all medication is stored safely, and that pupils with medical conditions know where they are at all times and have access to them immediately.

   This school will store medication that is in date and labelled in its original container where possible, in accordance with its instructions. The exception to this is insulin, which though must still be in date, will generally be supplied in an insulin injector pen or a pump.

   Parents are asked to collect all medications/ equipment at the end of the school term, and to provide new and in-date medication at the start of each term.

   This school disposes of needles and other sharps in line with local policies. Sharps boxes are kept securely at school and will accompany a child on off-site visits. They are collected and disposed of in line with local authority procedures.

9. **This school has clear guidance about record keeping.**

   Parents at this school are asked if their child has any medical conditions on the enrolment form.

This school uses an IHP to record the support an individual pupil needs around their medical condition. The IHP is developed with the pupil (where appropriate), parent, school staff, specialist nurse (where appropriate) and relevant healthcare services.

This school has a centralised register of IHPs, and an identified member of staff has the responsibility for this register.

IHPs are regularly reviewed, at least every year or whenever the pupil's needs change.

The pupil (where appropriate) parents, specialist nurse (where appropriate) and relevant healthcare services hold a copy of the IHP. Other school staff are made aware of and have access to the IHP for the pupils in their care.

This school makes sure that the pupil's confidentiality is protected.

This school seeks permission from parents before sharing any medical information with any other party.

This school meets with the pupil (where appropriate), parent, specialist nurse (where appropriate) and relevant healthcare services prior to any overnight or extended day visit to discuss and make a plan for any extra care requirements that may be needed. This is recorded in the pupil's IHP which accompanies them on the visit.

This school keeps an accurate record of all medication administered, including the dose, time, date and supervising staff.

This school makes sure that all staff providing support to a pupil and other relevant teams have received suitable training and ongoing support, to make sure that they have confidence to provide the necessary support and that they fulfil the requirements set out in the pupil's IHP. This should be provided by the specialist nurse/school nurse/ other suitably qualified healthcare professional and/ or the parent. The specialist nurse/school nurse/ other suitably qualified healthcare professional will confirm their competence, and this school keeps an up-to-date record of all training undertaken and by whom.

10. **This school ensures that the whole school environment is inclusive and favourable to pupils with medical conditions. This includes the physical environment, as well as social, sporting and educational activities.**

    This school is committed to providing a physical environment accessible to pupils with medical conditions and pupils are consulted to ensure this accessibility. This school is also committed to an accessible physical environment for out-of-school activities.

    This school makes sure the needs of pupils with medical conditions are adequately considered to ensure their involvement in structured and unstructured activities, extended school activities and residential visits.

    All staff are aware of the potential social problems that pupils with medical conditions may experience and use this knowledge, alongside the school's bullying policy, to help prevent and deal with any problems. They use opportunities such as PSHE and science lessons to raise awareness of medical conditions to help promote a positive environment.

    This school understands the importance of all pupils taking part in physical activity and that all relevant staff make appropriate adjustments to physical activity sessions to make sure they are accessible to all pupils. This includes out-of-school clubs and team sports.

    This school understands that all relevant staff are aware that pupils should not be forced to take part in activities if they are unwell. They should also be aware of pupils who have been advised to avoid/ take special precautions during activity, and the potential triggers for a pupil's medical condition when exercising and how to minimise these.

    This school makes sure that pupils have the appropriate medication/equipment/food with them during physical activity.

    This school makes sure that pupils with medical conditions can participate fully in all aspects of the curriculum and enjoy the same opportunities at school as any other child, and that appropriate adjustments and extra support are provided.

All school staff understand that frequent absences, or symptoms, such as limited concentration and frequent tiredness, may be due to a pupil's medical condition. This school will not penalise pupils for their attendance if their absences relate to their medical condition.

This school will refer pupils with medical conditions who are finding it difficult to keep up educationally to the SENCO/ALNCO/Special Educational Needs Advisor who will liaise with the pupil (where appropriate), parent and the pupil's healthcare professional.

Pupils at this school learn what to do in an emergency.

This school makes sure that a risk assessment is carried out before any out-of-school visit, including work experience and educational placements. The needs of pupils with medical conditions are considered during this process and plans are put in place for any additional medication, equipment or support that may be required.

11. **This school is aware of the common triggers that can make common medical conditions worse or can bring on an emergency. The school is actively working towards reducing or eliminating these health and safety risks and has a written schedule of reducing specific triggers to support this.**

    This school is committed to identifying and reducing triggers both at school and on out-of-school visits.

    School staff have been given training and written information on medical conditions which includes avoiding/reducing exposure to common triggers. It has a list of the triggers for pupils with medical conditions at this school, has a trigger reduction schedule and is actively working towards reducing/eliminating these health and safety risks.

    The IHP details an individual pupil's triggers and details how to make sure the pupil remains safe throughout the whole school day and on out-of-school activities. Risk assessments are carried out on all out-of-school activities, taking into account the needs of pupils with medical needs.

    This school reviews all medical emergencies and incidents to see how they could have been avoided, and changes school policy according to these reviews.

12. **Where a child is returning to school following a period of hospital education or alternative provision (including home tuition), this school will work with the local authority and education provider to ensure that the child receives the support they need to reintegrate effectively.**

    This school works in partnership with all relevant parties including the pupil (where appropriate), parent, school's governing body, all school staff, catering staff, employers and healthcare professionals to ensure that the policy is planned, implemented and maintained successfully.

13. **Each member of the school and health community knows their roles and responsibilities in maintaining and implementing an effective medical conditions policy.**

    This school works in partnership with all relevant parties including the pupil (where appropriate), parent, school's governing body, all school staff, catering staff, employers and healthcare professionals to ensure that the policy is planned, implemented and maintained successfully.

    This school is committed to keeping in touch with a child when they are unable to attend school because of their condition.

14. **The medical conditions policy is regularly reviewed, evaluated and updated. Updates are produced every year.**

    In evaluating the policy, this school seeks feedback from key stakeholders including pupils, parents, school healthcare professionals, specialist nurses and other relevant healthcare professionals, school staff, local emergency care services, governors and the school employer. The views of pupils with medical conditions are central to the evaluation process.

* The term 'parent' implies any person or body with parental responsibility such as a foster parent, carer, guardian or local authority.

This information is based on *Medical Conditions at School* – A Policy Resource Pack from The health conditions in schools alliance

www.medicalconditionsatschool.org.uk

INTIMATE CARE POLICY GUIDANCE

GUIDANCE FOR SAFER WORKING PRACTICE

FOR THOSE WORKING WITH CHILDREN AND YOUNG PEOPLE IN EDUCATIONAL SETTINGS (2015) RECRUITMENT CONSORTIUM – SCHOOL CODE OF CONDUCT

INTIMATE / PERSONAL CARE

General Principals

1. Each schools or setting must have clear nappy or pad changing and intimate / personal care / administration of medicines or medical procedures etc. policies, which ensure that the health, safety, independence and welfare of children is promoted and their dignity and privacy are respected.

2. A written Care Plan must be in place for any pupil requiring intimate care.

3. The views of parents, carers and the pupil, regardless of their age and understanding, should be actively sought in formulating the plan and in the necessary regular reviews of these arrangements.

4. At the same time the plan should take account of the protection of staff from unfounded allegations of inappropriate conduct.

5. Staff must be given appropriate training and equipment e.g. protective gloves etc. to enable them to comply with standard precautions in relation to infection control.

6. Arrangements for intimate and personal care should be open and transparent and accompanied by recording systems. Which are regularly reviewed by senior staff

7. Pupils should be encouraged to act as independently as possible and to undertake as much of their own personal care as is possible and practicable.

8. If assistance is required, this should normally be undertaken by one member of staff. However, they must ensure that another appropriate adult is in the vicinity who is aware of the task being undertaken. In some circumstances a care plan may specify that a second member of staff is required.

9. In some circumstances if there is a concern about possible complaints or allegations by the child or parent / carers then the use of a second adult or other arrangements must be considered.

10. Only supply staff engaged and appropriately trained specifically to support a child needing intimate care should be used.

11. Staff must be responsive to the child's reactions to intimate care. If a child expresses concern or distress about the carrying out of intimate care by a particular member of staff this will be discussed with the child, parent / carers and the member of staff and any changes to the Care Plan decided upon.

12. A signed record should be kept of all intimate and personal care tasks undertaken and, where these have been carried out in another room, should include times left and returned. An administration of medicines etc. must be recorded as required by the Care Plan.

13. Any vulnerability, including those that may arise from a physical or learning difficulty should be considered when formulating the individual pupil's care plan.

14. Pupils are entitled to respect and privacy at all times and especially when in a state of undress, including, for example, when changing, toileting and showering. However, there needs to be an appropriate level of supervision in order to safeguard pupils and satisfy health and safety considerations. This supervision should be appropriate to the needs and age of the young people concerned and sensitive to the potential for embarrassment.

15. Child Protection procedures must be followed if during intimate care staff are concerned about for example, marks, bruises soreness or other indicators of possible abuse and the DSL notified immediately.

16. If an adult has concerns about the conduct of a colleague when carrying out intimate care or a child or parent / carer makes an allegation about a member of staff the Headteacher or senior manager must be informed immediately and allegation procedures followed.

17. Senior managers

MUST ensure that staff are aware that they must:

- Adhere to their organisation's intimate care policy.
- Make other staff aware of the task being undertaken.
- Always explain to the pupil what is happening before a care procedure begins.
- Consult with colleagues where any variation from agreed procedure/care plan is necessary.
- Record each occasion IC etc. is carried out including the name of the colleague made aware.
- Ensure that the justification for any variations to the agreed procedure/care plan is shared with the pupil and their parents/carers.
- Always consider the supervision needs of the pupils and only remain in the room where their needs require this.
- Follow Child protection or allegation procedures if they have concerns raised by the operation of the Care Plan.
- **NOT** assist with intimate or personal care tasks which the pupil is able to undertake independently.

INTIMATE CARE POLICY

EXEMPLAR

Date policy formally agreed by Governors:	
Signature of Chair of Governors:	
Date policy becomes effective:	
Review dates:	
Person responsible for implementation and monitoring:	

DEFINITIONS OF INTIMATE CARE

Intimate care may mean different things to different people but it usually used to describe any, or all, of the following activities;

- Washing any part of the body
- Dressing/Undressing
- Changing Nappies
- Assisting to use the toilet
- Medical intervention

PROMOTING PERSONAL DEVELOPMENT – CONTINENCE

Achieving continence is one of the many developmental milestones usually reached within the context of learning before a child transfers to school. However we acknowledge that there may be children with longer term continence issues for whom an individual Health Care Plan (HCP) may need to be put in place.

In addition there may be children joining us in school who are at various points of developing their independence in toileting may well need short term support in this important area of self care.

No child will be refused a place in school in relation to continence issues and in house documentation for parents will openly acknowledge this.

Keldmarsh Primary School is committed to working with children, parents and any support agencies deemed necessary to ensure appropriate provision is made for all children with needs in this specific area of personal development and in so doing fulfil a commitment to the promotion of our inclusive school ethos.

We accept our responsibility to meet the needs of children with delayed personal development in the same way we aim to meet medical needs of children with any developmental, physical, social or academic adaptation. We aim to make reasonable adjustments to meet the needs of each child.

CHILD PROTECTION

Treat every child as an individual

We recognise that it is important to not make assumptions and that every individual family will have their own way of doing things, their own names for body parts etc. Cultural, ethnic and religious differences may affect what is or is not appropriate. We ask the child and/or parents and respect their wishes.

Involve the child as far as possible in their own intimate/medical care

Promoting independence and allowing a child to manage their own self-care when able will be promoted. We support the child in doing all they can for themselves. If a child is fully dependent on the staff member, we ensure that they talk with them about what they are doing and give them choices wherever possible.

We will be responsive to a child's reactions and make sure that intimate care is as consistent as possible

We will ensure that we take opportunities to talk with parents and learn from them how they undertake intimate care tasks but we will, wherever possible, discuss our actions with the child e.g. 'Is it okay to do it this way?', 'Can you wash there?', 'How does mummy/daddy do this?' and 'Does that feel comfortable?'.

Supply staff are not permitted to carry out personal care for a child, unless that supply staff member has worked sufficient hours in the building to have built up

a relationship with the child and this will be decided by the Headteacher.

Given the above proviso, we have no anticipation that meeting the child's medical or continence needs should raise any issues of child protection as all staff have been DBS checked. Therefore it will be normal practice for only one adult to be involved in attending to a child's personal needs. Staff should ensure that another appropriate adult is informed of the task to be undertaken.

Students on a work placement will not be involved in supporting children in this area of care.

At all times staff will be encouraged to remain highly vigilant for any signs or symptom of improper practice, as they do for all activities within school.

If any marks or injuries are noticed on a child during changing this should be immediately referred to the Designated Safeguarding Lead to follow up in line with safeguarding procedures.

A discussion will take with parents regarding the arrangements and those staff who are likely to be involved in the changing routine.

HEALTH AND SAFETY

In school, the medical room is the designated space for attending to a child's personal and/or medical needs. There are shower facilities next to the medical room in school for older children or in extreme circumstances for Foundation Stage children.

The appropriate resources provided in the medical room which will be maintained by the admin staff:

1. Non-latex disposable gloves and aprons
2. Changing Mat
3. Wet wipes
4. Where necessary spare nappies and/or pull up
5. Nappy sacks
6. Spare underwear
7. Plastic bags for wet/soiled clothing
8. Antibacterial cleanser
9. Air Freshener
10. First aid kit and medical supplies

If a child requires a medical procedure, accidentally wets or soils him/herself or requires intimate wider care they will be attended to in either of the designated areas referred to above. Spare resources can be found in the medical room but it is anticipated that you will check that you have everything to hand before you start any process to avoid having to leave the child in a state of undress.

Staff involved in any intimate care procedure will be expected to wear non-latex disposable gloves. Aprons provided will be considered appropriate for staff involved in any medical / intimate care if needed.

Wet or soiled nappies will be double wrapped and disposed of via the normal domestic waste route.

Changes of clothes should routinely be provided by parents if changes can be anticipated. Wet or soiled underwear/clothing will be returned to parents. Temporary storage of these will be in a tied bag (wet or lightly soiled) on the child's peg or brought to the medical room for storage (heavy soiling) if required prior to the child being collected at the end of the session.

The changing area will be cleaned and disinfected after use by the member of staff attending the child.

Hot water and liquid soap will be available to wash hands as soon as the task is complete. Paper towels will be available for drying hands.

AGREEING A PROCEDURE FOR PERSONAL CARE

Parents will be kept fully informed of the procedures the school will follow should their child need changing during school time or need medical intervention. A copy of the school policy will be made available on request.

Guidelines for staff involved in the process as detailed below will be visibly displayed in both designated changing areas. This will ensure they follow the correct procedure.

- Disposable non-latex gloves should be worn when conducting medical procedures or changing nappies.
- If at all possible, children should be changed standing up.
- Be familiar with any special names the child uses for body parts
- The child's skin should be cleaned with a disposable wipe. (Flannels should not be used to clean bottoms).
- Nappy creams/lotions should be labelled with the child's name and only if prescribed for that child - they must NOT BE SHARED.
- Any creams should be used sparingly as if applied too thickly they can reduce the absorbency of the nappy.

If the procedure ids for a soiled nappy, this should be folded inward to cover faecal material and double-wrapped in a nappy bag. Soiled nappies should be disposed of into the pedal bin provided. The disposal bin should be lined with a disposable liner and emptied daily, replacing the used liner. These bins should be stored away from the reach of children.

- Any soiled or damp clothing should be placed in a plastic carrier bag and stored for a temporary basis in the changing area and given to parents at the end of the session.
- Once the child has been changed and removed from the changing area, the surface should be cleaned with a detergent spray or antibacterial wipes and left to dry.
- Gloves and aprons and any items used for cleaning the changing area will be disposed of in yellow bags via clinical waste.
- Hands should be thoroughly washed afterwards.

Should a child with particularly complex needs be admitted to the school, we will work closely with parents and health care professionals involved in any forward planning activity.

RESOURCES

It is appreciated that caring for may take up to ten minutes, even longer in certain circumstances. In the school, designated staff members will carry out medical procedures as agreed with parents and stated on the child's Individual Health Care Plan. Changing nappies will generally be undertaken by the nursery nurse (Foundation Stage), a teaching assistant (from the class of the child) or child support assistant (employed to assist the particular child).

Where a child has a longer term need, the school's leadership team will ensure that additional resources are allocated to enable the individual needs of the child to be met. The Admin Assistant with responsibility for dealing with the medical needs in school, will be involved in this changing also.

At lunchtime, general continence issues involving younger children will come under the remit of the midday supervisors although it is anticipated that children with health care needs will be dealt with by their assigned member of staff wherever appropriate.

If, at any time, supervision of the children is deemed to be compromised in any way additional staff will be deployed in order that the personal needs of any child can be addressed as quickly as possible. This may mean that another class TA will provide emergency class cover.

KEYS TO SUCCESS

A successful transition to routine independence in this area of self care is more likely to be achieved when we, as practitioners work closely with parents with a positive approach to supporting the child in this aspect of their development.

We will not assume that the child has failed to achieve full oversight of their medical or continence requirements because this has not been attempted in the home. However, where this is the case we will have a positive and structured approach developed, in partnership with parents and carers, to ensure a successful outcome for a child.

If there is further concern that delayed continence may be linked with delays in other aspects of the child's development this will be sensitively discussed with parents and carers and a specifically planned programme be jointly developed and agreed.

There are other professionals who can help with advice and support. The Family Health Visitor or school nurse will have knowledge of who can be contacted to offer support and advice in this area. Health care professionals can also carry out a full health assessment in order to rule out any medical cause of continence problems.

ROUTINE PARTNERSHIP WORKING

In order to achieve a clear understanding of the shared responsibilities of both parents and school it may be appropriate to set up a mutual agreement which will define each other's expectations and require the completion of an Individual Health Care Plan.

If this is deemed necessary issues discussed and agreed may cover the following areas.

The parent:

- Agreeing to ensure that the child is changed at the latest possible time before being brought to school
- Providing the school/setting with any materials required for medical procedures or spare nappies/underwear, a change of clothing and any prescribed creams
- Understanding and agreeing the procedures that will be followed when their child is cared for at school – including the procedure of any intimate care.

- Agreeing to inform the school should the child have any marks/rashes
- Agreeing to change a child as required within reason, however should this be frequent, a review of the Health Care Plan would be completed with parents
- Agreeing to review arrangements whenever deemed necessary

The School/setting:

- Agreeing to carry out agreed medical / continence procedures when required
- Agreeing to carry out the procedures as agreed with parents and stated on Individual Health Care Plan, recording the times and procedure carried out
- Review the Individual Health Care Plan whenever deemed appropriate
- In relation to continence, agreeing to monitor the number of times the child is changed in order to identify progress made
- Agreeing to discuss any marks or rashes seen

USEFUL CONTACTS:

School Nurse

Beverley Health Centre
Manor Road
Beverley
HU17 7BZ
(01482) 862733

Continence Advisory Service

Horkstow House
Brumby Resource Centre
East Common Lane
Scunthorpe
DN16 1QQ
(01724) 298325

Learning Disability Team

Barton House
Brumby Resource Centre
East Common Lane
Scunthorpe
DN16 1QQ
(01724) 298222

Early Years Advisory Officer SEN/Inclusion

Ashby Turn Children's Centre
Ashby High Street
Scunthorpe
DN16 2RY
(01724) 846729

FURTHER INFORMATION AND GUIDANCE

Toileting Issues for Schools and Nurseries
(Leicester, Leicestershire and Rutland Specialist Community Child Health Services).
Available from Early Years Co-ordinator (SEN)

Early Years Support Team
New Parks House
Pindar Road, Leicester
LE3 9RN
early.yearssupport@leicester.gov.uk

Enureris Resource and Information Centre (ERIC)

34 Old School House
Britannia Road
Kinswood, Bristol
BS15 8BD
0117 960 3060
www.eric.org.uk

Good Practice in Continence Services, 2000
Available free from Department of Health

PO Box 777
London
SE1 6XH
www.doh.gov.uk/continenceservices.htm

Managing Bowel and Bladder problems in Schools and Early Years Settings
(Guidelines for good practice)

PromCon
Disabled Living, Red Bank House
4 St Chad's Street, Manchester
M8 8QA
0870 777 4714
promocon@disabledliving.co.uk
www.promocon.co.uk

Keep it clean and healthy, Infection Control Guidance for Nurseries, Playgroups and other Childcare settings
Published by Pat Cole

Hartford Cottage,
1 Longstaff Way, Hartford
Huntingdon, Cambridge
PE29 1XT
pat@cole-hartford.fsnet.co.uk

By kind permission of Keldmarsh Primary School, Beverley.

CARE CHART

Name of school/setting	

Date	Time started and finished	Name of Child	Procedure undertaken	Initials of Staff (carrying out procedure)	Initials of Staff (informed of procedure)

PROCEDURE FOR CHANGING CHILDREN WHO WET OR SOIL

1. Wash hands.
2. Assemble equipment including any provided by the parent (nappies, change of clothes, etc)
3. Ask child to stand on changing mat.
4. Put on gloves / apron.
5. Remove wet/soiled nappy or clothing.
6. The child's skin should be cleaned with a disposable wipe(s).
7. Nappies should be folded inwards on themselves and double-wrapped in a nappy bag. (Dispose of nappy/pull ups in pedal bin provided).
8. Any soiled or damp clothing should be placed in a plastic bag and stored for a temporary basis in the changing area and given to parents at the end of the session.
9. Once the child has been changed and removed from the changing area, the surface should be cleaned with a detergent spray or antibacterial wipes and left to dry.
10. Gloves and aprons and any items used for cleaning the changing area will be disposed of in yellow bags via clinical waste.
11. Hands should be thoroughly washed afterwards.

HEAD LICE SCHOOL LETTER

EXEMPLAR

Dear Parent/Carer

We have had reports of live head lice infestations at school. We are therefore asking you to check your child's hair.

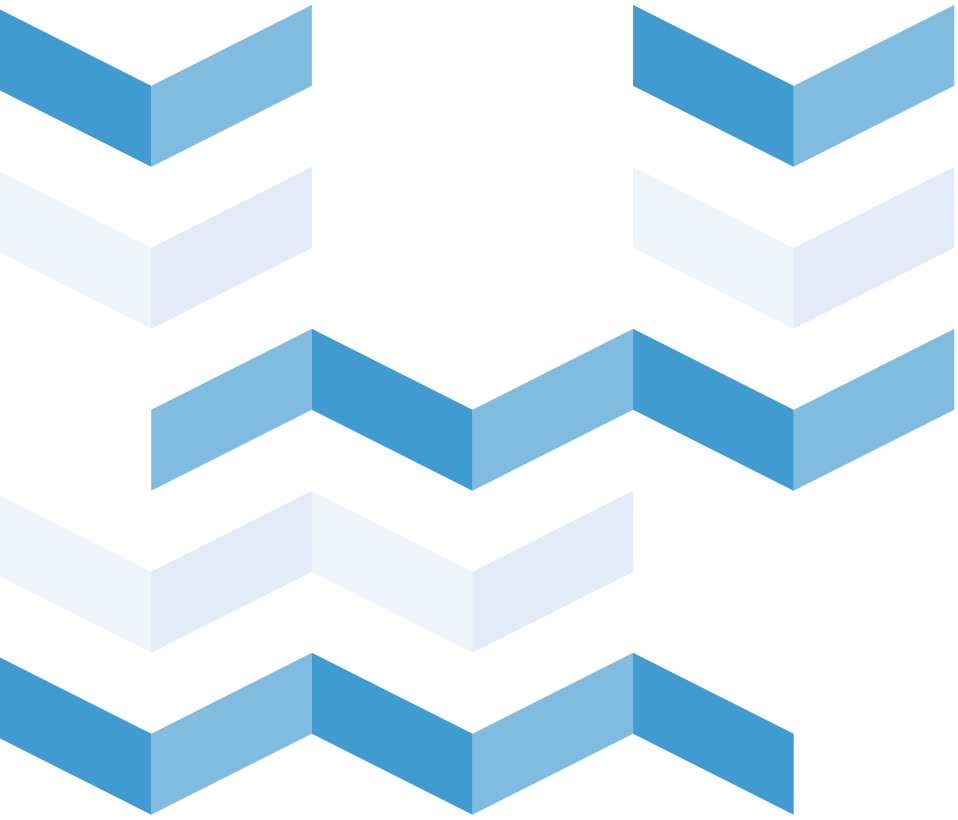
It is vital that every child's head is checked to determine whether or not there are lice present. The method we are advising is wet-combing (detailed below).

Wet Combing Procedure:

- Wash and rinse the hair in the normal way with your regular shampoo.
- Check the water for any lice.
- While the hair is still wet, apply plenty of conditioner and comb through to detangle with a normal comb. Using a fine toothed head lice detector comb (available from your local pharmacy), slot the teeth of the comb into the hair at the roots so that the comb touches the scalp and draw the comb through to the ends of the strands. At the end of every stroke check the comb for evidence of lice then wipe and rinse the comb before the next stroke.
- The conditioner lubricates the hair making combing easier and is washed out at the end wet-combing the full head.
- If any lice are found, this routine should be continued every four days for a period of two weeks.
- It is advisable to use this routine on a regular basis e.g. weekly so that any lice present can be detected early.
- If you find live lice please notify your child's class teacher and also check all members of the family using the wet-combing method. Go to your local pharmacy to receive advice and treatment.
- It is helpful if you also inform anyone with whom your child has had close contact with e.g. Cub's, Brownies, friends, extended family etc.

If you require any further advice or help about the problem of head lice please do not hesitate to contact your school nurse, pharmacist or GP Surgery.

Produced by Nicki Bush: Pharmaceuticals and Medicine Manager – ER Public Health Team.



STAFF GUIDANCE FOR SECONDARY SCHOOLS

EXEMPLAR

SUPPORTING STUDENTS AT SCHOOL WITH MEDICAL CONDITIONS

The Children and Families Act 2014, from September 2014, places a duty on schools to make arrangements for children with medical conditions. Pupils with special medical needs have the same right of admission to school as other children and cannot be refused admission or excluded from school on medical grounds alone. However, teachers and other school staff in charge of pupils have a common law duty to act in loco parentis and may need to take swift action in an emergency. This duty also extends to teachers leading activities taking place off the school site. This could extend to a need to administer medicine.

Aims

The school aims to:

- assist parents in providing medical care for their children;
- educate staff and children in respect of special medical needs;
- adopt and implement the LA policy of Medication in Schools;
- arrange training for volunteer staff to support individual pupils;
- liaise as necessary with medical services in support of the individual pupil;
- ensure access to full education if possible;
- monitor and keep appropriate records.

Entitlement

The school accepts that pupils with medical needs should be assisted if at all possible and that they have a right to the full education available to other pupils. The school believes that pupils with medical needs should be enabled to have full attendance and receive necessary proper care and support.

The school accepts all employees have rights in relation to supporting pupils with medical needs as follows:

- choose whether or not they are prepared to be involved;
- receive appropriate training;
- work to clear guidelines;
- have concerns about legal liability;
- bring to the attention of management any concern or matter relating to supporting pupils with medical needs.

Expectations

It is expected that:

- Parents will be encouraged to co-operate in training children to self-administer medication if this is practicable and that members of staff will only be asked to be involved if there is no alternative;
- Where parents have asked the school to administer the medication for their child they must supply any such prescription medication clearly labelled with the dosage regime on the outside. The name of the pharmacist should be visible. Any medications not presented properly will not be accepted by school staff. Pupils should not bring in their own medicine. This should be brought into school by the parent.
- That employees will consider carefully their response to requests to assist with the giving of medication or supervision of self-medication and that they will consider each request separately.
- The school will liaise with the School Health Service for advice about a pupil's special medical needs, and will seek support from the relevant practitioners where necessary and in the interests of the pupil.
- Any medicines brought into school by the staff e.g. headache tablets, inhalers and spacers for personal use should be stored in an appropriate place and kept out of the reach of the pupils. Any staff medicine is the responsibility of the individual concerned and not the school.

GUIDELINES AND PROCEDURES FOR THE MANAGEMENT OF MEDICINES AND MEDICAL CONDITIONS

Introduction

- Parents have the prime responsibility for ensuring pupils take their medication.
- The school supports the parents and pupils who require medication, in order to ensure they are able to attend school regularly and with the minimum of disruption to their education.
- Pupils are encouraged to take responsibility for their own medication in school in order to promote their health and wellbeing and to foster a respect for medicines.
- Prior to any medications being brought onto the premises, parents must contact the school to allow for appropriate arrangements to be made and the pro-forma for permission for the school to administer medication will be signed by the Head teacher.
- The Learning Support Department/Office will ensure all staff are aware of pupils with significant medical conditions and provide appropriate support and training.
- The school will liaise with the School Nurse regarding significant medical conditions to provide access for support training when appropriate.
- Health care plans should be stored in an appropriate secure place.

Prescribed Medicines

- Prescribed medicines should only be brought into school (or to school activities) when essential.
- Parents must contact the school prior to pupils bringing the medication into school to allow for the appropriate arrangements to be made.
- Medicines should be provided in the original container as dispensed by a pharmacist and should include the prescriber's instructions.
- Medicines should be clearly labelled with the pupil's name.
- The school encourages and supports pupil self-management of medicines.
- In appropriate circumstances agreed between the school and parents, the medicines will be stored in a locked cupboard in the medical room and made available to the named pupil at the appropriate time.
- In order to avoid the storage of excessive amounts of medicine, the quantity stored will be agreed between the school and parent.
- It is the pupil's responsibility to collect his medication at the correct time.
- In the event of a pupil refusing to take prescribed medication as requested by parents, school staff will not force them to do so. The refusal will be documented and the parent informed.
- Medicines requiring refrigeration will be stored in the staff room fridge. All the above instructions must be adhered to.
- Prescribed medicines should be collected by the parent when no longer required or when the expiry date has been reached in order for them to arrange for safe disposal.
- Where a Senior Teaching Assistant (TA) administers medicine, the amount taken will be recorded and dated.

Controlled Drugs

- As a controlled drug is a prescribed medication, all of the above procedures should be followed.
- A child who has been prescribed a controlled drug may not legally have it in their possession.
- Only the Senior TAs will administer Ritalin.
- A form must be signed by the parent to give agreement for medicine to be administered.

Non-Prescription Medicines

- Non-prescription medicines should only be brought into school when essential (or to school activities) when essential I- by both staff and students.
- Parents must contact the school prior to pupils bringing the medication into school to allow for the appropriate arrangements to be made.
- Medicines carried by staff and students should be in the original container to include the manufacturer's instructions,
- Medicines should be clearly labelled with the pupil's name.
- The school encourages and supports pupils in the self-management of medicines.
- Pupils are encouraged to carry their medication on their person.
- In exceptional circumstances agreed between the school and parents non prescribed medicines will be stored in a locked cupboard in the medical room and made available to the named pupil at the appropriate time.
- In order to avoid the storage of excessive amounts of medicines, the quantity stored will be agreed between the school and parent.
- It is the pupil's responsibility to collect their medication at the correct time.

- Non-prescription medicines should be collected be the parent when no longer required or when the expiry date has been reached in order for them to arrange safe disposal.

Long Term Medical Needs

- Pupils with long term medical needs will be supported in school.
- An individual care plan will be written, involving parents/carers, health professionals, the pupil and school staff.
- Training will be provided for staff as required.

Students with an EHC Plan

Some young people may also have SEN and may have an Education, Health and Care (EHC) Plan which brings together health and social care needs, as well as their special educational provision. The SEND Code of Practice is followed in that provision will now be planned and delivered in a coordinated way with the healthcare plan (EHCP).

EMERGENCY MEDICATION

Asthma

- It is parents' responsibility to inform the school if the pupil has asthma.
- A record of all pupils suffering from asthma is kept in school and is updated annually, or as required.
- All pupils suffering from asthma are encouraged to keep their inhalers and spacers with them at all times.
- The inhaler should be clearly labelled with the pupil's name, date of birth and form group.
- A duplicate inhaler can be stored in the school office and will be made available to the named pupil at all times, once again the inhaler should be clearly labelled as described above.
- For those pupils with significant asthma a healthcare plan should be provided by a Health care professional, this should be stored with the inhaler.
- It is the responsibility of the parent to check inhaler expiry dates and replace as necessary.

Anaphylaxis

- Parents should provide a copy of the Doctor's treatment plan with the medication.
- It is the parents' responsibility to inform the school if a pupil suffers from anaphylaxis.
- A record of pupils suffering from anaphylaxis is kept in school and updated annually or as required.
- Any emergency medication e.g. Epipen, should be carried by the pupil at all times.
- All medicines should be clearly labelled with the pupil's name, date of birth and form group.
- A duplicate kit can be stored in the school office and should be readily available to the named pupil and those staff trained in its use. Once again this should be clearly labelled as described above.
- All pupils suffering from anaphylaxis should have a healthcare plan provided by a health care professional; this should be stored with any medication.
- It is the responsibility of the parent to check the expiry dates of any medicines stored in school and replace as necessary, on a termly basis.

Diabetes

- It is the parents' responsibility to inform the school if a pupil suffers from diabetes.
- A record of pupils suffering from diabetes is kept in school and updated annually or as required.
- Any emergency medication e.g. Glucose tablets should be carried by the pupil at all times.
- All medicines should be clearly labelled with the pupil's name date of birth and form group.
- A duplicate kit can be stored in the school office and should be readily available to the named pupil and those staff trained in its use. Once again this should be clearly labelled as described above.
- All pupils suffering from diabetes should have a healthcare plan provided by a health care professional; this should be stored with any medication.
- It is the responsibility of the parent to check the expiry dates of any medicines stored in school and replace as necessary.

Epilepsy

- It is the parents' responsibility to inform the school if the pupil has epilepsy.
- A record of pupils with epilepsy is kept in school and is updated annually or as required.
- All pupils with epilepsy should have a healthcare plan provided by a health care professional; this should be stored with any medication.
- Any emergency medication required e.g. rectal diazepam, must be clearly labelled and include full instructions for its use from the prescribing doctor. It should be readily available to those staff who have received the appropriate training in its use.
- It is the responsibility of the parent to check the expiry dates of any medicines stored in school and replace as necessary.

Emergency Procedures

- First Aid cover is available at all times.
- Ambulances should be requested via the school office staff, who have been trained to give the appropriate information. If necessary an ambulance can be called from any telephone via the 999 system.
- Pupils should travel to hospital via ambulance, accompanied by a member of staff, who should remain until the arrival of a parent/carer.
- Staff should not normally take pupils to hospital in their own cars. However, if it is necessary the driver should be accompanied by another member of staff and must have Public Liability insurance.

Educational Visits

- The school encourages and supports children with medical needs who wish to take part in educational visits.
- Parental views and medical advice will be sought prior to the visit and if necessary a risk assessment for the individual pupil will be completed.
- A named person will be responsible for the pupil and if necessary the safe storage of any medicines.
- Any healthcare plans will be taken on visits.

Hygiene and Infection Control

- Staff have access to protective disposable gloves kept in all First Aid Boxes.
- Any soiled material will be disposed of in yellow clinical waste bags.
- Any affected areas will be cleaned using approved products.
- The school provides a medical room with access to running water.

Disposal

- Parents are responsible for ensuring that date-expired medicines or medicines that are no longer required are returned to a pharmacy for safe disposal, on a termly basis.
- Sharps boxes are provided for the safe disposal of needles.
- Collection and disposal of the boxes is arranged with the local council.

Confidentiality

All staff should treat medical information confidentially. The school will agree with the pupil where appropriate or otherwise the parent, who else should have access to medical information.

Date of policy	
Date of review	
Responsibility of	

Compliance: This policy complies with the statutory requirements laid out in the document '*Supporting Pupils at School with Medical Conditions*' (Sept 2014) and adheres to the East Riding document '*Managing Medicines in Schools - Guidance and procedures*' (Jan 2014).

By kind permission of Beverley Grammar School.

PHARMACY LETTER FOR EMERGENCY AUTO-INJECTORS

EXAMPLE WORDING FOR SIGNED ORDER

[Add name and address of school]

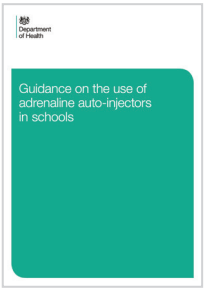
(if not on headed paper or if address isn't included in the header)

[Insert date]

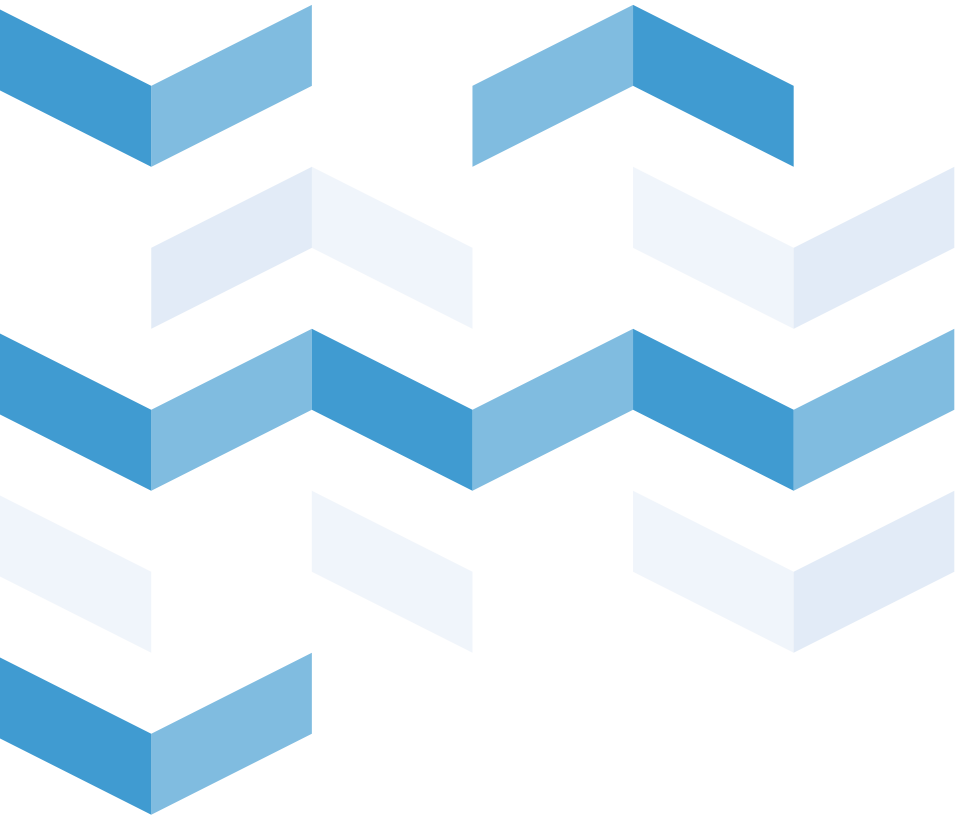
To *[add name and address of supplier]*

Please supply ***[write the number of auto-injectors required]*** auto-injectors to ***[add the name of school]*** to be used for the purpose of supplying the medicinal product to pupils at the school in an emergency in accordance with the regulations.

[Signature of the Principal or Headteacher of the school]
[Print name of Principal or Headteacher]



This request complies with the statutory guidance laid out in the document: *Guidance on the use of adrenaline auto-injectors in schools* (DoH September 2017).



PHARMACY LETTER FOR EMERGENCY SALBUTAMOL INHALERS

EXAMPLE WORDING FOR SIGNED ORDER

[Add name and address of school]

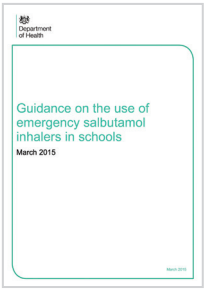
(if not on headed paper or if address isn't included in the header)

[Insert date]

To *[add name and address of supplier]*

Please supply ***[write the number of inhalers required]*** salbutamol inhalers to ***[add the name of school]*** to be used for the purpose of supplying the medicinal product to pupils at the school in an emergency in accordance with the regulations.

[Signature of the Principal or Headteacher of the school]
[Print name of Principal or Headteacher]



This request complies with the statutory guidance laid out in the document: *Guidance on the use of emergency salbutamol inhalers in schools* (DoH September 2014).

EMERGENCY SALBUTAMOL INHALER RECORD

Name of school/setting			
Inhaler number		Expiry date of inhaler	
Batch number of inhaler		Type of spacer to use	

Date	Time	Name of pupil *(if appropriate)*	Number of doses used	Description of place/activity where attack took place *(if appropriate)*	Comments	Running balance*	Signatures of staff members

Reorder new emergency salbutamol inhalers when total reaches 150 (50 doses remaining).

*Start a new record sheet when commencing new emergency salbutamol inhalers.

This complies with the statutory guidance document: *Guidance on the use of emergency salbutamol inhalers in schools* (DoH March 2015).

8.21a

EMERGENCY SALBUTAMOL INHALER RECORD (EXEMPLAR)

Name of school/setting	Edification Primary School		
Inhaler number	1	Expiry date of inhaler	01/02/17
Batch number of inhaler	BN12345	Type of spacer to use	Aero Chamber

Date	Time	Name of pupil *(if appropriate)*	Number of doses used	Description of place/activity where attack took place *(if appropriate)*	Comments	Running balance*	Signatures of staff members
01/10/16		N/A	0	N/A	New inhaler received from Pills Pharmacy, Main St.	200	A Staff / Another Staff
06/10/16	1245	Tiny Tim Bloggs	2 to test and 2 given	Sports Hall during PE.	Recovered well and returned to PE.	196	A Staff / Another Staff
01/11/16	1015	N/A	2	N/A	Inhaler kit check	194	A Staff
03/12/16	1020	N/A	2	N/A	Inhaler kit check	192	A Staff
12/12/16	1435	Philomena Peel	2 to test 10 given	Playground	Poor response. Ambulance and parents called.	180	A Staff / Another Staff

When out of date or empty, this is what would be recorded at the end:

02/02/17		N/A	0	N/A	Inhaler out of date and disposed of via Wasteisus Ltd, Any St. The City.	0	A Staff

Reorder new emergency salbutamol inhalers when total reaches 150 (50 doses remaining).

*Start a new record sheet when commencing new emergency salbutamol inhalers.

This complies with the statutory guidance document: *Guidance on the use of emergency salbutamol inhalers in schools* (DoH March 2015).

STANDARD RISK ASSESSMENT FORMAT (UN-SCORED)

Operation/Task and Location	
Premises (Insert name of school)	
Assessor(s) (Name of person completing risk assessment)	

Risk Assessment Number		EAST RIDING OF YORKSHIRE COUNCIL
Date of Assessment		
People at Risk	☐ Employees and visitors ☐ Public	

SAFE WORKING METHOD

DETAILS OF HOW THE TASK WILL BE CARRIED OUT

This risk assessment has been devised to summarise the controls and precautions outlined in the Medical Conditions at School Management Resource Pack, which in turn refers to the DfE Supporting Pupils at Schools with Medical Conditions (December 2015).

Parents have a responsibility to ensure that the school is notified of any medical condition at the earliest opportunity and whether or not medication is required and ensure the school is kept up to date with any changes. Medication must be provided by the parents and it is the parent's responsibility to ensure an adequate supply (and in date).

Only medicines that have been prescribed by a healthcare professional or for short term use for a minor ailment (such as paracetamol) should be accepted and authorised by the Headteacher, and Form 4 completed.

Paracetamol Oral Suspension should be provided in sachet form only and in a sealed envelope with the child's name, class and dosage clearly marked on the front of the envelope.

Schools must only accept medication:

- That is in the original container;
- Where parents have completed a Parental Agreement (Form 3) for the school to administer prescribed medication;
- Having obtained written consent of the parent to prescribe paracetamol oral suspension (Form 6)
- That is clearly labelled with the child's details, dosage instructions, and the time the last dose was given to the child

A trained member of staff will ensure that the labelling is checked and cross referenced against the individual health care plan (which includes all details of the child, including a photograph, dosage, medication) prior to administration.

Procedures are in place that the school check each and every medication container/envelope to ensure all information is clearly stated:

- Check the child's name
- Check the prescribed dose
- Check expiry date
- Check written instructions provided by prescriber/parent
- Check that the time of the last dose given by parents has been provided

If this information is not clearly stated the school will contact the parent/guardian/health professional before administering or allowing the child to self-administer.

If the sachet or container is damaged or punctured in any way it should not be administered either by the school or the child, and the parent/guardian or healthcare professional should be contacted for advice.

Where possible only one member of staff will administer medication at any one time to avoid confusion. Ideally the administration of medication will be with supervision by another trained member of staff. A suitable number of staff are trained to carry out the role of administration of medication to provide continuous cover and consistency in procedures.

The time of the previous dose must be checked to ensure that the minimum time between each dose has been achieved (eg at least four hours required between doses of paracetamol oral suspension.)

Sachets of paracetamol oral suspension should be massaged before providing a child with their medication or allowing them to self-administer.

Medication should be stored securely in accordance with the label (refrigerated, secured in lockable container) away from other first aid supplies. Emergency medication must be readily accessible at all times.

Good hygiene practice must be adopted at all times, including a clean environment, good hand-washing and the wearing of non-latex disposable gloves if required.

If the administration of medication involves use of sharps, the sealed sharps bin must be readily accessible for swift, safe discard.

Details of the date, time, dosage, supervisor details, and any reactions/side effects to the medication will be recorded in writing by nominated person (Form 5 or 6).

Medication should be kept in the original container, resealed and the care plan/administration sheet will be returned together to agreed, secure storage location.

Parents and health professionals will be notified as soon as possible if a child refuses to take medication and advice sought on appropriate action.

Parents will be notified as soon as possible if any adverse reactions or side effects present following the administration of medication.

Staff responsible for administering medication will notify appropriate colleagues if additional resources are required, such as disposable gloves, disposable aprons, etc.

EMERGENCY ARRANGEMENTS

First aid provision on school site – First aid provision monitored and appropriate to the needs of all children, including any specific provision to manage complex medical needs.

Specific emergency plans documented via consultation with the school, parents and health professionals, recorded in individual care plan – all relevant staff made aware of procedures to be followed.

Emergency Inhalers available.

'Grab bags' stocked and readily accessible if required in emergency.

First aid provision on school trips/educational visits is considered and appropriate to individual needs.

School staff specifically trained in medical conditions which may become complex or life threatening – Individual Care Plans/Parental Agreements in place clearly document emergency response procedures.

Emergency Services assistance summoned where required.

PERSONAL PROTECTIVE EQUIPMENT REQUIRED

- Disposable nitrile gloves (non latex)
- As stated in Individual Health Care Plans

TRAINING REQUIREMENTS

Nominated staff have received training specific to the medical conditions of children at the school, including:

- Asthma
- Anaphylaxis
- Diabetes
- Epilepsy

This list is not exhaustive, please insert details of all training needs identified and to be maintained). School appointed 'champions' of particular medical conditions require specific training relevant to their role.

The school have in place a training matrix to ensure that all medical training needs are regularly reviewed and refreshed. Staff Training records (Form 8) is completed for each member of staff.

School Nurse Team/Medical professionals ensure school is kept up to date with latest guidance.

ADDITIONAL RISK ASSESSMENTS RELEVANT TO THIS WORK OPERATION/TASK (COSHH, MOVING & HANDLING, LONE WORKING ETC.)

- Individual Health Care Plans for children with medical conditions
- Educational Visits risk assessments
- Model templates available on Safety Services Insight
- COSHH
- Infection Control

PLEASE NOTE THIS LIST IS NOT EXHAUSTIVE CONSIDER OTHER ASSESSMENTS THAT MAY BE RELATED.

RISK ASSESSMENT

Significant identified hazards	Control measures required to reduce level of risk to acceptable level
Incorrect medication administered	■ Wherever possible parents will administer medication at home to avoid disrupting the school day. ■ Effective communication between receiver of medication and the member of staff nominated to administer or supervise. ■ Parents required to ensure that all medication is clearly labelled with the child's details and required dosage and intervals. School to check this prior to storing and administering. ■ School will, at each dosage, check the labelling on the container and the corresponding details on the healthcare plan/parental request form. ■ Care plan/parental request should include a photograph of the child to ensure that the right child receives the right medication. ■ Medication must be stored with the care plan. ■ School must not accept any medication that is not correctly labelled or requirements have not been recorded in writing. ■ Medication is stored securely. Non emergency medication can be locked away but emergency medication (inhalers, auto adrenaline injectors) must be stored securely but be readily accessible in the event of emergency. ■ Only trained, nominated staff are to administer medication. ■ 'Champions' of specific medical conditions are trained to support children in school – ensuring that policy and procedures are adhered to and identifying further training needs as they arise.
Incorrect dosage administered	■ Only trained, nominated staff are to administer medication. ■ Only one member of trained staff at any one time should be responsible for administering medication and completing records, supervised by another trained member of staff wherever possible. ■ The dosage must be stated on the individual health care plan, prescription labelling, or sealed envelope, and recorded on the Administration Sheet. Nominated member of staff must refer to each individual child's specific form at the time of each administration. ■ Written records of dosage of prescribed medication maintained by nominated member of staff. ■ Effective communication between school and parents to ensure that all information regarding dosage is clearly stated in writing– any changes recorded and shared with relevant staff. Only the most current information should be accessible and stored with the medication. ■ Parents to ensure that the school have an adequate supply of medication to ensure the school are able to fulfil the required dosage.

Child refuses to take medication	■ School will not force the child to take their medication. ■ Parent/guardian/health professional should be notified of the refusal to take the medication as soon as possible. ■ The school must ensure they record details of any attempt to administer the medication and details of the refusal (when, why, etc) ■ If refusal results in illness or emergency the schools emergency procedures should be followed.
Exposure to illness of infection as a result of having to administer medication	■ Children should remain away from school for the recommended period of absence in the event of a contagious infection or complaint – proximity to children who may cause infection is thereby eliminated. ■ A good standard of personal hygiene should be practiced whenever administering medication, including hand-washing and a clean environment within which to handle and administer medication. ■ Sharps must be handled in line with training and discarded straight in to a sealed sharps bin. ■ Non latex gloves provided, worn and disposed of following each use. ■ Additional personal protective equipment required as necessary is provided.

This Risk Assessment has been completed in accordance with the Council's guidance relating to the Management of Health and Safety at Work Regulations.

Assessor's Signature	Manager's Signature

Record of Risk Assessment reviews where there has been no changes		
Assessor Name	Assessor Signature	Date of Review

I acknowledge that I have read and understand the attached risk assessment		
Print Name	Signature	Date

INFECTION CONTROL AUDIT

School			
Date of Audit			
Completed by		Role	
Assisted by		Role	

#	School Policies and Procedures	Yes	No	N/A	Comments
1	The school's policies include up to date infection control procedures				
2	Procedures reflect Local Authority (LA) guidance and evidence-based best practice				
3	The school has a policy for dealing with potentially infectious spills				
4	The school has an emergency management plan which includes outbreak plans				
5	Parents are informed of the school's policy for excluding infectious pupils				
6	Exclusion periods for staff and pupils are enforced				
7	The school has up to date contact details for parents				
8	Parents inform the school if their child is particularly vulnerable to infections				
9	The school has a copy of the current PHE guidance on infection control in schools				
10	Infection control procedures are included in staff induction and training				
11	Staff have access to the list of notifiable diseases				
12	Staff have access to telephone numbers for key health contacts				
13	Immunisation status is checked at school entry				
14	Staff receive appropriate immunisations				
15	Annual influenza vaccination is recommended for those at risk				
16	Female staff of child-bearing age are advised to check immunity to rubella				
17	Pregnant staff are aware of additional infection risks				
18	The risk of Legionnaire's disease from water storage systems is assessed				

19	Control measures to prevent Legionnaire's disease are implemented				
20	Staff are aware of the action required following exposure to blood-borne viruses				
21	Ease of decontamination is assessed prior to purchasing equipment				
#	**Hand Hygiene/Personal Hygiene**	Yes	No	N/A	Comments
22	Hand hygiene is included in staff induction				
23	Pupils are taught about the importance of personal hygiene as part of the curriculum				
24	Pupils are encouraged to wash their hands before eating and after using the toilet				
25	Hand hygiene is promoted (e.g. by displaying suitable posters)				
26	Hand basins are supplied with hot (less than 43°C) and cold water				
27	Liquid soap is available at all hand basins				
28	Paper towels are available at all hand basins				
29	Sufficient waste bins (ideally foot-operated) are available				
30	Waste bins are not overfull or odorous				
31	There are no communal bars of soap, nailbrushes or refusal towels				
32	Staff and pupils use paper tissues when coughing and sneezing				
33	Pupils are discouraged from sharing personal care items (hairbrushes)				
#	**Personal Protective Equipment (PPE)**	Yes	No	N/A	Comments
34	Disposable gloves (of appropriate sizes) and aprons are accessible to staff				
35	Suitable eye protection is available for tasks where there is a risk of splashing				
36	PPE carries appropriate safety markings				
37	Gloves are low-protein and powder free				
38	Non-latex gloves (e.g. nitrile) are available for staff with latex allergies				
39	Staff know when and how to use PPE				

#	School Meals Service	Yes	No	N/A	Comments
40	The catering facilities are registered with the LA				
41	There is a satisfactory food safety management system in place				
42	The LA routinely inspects the catering facilities				
43	Inspection reports are monitored by the school				
44	LA inspection reports are satisfactory				
45	Any problems highlighted by LA inspections are swiftly addressed				
46	Food handlers who are infectious are excluded from work				
47	Catering staff report any illness or symptoms to their manager immediately				
48	The catering manager informs the EHO of staff with infections				
49	Staff understand and follow the food safety management system				
50	Adequate cleaning procedures are in place and followed by staff				
51	Staff are suitably trained, supervised and instructed in food hygiene matters				
52	There are sufficient hand basins with hot and cold running water				
53	Liquid soap and paper towels are available				
54	Kitchen cleaning materials are stored away from other cleaning items and food				
55	There is a thermometer in the fridge and freeze				
56	Daily temperatures are recorded				
57	Temperatures are rectified if inadequate (fridges must be <8are rectified if inadequate (fridges must be <8°C, freezers <-18°C)				
58	There are no inappropriate items (e.g. animal food, medicine) in the fridge				
59	Food products are within their expiry dates				
60	Open food is stored in covered containers				
61	Waste bins are clean and in good condition with a securely fitting lid				
62	Dining tables are cleaned and disinfected immediately before food is served				
63	Dining room chairs are cleaned regularly				
64	Food spills are removed immediately				

#	Tuck shops	Yes	No	N/A	Comments
65	Surfaces are cleaned and disinfected (as appropriate) prior to serving food				
66	Fruit and vegetables are washed thoroughly before consumption				
67	Hands are washed before handling food				
#	**Packed Lunches**	Yes	No	N/A	Comments
68	Parents are aware of the importance of good food hygiene				
69	There are cold storage facilities for pupil's packed lunches				
#	**Food Safety in the Classroom**	Yes	No	N/A	Comments
70	Pupils are taught food hygiene rules				
71	High standards of hygiene are encouraged				
#	**Drinking Water**	Yes	No	N/A	Comments
72	Contact details for the water company are available				
73	Pupils have free access to drinking water throughout the day				
74	Drinking water is available at several points (not from outlets in or near toilets				
75	Drinking water outlets are decontaminated regularly and well maintained				
76	Pupils can carry their own drinking water bottle that they can clean every day				
#	**Laundry**	Yes	No	N/A	Comments
77	Laundry facilities are situated away from food areas and inaccessible to pupils				
78	There is a hand basin with liquid soap and hand towels				
79	The washing machine has a pre-wash cycle				
80	Staff do not rinse or wash soiled fabrics by hand				
81	Staff wear appropriate PPE when handling soiled laundry				
82	Staff wash their hands after handling laundry and after removing gloves				
83	Leak-proof laundry bags are available				
84	Staff are aware of the procedure for dealing with pupils with soiled clothing				
85	Fabrics are laundered using effective methods				

#	Waste Disposal	Yes	No	N/A	Comments
86	Appropriate PPE is worn when handling waste				
87	Hands are washed after handling waste				
88	The school has notified the Environment Agency that it produces clinical waste and appropriate paperwork is completed				
89	There is a foot-operated clinical waste bin in the medical room				
90	Clinical waste bins are cleaned and disinfected regularly				
91	Clinical waste bags are not filled more than two-thirds full				
92	Filled bags are labelled and stored in a secure designated area for collection				
93	Sharps bins conform to BS7320				
94	Sharps bins are kept out of reach of pupils				
95	Sharps bins are not filled more than two-thirds full				
96	Filled sharps bins are sealed and stored in a secure designated are for collection				
97	Staff are aware of the procedure for dealing with discarded sharps found on the premises				
98	Clinical waste is collected by an authorised waste carrier				
99	Household waste is placed in black plastic bags (or appropriate recycling bins)				
100	Sanitary disposal units are not overfull or odorous				
101	Staff segregate waste correctly				
#	Pest Control	Yes	No	N/A	Comments
102	Staff report building defects and signs of infestation promptly				
103	The school responds swiftly to staff reports				
104	A pest control company carries out regular inspection and treatment as necessary				

#	Animals	Yes	No	N/A	Comments
105	There is a written policy concerning animals on the school premises				
106	A knowledgeable staff member is responsible for animal care				
107	Animal equipment is cleaned and disinfected regularly				
108	Animals have up to date immunisations and treatments				
109	Hands are washed after contact with animals or their equipment				
110	Staff are aware of procedures to be followed when wild animals are found				
111	Pupils practice good hygiene during lessons involving any contact with animals				
112	Health and Safety Executive guidance regarding farm visits is adhered to				
#	Classroom and Sports Equipment	Yes	No	N/A	Comments
113	Rotas' are in place to make sure equipment is cleaned regularly				
114	Equipment is stored in clean dry containers/ cupboards				
115	Equipment is visibly clean				
116	Modelling materials are replaced regularly				
117	Sandpits are covered when not in use				
118	Sandpits are raked regularly				
119	Discoloured or foul smelling sand is replaced promptly				
#	Swimming Pools	Yes	No	N/A	Comments
120	The pool manager maintains the pool with adequate levels of disinfection				
121	The pool manager follows appropriate protocols for pool maintenance and cleaning				
122	The pool manager has a procedure for dealing with contamination incidents				
123	Pupils with diarrhoea are excluded from swimming				
124	Pupils follow the pool hygiene procedures				

Date next audit due	

OUTBREAK PLAN TEMPLATE FOR SCHOOLS

Schools are strongly advised to produce a documented Outbreak plan, outlining roles and responsibilities of the Head/staff members, when an outbreak caused by a notifiable infection occurs. The plan should be reviewed on an annual basis.

It is advised that the following be included in an Outbreak Plan:

SCHOOL DETAILS

School	
Address and telephone number	
Name of Headteacher	
Name of Deputy Head	

SCHOOL NURSE DETAILS

Name of School Nurse	
Location	
Telephone Number	

SICKNESS MONITORING AND OUTBREAK MANAGEMENT

Details of the person who has been identified to have the responsibility for Coordinating Outbreak management within the school

Details of the person who has been given the responsibility for monitoring sickness both in children and staff in order to aid early detection of outbreaks in school

- List the systems in place to monitor the levels of statutory notifiable illness in the school.
- Details of who should be responsible for notifying the Communicable Disease Control team of a suspected Outbreak at the school. (It is recommended that two people are identified to allow for sick leave).

Contacts		Contact details	
1st contact		Name	
2nd contact		Name	

Appendix 1 is a log sheet which you may find useful during outbreak situations.

RESPONSIBILITIES OF STAFF NAMED ABOVE:

- To be responsible for compiling a list of ill children/staff which should include name, date of birth, address, GP details if known, home contact telephone number and onset date of illness if known.
- To update your local Health Protection Team of any new cases of illness on a daily basis until the Outbreak is declared closed by the communicable disease team.
- To monitor that the 48 hours symptom free rule is complied with. (Ensure there are systems in place to facilitate this).
- To inform the School Nurse of the outbreak.
- Ensure that systems for the control of the infection within the school are put into immediate effect after consultation with the Head teacher and Health Protection Nurse in the CD team. i.e. consider suspending outside school activities.

Heads of Schools should be responsible in consultation with the health protection team for producing information either verbally or written for parents when required.

Heads of Schools should ensure that adequate hygiene facilities and appropriate practices are adhered to at all times, but especially when dealing with bodily fluids i.e. faeces, vomit, blood, urine, semen, and saliva. This is essential to reduce the spread of infection and to prevent the outbreak escalating. The Infection Control Audit Tool for Schools details the standards that you should be aiming to achieve.

Date	
Date for Review	
Signature of Headteacher	
Name Printed	

APPENDIX 1 – SCHOOL OUTBREAK LOG SHEET

School Name	
School Address	
Headteacher	
Contact details	
Date form completed	
Form completed by	
Number of pupils and age range	

Surname	First Name	DOB	Sex	Class or form	Symptoms	Date of onset	Excluded from School?	Date recovered	GP's Name	Recent activities*

* Include dates and brief details of any recent school trips or activities person has been involved in, particularly foreign travel, farm visits, animal handling, swimming, or water sports. Use a second sheet to record details if necessary.

Details of any action the school has taken