October 2024

Supporting Pupils with Medical Conditions

1. Roles and Responsibilities

Responsibility of Parents

In modern terminology the term 'parent' is understood to mean not just a parent but anyone who has parental responsibility for the care of a child. Parents have the principal responsibility for the administration of medication to their children, who have the right to be educated with their peers, regardless of any short or long-term needs for medication whilst at school.

Wherever possible, medication should be given at home by parents. If prescribed medicines are to be taken three or more times per day, parents should ask the prescribing doctor if the administration of the medication can occur outside normal school hours. Non-prescription medication (such as cough medicines) cannot be administered in school. There have been a few cases where GPs have advised parents to administer certain treatments (such as hayfever eye drops) to children without providing a prescription (where in the past a prescription has always been given). If parents wish for school staff to administer such treatments, they should be informed to request a prescription from their GP.

The parents have the principal duty to inform the school of their children's medical conditions and to make a request for the Head to make arrangements for medication to be administered in school. This can occur if the child:

- has been newly diagnosed
- is due to return after a long term absence and has a chronic illness or long-term complaints, such as asthma, diabetes, epilepsy or another condition
- is recovering from a short-term illness and is well enough to return to school whilst receiving a course of antibiotics or other medication
- has needs that have changed
- is due to attend a new school

Responsibility of Health Care Professionals

In situations where the condition requires a detailed individual healthcare plan or specific specialist training is required for school staff, this will often require direct input from Healthcare Professionals with clinical responsibility for the child. Examples include community or specialist nurses and, in the case of children with mobility needs, occupational therapists or physiotherapists.

Often the specific details in an individual healthcare plan can only be provided by professionals who have access to the confidential notes that the Consultants and other healthcare professionals working with the child in question have prepared.

The role of the Occupational Therapists and physiotherapists are clear; schools can contact these services via the contact information provided previously.

The School Nursing Team is able to provide training on anaphylaxis and continence issues and can provide a 'signposting role' should schools have difficulty accessing professional medical assistance or if there is uncertainty about which consultant to contact.

The specialist nurses employed by the Northumbria Trust are hospital-based and work directly with the relevant consultants. They provide training for diabetes and epilepsy and can offer the necessary assistance with healthcare plans for these conditions.

Responsibility of School Staff

Each request for medicine to be administered to a pupil in school should be considered on its merits. The Head should give consideration to the best interests of the pupil and the implications for the school.

It is generally accepted that school staff may administer prescribed medication whilst acting in loco parentis. However, it is important to note that this does not imply that there is a duty upon these workers to administer medication and the following should be taken into account:

- no member of staff should be compelled to administer medication to a pupil
- no medication can be administered in school without the agreement of the Head or her nominated representative
- the Head and Governors must nominate a member of staff to assume the role of Medication Coordinator, who will have overall responsibility for the implementation of this policy. The school's own health and safety policy has identified Mrs Yvonne Hammond as medication Co-ordinator.
- If it has been agreed that medication can be administered, named volunteers should be identified to undertake this task
- The volunteers should receive the appropriate guidance and training (where necessary)

- Parents requesting administration of medication for their children should be referred to the school's web page where they can access a copy of this document. They should be asked to complete Part 1 of the form 'Administration of Medication to Pupils – Agreement between Parents and School', a copy of which can be found in Appendix 1. Completion of this form safeguards staff by allowing only prescribed medication to be administered
- School staff may consult with the prescriber to ascertain whether medication can be given outside of school hours

Day Trips, Residential Visits and Sporting Activities

School staff should be aware of how a child's medical condition will impact on their participation in such events, however, there should be enough flexibility for all children to participate according to their abilities and with any reasonable adjustments. The only exception would be in cases where evidence from a clinician, such as a GP or specialist consultant, states that participation is not possible.

To determine the reasonable adjustments required, the school should complete a personalised risk assessment. This will ensure that planning arrangements take account of any steps needed to ensure that pupils with medical needs are included. The risk assessment will require consultation with parents and pupils and advice from the relevant healthcare professionals to ensure that pupils can participate safely. In certain situations, it may also be appropriate to consult the intended activity providers.

The specific arrangements for a child attending an off-site visit should be recorded with the relevant visit specific information and logged on the EVOLVE system, together with supporting information, such as the risk assessment. These arrangements enable the child to participate fully in such activities and ensure social inclusion, as recommended by the Outdoor Education Advisory Board's National guidance 3.2e 'Inclusion'.

In general, the arrangements detailed in this policy for the safe storage and administration of medication should also apply when taken off site. Medication should be stored in a locked bag or box and held by a designated member of staff who is trained to administer it. Associated documentation, such as the personalised risk assessment or Healthcare plan should also be available and securely stored with the medication or on an encrypted digital device (which does not rely on a data signal to access it).

The EVOLVE system has a facility which allows a visit form along with all associated attachments to be downloaded electronically to a Compressed (zipped) folder to a digital device. This may assist those schools wishing to store documents on an encrypted digital platform.

Emergency medication, such as inhalers, AAIs etc, should be readily available and not locked away. A record of any medication administered should be kept (see Appendix 5).

Liability and Indemnity

Members of staff administering medication in accordance with appropriate training or the details supplied by the parent may rest assured that they are indemnified under the conditions of the existing insurance policies. In such circumstances, any liabilities rest with the insured party (the County Council in the case of maintained schools).

2. General Procedures

1. If medication cannot be given outside of school hours, parents should fill in the aforementioned request form (Appendix 1) giving the dose to be taken, the method of administration, the time and frequency of administration, other treatment, any special precautions and signed consent.

2. The parent (not the pupil) should bring all essential medication to school. It should be delivered personally to the Head or Medication Coordinator. Only the smallest practicable amount should be kept in school.

3. All medication taken in school must be kept in a clearly labelled pharmacy bottle, preferably with a child safety top, which must give the owner's name, the contents and the dosage to be administered.

4. Whilst medication is in school it should be kept in a locked cupboard or fridge (if so required), preferably in the staffroom or main office. In the event of an emergency it should be readily accessible to the named volunteer or young person, when required. The exceptions to this are inhalers, adrenaline auto-injectors and insulin. These medications should be carried by the child or may be kept in the classroom, depending on the child's age and developing independence.

5. Medication to be taken orally should be supplied with an individual measuring spoon or syringe. Eye drops and ear drops should be supplied with a dropper. A dropper or spoon must only be used to administer medicine to the owner of that implement.

6. When medication is given, the name of the drug, the dose, the mode of administration, the time that treatment is required to be given and date of expiry should be checked. A written record should be kept of the time it was given and by whom to avoid more than one person ever giving more than the recommended dose. This should be kept with the parental consent form. See form in Appendix 1. The parental consent form should be updated regularly (ideally annually) to take account of changes in a pupil's condition.

7. Where any change of medication or dosage occurs, clear written instructions from the parent should be provided. If a pupil brings any medication to school for

which consent has not been given, school staff can refuse to administer it. In such circumstances the Head should contact the parent as soon as possible.

8. Renewal of medication which has passed its expiry date is the responsibility of the parent. Nevertheless, schools should have robust procedures in place to ensure that out of date medication is not administered in error. If parents are unable to collect expired medication then staff should take it to the local pharmacy so that it can be disposed of safely. The medication must not be disposed of in any other way.

9. In all cases where, following the administration of medication, there are concerns regarding the reaction of the pupil, medical advice should be sought immediately and the parents informed.

10. A new duty on schools requires them to have procedures in place to cover transitional arrangements between schools. The existing school should make contact with the new school the child will be moving to and provide all relevant information. The timescale for doing this should take into account the need for the new school to have sufficient arrangements in place from day one (normally a few months ahead of time). If there is a health care plan in place this will be sent to the receiving school along with transfer information or sooner if necessary to access specialist training or equipment.

    If members of staff are in doubt about any of the above procedures they should check with the parents or a health professional before taking further action.

3. Refusal or Forgetting to Take Medication

If pupils refuse medication or forget to take it, the school should inform the child's parent as a matter of urgency. If necessary, the school should call the emergency services.

4. Non-prescribed Medication

Generally, non-prescription over the counter medication (such as cold remedies and cough medicines) will not be administered in school. However, in some circumstances the school may consider administering certain medication and each request received by a parent to do so will be assessed individually. An 'Administration of Medication to Pupils - Agreement between Parents and School' form' (appendix 1) will be required in all cases before any medication can be administered. This is at the discretion of the head teacher.

As mentioned in the "What's New" section on page 2, the NHS North of England Commissioning Support Unit have issued guidance to Local Authorities in relation to the administration of non-prescribed medication, commonly known as over the counter medication, within schools. This is based on national guidance

issued to GPs by NHS England to curb the routine prescribing of products that are for:

- A self-limiting condition, which does not require any medical advice or treatment as it will clear up on its own, such as sore throats, coughs and colds
- A condition that is suitable for self-care, which can be treated with items that can easily be purchased over the counter from a pharmacy, such as indigestion, mouth ulcers and warts and verrucae.

To clarify, GPs in Northumberland will no longer be routinely prescribing medication which is otherwise available over the counter in a pharmacy, although there will be exceptions to this in specific cases.

It is not anticipated that this change will have a major impact on schools, as the advice would remain that any treatment of minor conditions where the child is still able to attend school, should, in the main be undertaken at home by the parent or carer. Schools are not expected to administer medication such as cough medicines, cold remedies, hayfever eye drops etc. Staff should not ask parents to obtain a prescription to allow these products to be administered within school as it is extremely unlikely that the GP will provide this. The final decision on whether to administer over the counter medication lies with the Headteacher.

Where a decision is made by the Head to administer over the counter medication to a pupil, the following should be ensured:

- An ‘Administration of Medication to Pupils - Agreement between Parents and School’ form (appendix 1) is completed and includes any information given to the parent by the GP or Pharmacist, including dosage.
- The medication is in the original packaging from the manufacturer which includes the name of the medicine and recommended dosage range (ensure this includes the dosage range for the age of the child).
- The expiry date is checked to ensure the medication is still in date.
- The dosage on the parental agreement form matches that on the packaging/information leaflet provided with the medication and the parent is contacted if there is a discrepancy.

Non-prescription medication should be used on a time limited basis. If it appears that the child is frequently receiving this medicine, it may be appropriate to recommend that an appointment with the GP is needed to discuss the continued need for the medicine.

It is envisaged that the vast majority of medication administered within the schools will still be prescribed.

Paracetamol

At the discretion of the Headteacher, paracetamol can be issued, provided the practice is strictly controlled by adopting the same standards as for other medication. Once again, a formal agreement should be made between the school and the parents (Appendix 1). The Head should authorise specific members of staff to dispense the tablets. In order to monitor and prevent the danger of any individuals overdosing on the medication the nominated member of staff should keep a record of when it was issued, giving such information as the name of the pupil and the time and the dose which was administered (see Appendix 5). Before administering the medication, members of staff should always ask the child whether any side effects or allergic reactions have been experienced previously.

Paracetamol should never be administered without first checking maximum dosages and when the previous dose was taken. A record must be kept of the dose given, and the parents contacted indicating the amount and frequency of the doses administered. Overall control of the administration of such analgesics can help in preventing pupils bringing their own supplies into school.

500mg paracetamol tablets are recommended for such problems as migraines and period pain.

The paracetamol must be kept securely under lock and key and dispensed with care since over-dosage is dangerous. Paracetamol must not be kept in first-aid boxes.

In the main, children of First or Primary School age should only be given paracetamol in exceptional circumstances, such as if a child has a raised temperature, the Head can authorise the use of paracetamol via a formal agreement with the parent, as described above.

On no account should aspirin or preparations that contain aspirin be given to pupils unless a doctor has prescribed such medication.

5. Individual Healthcare Plan

This section of the policy covers the role of individual healthcare plans in supporting pupils at school who have long-term, severe or complex medical conditions. Statutory guidance imposes a requirement to identify the member of staff who is responsible for the development of these plans. The school healthcare plan in Appendix 3 must always be completed by school staff, regardless of any other health care plan or other documentation provided by a healthcare professional.

The governing body should ensure that there are robust school arrangements to:

- establish the need for a plan
- ensure that plans are adequate
- review plans at least annually or earlier if evidence indicating that the child's needs have changed is brought to it's attention

Healthcare plans should be developed with the child's best interests in mind and the school should ensure that it assesses and manages risks to the child's education, health and social well-being and minimises disruption.

Personalised risk assessments, moving and handling risk assessments, emergency procedures and other such documents should be used to supplement the individual healthcare plan, as appropriate.

A healthcare plan template is given in Appendix 3. To ensure compliance with the statutory guidance the following issues have been taken into account:

- the pupil's medical condition, its triggers, signs, symptoms and treatments
- the pupil's resulting needs, including medication (with details of dose, side-effects and storage arrangements) and other treatments, time, facilities, equipment, testing, access to food and drink where this is used to manage his/her condition, dietary requirements and environmental issues such as crowded corridors, travel time between lessons
- specific support for the pupil's educational, social and emotional needs – for example, how absences will be managed, requirements for extra time to complete exams, use of rest periods or additional support in catching up with lessons, counselling sessions
- the level of support needed, (some children will be able to take responsibility for their own health needs), including in emergencies. If a child is self-managing their medication, this should be clearly stated with appropriate arrangements for monitoring
- who will provide this support, their training needs, expectations of their role and confirmation of their proficiency to provide support for the child's medical condition from a healthcare professional, together with an indication of the arrangements for cover that will be available when those supporting are unavailable
- who in the school needs to be aware of the child's condition and the support required
- the need to establish arrangements which enable written permission from parents and the Head to be drawn up, thus authorising a member of staff to administer medication or allowing the pupil to self-administer during school hours
- the designated individuals to be entrusted with information about the child's condition where the parent or child has raised confidentiality issues
- what to do in an emergency, including whom to contact, and contingency arrangements. Some children may have an emergency healthcare plan

prepared by their lead clinician that could be used to inform development of their individual healthcare plan.

- the separate arrangements or procedures required for school trips, educational visits or other extra-curricular activities.

6. Practical Advice for Common Conditions

A small number of children need medication to be given by injection, auto-injectors or other routes. The most appropriate arrangements for managing these situations effectively are best determined by agreement between the school, parent, school nurse (where there is one) and the doctor who prescribed the medication. Experience suggests that it is helpful to have a meeting of all interested parties in school, as it is essential that parents and teaching staff are satisfied with the arrangements that are made.

Members of staff willing to administer medication should be made fully aware of the procedures and should receive appropriate training from competent healthcare staff. More information on training requirements is given below in the sections of this policy covering common medical conditions. The majority of parents will be aware of the contact details for their child's specialist nurse or consultant. Schools should contact them directly in the first instance. The School Nursing Team can be contacted for advice and is able to direct staff to other health agencies, where necessary. An individual healthcare plan for each pupil with a medical need must be completed and conform to the procedures described on pages 11 and 12. Information in the appendices should prove helpful.

The medical conditions in children that most commonly cause concern in schools are asthma, epilepsy, diabetes and anaphylaxis. Essential information about these conditions is provided within this policy.

7. Anaphylaxis

What is Anaphylaxis?

Anaphylaxis is an extreme allergic reaction that occurs rarely in people who have an extreme sensitivity to a particular substance known as an allergen. It can affect the whole body, including the airways and circulation. Often it occurs within minutes of exposure to the allergen, though sometimes it does not arise until many hours later. Anaphylaxis is potentially life threatening - delays in giving adrenaline are a common finding in fatal reactions.

What Causes it?

Common causes of anaphylaxis include:

- edible triggers, such as peanuts, tree nuts, fish, shellfish, dairy products,
- wheat, sesame, soya and eggs
- other triggers, such as latex, the venom of stinging insects (for example wasps, bees and hornets), medication such as penicillin, antibiotics, ibuprofen and other drugs or injections

Anaphylactic shock is the most severe form of allergic reaction. This occurs when the blood pressure falls dramatically and the patient loses consciousness.

What are the Signs of the Condition?
Common signs of anaphylaxis in children include:

- swelling in the throat, which can restrict the air supply thus causing breathing difficulties
- severe asthma
- dizziness
- itchy skin, generalised flushing of the skin, tingling or itching in the mouth or hives anywhere on the body
- swelling of the lips, hands and feet
- abdominal cramps, nausea and vomiting

What is the Treatment for the Condition?
The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine) into the muscle of the upper outer thigh via an adrenaline auto injector (AAI), such as an epiPen, anapen or jext. An injection should be given as soon as a reaction is suspected.

Anaphylaxis is potentially life threatening - delays in giving adrenaline are a common finding in fatal reactions. It should always be regarded as a medical emergency which requires an ambulance to be called immediately. Always make it clear to the emergency operator that the child is showing symptoms of anaphylaxis so that they can prioritise the call. A useful poster on emergency arrangements to be taken is provided in Appendix 7.

What Arrangements are in Place at our School?
Healthcare Plan
Anaphylaxis is manageable. With sound precautionary measures, the development of a suitable healthcare plan and support from members of staff, school life may continue as normal for all concerned.

It is important that appropriate local procedures for the use of adrenaline auto-injectors, should include the following:

- awareness among all members of staff that the child has this particular medical condition
- awareness of the symptoms associated with anaphylactic shock
- knowledge of the type of injector to be used
- labelling of injectors for the child concerned, for example adrenaline, antihistamine
- knowledge of the locations where the injector is stored, preferably in an easily accessible place but not locked in a cupboard or office where access is restricted.
- the provision of appropriate instruction and training to nominated members of staff
- familiarity with the names of those trained to administer treatment
- an understanding of the need to keep records of the dates of issue
- knowledge of emergency contacts

This type of information should be suitably displayed in the areas where the medication is to be kept. This information should include the name of the child and,

ideally, a photograph. Care must be given to ensure confidentiality. The information should be accessible but not publicly displayed. Most schools keep this information in the staff room and main office. The information should accompany the medication on school trips. The arrangements for swimming and other sporting activities should also be considered.

Collectively, it is for the Head, the child's parents and the medical staff involved to decide how many adrenaline devices the school should hold, and where they should be stored.

Where children are deemed sufficiently responsible for carrying their own emergency treatment with them, it is nevertheless important that a spare set should always be kept safely on site. This should be accessible to all staff and stored in a secure place. In large schools or split sites, it is often quicker for staff to use an injector that is with the child rather than taking time to collect one from a central location. In an emergency situation it is important to avoid any delay.

Spare Emergency AAI
As mentioned previously, schools are now able to keep spare AAI's on the premises. It is important that school staff read the content of the DoH document Guidance on the use of adrenaline auto-injectors in Schools dated September 2017.

Supply
Spare AAIs are available, without a prescription, from a pharmacist; a sample letter requesting these can be found in the above document, which also details the various brands and doses available, depending on the age of the child (see page 7 of the above document). The spare AAI can be administered to a pupil whose own prescribed AAI cannot be administered correctly without delay or is not available; it does not replace a child's own prescribed AAI. Staff are also able to administer this to those children who have not been prescribed an AAI, but only in cases where both written medical authorisation and written parental consent for its use has been provided. In the event of a possible severe allergic reaction in a pupil who does not meet these criteria, emergency services (999) should be contacted and advice sought from them as to whether administration of the spare AAI is appropriate.

Any school wishing to keep spare AAIs should establish a policy or protocol for their use which is in line with this policy and the above DoH document. Schools can incorporate this into existing protocols for use of AAIs or into this policy. The protocol should include:

- arrangements for the supply, storage, care, and disposal of spare AAI(s) in line with this Supporting Pupils policy.
- a register of pupils who have been prescribed an AAI(s) (or where doctor has provided a written plan recommending AAI(s) to be used in the event of anaphylaxis).
- written consent from the pupil's parent/legal guardian for use of the spare AAI(s), as part of a pupil's individual healthcare plan
- ensuring that any spare AAI is used only on pupils where both medical authorisation and written parental consent has been provided.

- appropriate support and training for staff in the use of the AAI in line with the schools wider policy on supporting pupils with medical conditions.
- arrangements for purchase, storage and disposal of spare AAIs.
- details of the named individual responsible for overseeing the protocol and monitoring its implementation and maintaining the allergy register. The names of two individuals responsible for the supply, storage, care and disposal of the AAI should also be included.
- keeping a record of use of any AAI(s), as required by Supporting Pupils policy and informing parents or carers that their pupil has been administered an AAI and whether this was the school's spare AAI or the pupil's own device.

At Swansfield Park Primary School the spare AAI will be stored in the school office. It can only be used under the supervision of the Medication Officer (Mrs Yvonne Hammond or the Head Teacher.

All supporting paperwork, written parental consent and medical authorisation will be kept with the child's healthcare plan.

The AAI devices will be kept in a box labelled with the names of those children who we have authorisation to inject.

The Emergency Anaphylaxis Kit
It is good practice for schools holding spare AAIs to store these as part of an emergency anaphylaxis kit which should include:•

- 1 or more AAI(s).
- Instructions on how to use the device(s).
- Instructions on storage of the AAI device(s).
- Manufacturer's information.
- A checklist of injectors, identified by their batch number and expiry date with monthly checks recorded.
- A note of the arrangements for replacing the injectors.
- A register of pupils to whom the AAI can be administered.
- An administration record

Schools might like to keep the emergency kit together with the "emergency asthma inhaler kit" if one is kept (see section on Asthma below). Many food-allergic children also have asthma, and asthma is a common symptom during food-induced anaphylaxis.

Severe anaphylaxis is an extremely time-critical situation. Delays in administering adrenaline have been associated with fatal outcomes. Schools should ensure that all AAI devices, including those in the Emergency kit, are kept in a safe and suitably central location to which all staff have access, such as the school office or staff room, but in which the AAI is out of the reach and sight of children. They must not be locked away in a cupboard or an office where access is restricted. They should not be located more than 5 minutes away from where they may be needed. In larger schools, it may be prudent to locate a kit near the central dining area and another near the playground; more than one kit may be needed.

Any spare AAI devices held in the Emergency Kit should be kept separate from pupil's own prescribed AAI which might be stored nearby; the spare AAI should be clearly labelled to avoid confusion.

Storage and Care of the AAI

A school's allergy/anaphylaxis policy should include staff responsibilities for maintaining the spare anaphylaxis kit. It is recommended that at least two named volunteers amongst school staff should have responsibility for ensuring that:

- on a monthly basis the AAIs are present and in date.
- that replacement AAIs are obtained when expiry dates approach (this can be facilitated by signing up to the AAI expiry alerts through the relevant AAI manufacturer).
- the AAI devices should be stored at room temperature (in line with manufacturer's guidelines), protected from direct sunlight and extremes of temperature.

Schools may wish to require parents to take their pupil's own prescribed AAIs home before school holidays (including half-term breaks) to ensure that their own AAIs remain in date and have not expired.

Disposal

Once an AAI has been used it cannot be reused and must be disposed of according to manufacturer's guidelines. Used AAIs can be given to the paramedics on arrival.

School trips including sporting activities

Schools should conduct a risk-assessment for any pupil at risk of anaphylaxis taking part in a school trip, in much the same way as they already do so with regard to safe-guarding etc. Pupils at risk of anaphylaxis should have their AAI with them, and there should be staff trained to administer the AAI in an emergency.

Food Management

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 catering staff are employed by a separate organisation, it is important to ensure that the Kitchen Manager is fully aware of the child's particular requirements. A `kitchen code of practice' should be put in place.

Parents often ask for the Head 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.

Training

It would be reasonable for ALL staff to:

- be trained to recognise the range of signs and symptoms of an allergic reaction;
- understand the rapidity with which anaphylaxis can progress to a life threatening reaction, and that anaphylaxis may occur with prior mild (e.g. skin) symptoms;

- appreciate the need to administer adrenaline without delay as soon as anaphylaxis occurs, before the patient might reach a state of collapse (after which it may be too late for the adrenaline to be effective);
- be aware of the anaphylaxis policy;
- be aware of how to check if a pupil is on the register;
- be aware of how to access the AAI;

Where members of staff have volunteered to inject adrenaline in an emergency, the school will need to contact the School Nursing Team at Northumbria Healthcare to arrange for them to deliver an appropriate training session in the use of the auto-injectors. Colleagues can be reassured that these devices are simple to administer.

8. Asthma

What is Asthma?
People with asthma have airways which narrow as a reaction to various triggers. The narrowing or obstruction of the airways causes breathing difficulties.

What Causes it?
There are many things that can trigger an asthma attack. Common examples include:

- viral infections
- house dust mites
- pollen
- smoke
- fur
- feathers
- pollution
- laughter
- excitement
- stress

What are the Signs of the Condition?
The most common symptoms of an asthma attack include:

- coughing
- wheezing
- difficulty breathing
- nasal flaring
- a tight feeling in the chest (younger children may express this as ‘tummy ache’ or feeling like someone is sitting on their chest)
- Inability to talk or complete sentences (some children will go very quiet

What is the Treatment for the Condition?
The main types of medicines used to treat asthma are discussed briefly below:

Relievers
Usually it is a reliever that a child will need during the school day. Relievers (usually blue inhalers) are medicines that are taken immediately to relieve the symptoms of asthma during an attack. They quickly relax the muscles surrounding the narrowed

airways thus allowing them to open wider, making it easier for the child to breathe. They are sometimes taken before exercise.

Preventers
Preventer inhalers can be brown, red or orange in colour and can sometimes be in the form of tablets. Preventers are usually used out of school hours and it is rare for them to be needed during the school day.
Preventers protect the lining of the airways, help to calm the swelling and stop the tubes in the lungs from being so sensitive.

Spacers
Both kinds of inhalers are often used in combination with spacers which help deliver medicine to the lungs more effectively. Where prescribed, the spacer should be individually labelled with the child's name and kept with the inhaler.

Nebulisers
A nebuliser is a machine that creates a mist of medicine that is then breathed through a mask or mouthpiece. They are becoming increasingly less common. Pupils with asthma should not normally need to use a nebuliser in school. However, if they do have to use one then members of school staff will need to receive appropriate training from a healthcare professional.

Training
Since emergency treatments vary in each case, the parents will often be best placed to inform schools of the child's treatment regime. There may be a specialist nurse from the local NHS Trust who can deliver training and will have access to the medical advice that has informed the healthcare plan.
Children with asthma will often be looked after solely by their GP or Asthma Nurse. Although the GP would be unable to provide training it is likely that
they will provide the information that would help school staff to complete the healthcare plans. Children with complex conditions may have access to a specialist nurse with expert knowledge in oncology, nephrology, gastroenterology, urology or cystic fibrosis, who may be able to assist.

Designated Members of Staff
Designated members of staff should be trained in:

- recognising asthma attacks (and distinguishing them from other conditions with similar symptoms)
- responding appropriately to a request for help from another member of staff
- recognising when emergency action is necessary
- administering salbutamol inhaler through a spacer
- keeping appropriate records of asthma attacks.

ALL Members of Staff
In addition to this, it would be reasonable for ALL members of staff to be:

- trained to recognise the symptoms of an asthma attack and, ideally, how to distinguish them from other conditions with similar symptoms
- aware of this policy
- aware of how to check if a child is on the asthma register

- aware of how to access the emergency inhaler and who the designated members of staff are, and the policy on how to access their help.

Asthma UK has produced demonstration films on using a metered-dose inhaler and spacers suitable for staff and children.
http://www.asthma.org.uk/knowledge-bank-treatment-and-medicines-using-your-inhalers

Beat Asthma also has a useful resource page specifically aimed at schools:
http://www.beatasthma.co.uk/resources/schools/

What Arrangements are in Place at our School?
Healthcare Plan
Pupils with asthma will need to have an individual healthcare plan, details about which are given on page 11 and in Appendix 3.

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action needs to be taken at that time. An Asthma Action Plan (available from Asthma UK) is a useful way to store written information about a child's asthma. The child's GP or Asthma Nurse will complete this in conjunction with the child and his/her parent. It includes details of the inhalers used, asthma triggers for the child, emergency action and contacts for the GP or Asthma Nurse. This can be attached to the healthcare plan.

In early years settings it is foreseeable that the younger children will not have the ability to convey to members of staff that their symptoms are getting worse or identify what medicines they need to take and when. It is, therefore, imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms of asthma are getting worse and what action they need to take when this happens. This should be reinforced by asthma action plans, asthma medicine cards (both provided by parents) and regular training and support for staff.

Asthma Register
A register of children who have been diagnosed with asthma or prescribed a reliever inhaler should be kept. This is particularly crucial in larger schools, where there may be many children with asthma, and it will not be feasible for individual members of staff to be aware of which children these are. In primary settings, where a teacher has responsibility for a single class each year, this will be easier to manage (so a register may not be needed).
Schools should ensure that the asthma register is easy to access, and allows for a quick check to take place to establish if a child is recorded as having asthma and that consent for an emergency inhaler to be administered has been obtained.

Carrying the Medication
Pupils with asthma need to keep their reliever inhalers with them at all times
It is good practice to allow pupils who have asthma to have immediate access to their own medication from a relatively early age. This is especially important if the inhaler or nebuliser is needed to relieve symptoms regularly or if attacks are sporadic and particularly severe. Children with asthma learn from their past

experience of attacks; they usually know just what to do and will probably carry the correct emergency treatment.

If pupils are not able to do so then inhalers should be stored safely away and members of staff should issue them when the child needs the medication. This method may be more appropriate for younger pupils with asthma who may not be able to use the inhaler without help or guidance.

If the child is too young or immature to take personal responsibility for his/her inhaler, members of staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name.

All asthma medicine should be clearly labelled with the child's name. The expiry date of the medicines should be checked every six months.

Emergency Salbutamol Inhalers in Schools

As indicated above, schools are now permitted to keep a supply of salbutamol inhalers on site for use in an emergency. This is a sensible contingency arrangement in the event that children lose, forget or break their inhalers.

The emergency salbutamol inhaler should only be used by children:

- who have been diagnosed with asthma, and prescribed a reliever inhaler
- who have been prescribed a reliever inhaler
- for whom written parental consent for use of the emergency inhaler has been given

Information on the use of the emergency inhaler should be recorded in a child's individual healthcare plan.

Schools are not required to hold an inhaler – this is a discretionary power enabling them to do so if they wish. Those which choose to keep an emergency inhaler should use the guidance below to establish a protocol for its use.

Keeping an inhaler for emergency use will have many benefits. It could prevent an unnecessary and traumatic trip to hospital and, potentially, save the child's life. Having a protocol that sets out how and when the inhaler should be used will also protect members of staff by ensuring they know what to do in the event of a child having an asthma attack; this should include:

- Establishing arrangements for the supply, storage, care and disposal of the inhaler and spacers. Assigning these responsibilities to at least two volunteers is recommended
- Maintaining a register of pupils who have been diagnosed with asthma or prescribed a reliever inhaler. The register should confirm that parental consent has been obtained for use of the emergency inhaler and a copy of it should be kept with the emergency inhaler
- Having written parental consent for use of the emergency inhaler included as part of a child's individual healthcare plan. This consent can either be secured by amending the School/Parental Agreement Form (Appendix 1) to include this permission or by using the specific consent form for use of the

emergency inhaler (Appendix 6) which should be updated regularly, ideally annually, to take account of changes to a child's condition.

- Arranging for appropriate support and training for staff in the use of the emergency inhaler in line with this policy.
- Keeping a record of use of the inhaler (including when and where the attack took place, how much medication was given and by whom) and informing parents or carers that their child has used the emergency inhaler (this should be in writing so the parent can pass the information onto the child's GP – a sample letter is attached as Appendix 7)

The Medication Coordinator or Head will monitor the protocol to ensure compliance with it.

Supply

Schools can buy inhalers and spacers from a pharmaceutical supplier, such as a local pharmacy, without a prescription, provided the general advice relating to these transactions are observed. Schools can buy inhalers in small quantities provided it is done on an occasional basis and is not for profit.

A supplier will need a request signed by the Head (ideally on appropriately headed paper) stating:

- the name of the school for which the product is required;
- the purpose for which that product is required, and
- the total quantity required

Schools may wish to discuss with their community pharmacist the different plastic spacers that are available and what is most appropriate for the age-group in the school. They can also provide advice on use of the inhaler. Schools should be aware that pharmacies cannot provide inhalers and spacers for free and will, therefore, charge for them.

The Emergency Kit

An emergency asthma inhaler kit should include:

- a salbutamol metered dose inhaler
- at least two single-use plastic spacers compatible with the inhaler
- instructions on using the inhaler and spacer
- instructions on cleaning and storing the inhaler
- manufacturer's information
- a checklist of inhalers, identified by their batch number and expiry date, with monthly checks recorded
- note of the arrangements for replacing the inhaler and spacers
- a register of children permitted to use the emergency inhaler as detailed
- in their individual healthcare plans
- a record of when the inhaler has been used
- a copy of the school protocol on the use of the emergency salbutamol inhaler

Schools should consider keeping more than one emergency asthma kit, especially if they comprise several buildings, to ensure that all children within the school

environment are close to such equipment. The Department of Health suggests a stock of five spacers would be adequate for a typical school.

Salbutamol
Salbutamol is a relatively safe medicine, particularly if inhaled, but all medicines can have some adverse effects. Those of inhaled salbutamol are well known, tend to be mild, temporary and not likely to cause serious harm. The child may feel a bit shaky or may tremble, or may say that they feel their heart is beating faster. The main risk of allowing schools to hold a salbutamol inhaler for emergency use is that it may be administered inappropriately to a breathless child who does not have asthma. It is essential, therefore, that schools follow the advice previously given in relation to whom the emergency inhaler can be used by.
Children may be prescribed inhalers for their asthma which contain an alternative reliever medication to salbutamol (such as terbutaline). The salbutamol inhaler should still be used by these children if their own inhalers are not accessible – it will still help to relieve their asthma and could save a life.

Storage and Care of the Inhaler
Schools should ensure that the inhaler and spacers are kept in a safe central location, such as the school office or staffroom, which is known to all members of staff, and to which they have access to at all times. However, the inhaler must be stored out of the reach and sight of children. The inhaler and spacer should not be locked away.

The inhaler should be stored at the appropriate temperature (in line with the manufacturer's guidelines), usually below 30oC, protected from direct sunlight and extremes of temperature. The inhaler and spacers should be kept separate from any individual child's inhaler; the emergency inhaler should be clearly labelled to avoid confusion with a child's inhaler. An inhaler should be primed when first used (for example, spray two puffs). As it can become blocked again when not used over a period of time, it should be regularly primed by spraying two puffs.

To avoid possible risk of cross-infection, the plastic spacer should not be reused. It can be given to the child to take home for future personal use. The inhaler itself, however, can usually be reused, provided it is cleaned after use. The inhaler canister should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place. The canister should be returned to the housing when it is dry, and the cap replaced, and the inhaler returned to the designated storage place.

However, if there is any risk of contamination with blood (for example if the inhaler has been used without a spacer), it should also not be re-used but disposed of.
The two named volunteers should have responsibility for ensuring that:

- on a monthly basis the inhaler and spacers are present and in working order, and the inhaler has sufficient number of doses available
- replacement inhalers are obtained when expiry dates approach
- replacement spacers are available following use
- the plastic inhaler housing (which holds the canister) has been cleaned, dried and returned to storage following use, or replacements are available if necessary.

Disposal
Manufacturers' guidelines usually recommend that spent inhalers are returned to the pharmacy to be recycled. Schools should be aware that to do this legally, they will need to register as a lower-tier waste carrier, as a spent inhaler counts as waste for disposal.

Registration only takes a few minutes online, and is free, and does not usually need to be renewed in future years. The hyperlink to enable schools to register is provided below:
https://www.gov.uk/waste-carrier-or-broker-registration

However, following discussions, the Council's Waste Management and Disposal Team has determined that owing to the very small quantities of emergency inhalers which Northumberland schools will produce, a more sensible and pragmatic solution would be for each school to put them into its recycling and rubbish bins, as described below:

- If schools have an NCC recycling collection then the empty metal canister can be recycled via these bins, as the Council does permit empty aerosols to be added to its collections
- The plastic part of the inhaler should be placed into the rubbish bin, following which it will be sent with other waste to the 'energy from waste' plant

Schools requiring further information about this particular topic should call 0845 600 6400 and ask to speak to the Contracts and Commercial Team (Waste Management).

PE and Off-site Activities
Children with asthma should participate in all aspects of school life, including physical activities. They need to take their reliever inhaler with them on all off-site activities and these should also be available during physical education and sports activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work may need to be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

Action during an Attack
When a child has an attack they should be treated according to their individual healthcare plan or asthma card, as previously agreed. An ambulance should be called if:

- the symptoms do not improve sufficiently after 10 puffs on the inhaler q
- the child is too breathless to speak
- the child is becoming exhausted
- the child has a blue/white tinge around the lips
- the child has collapsed

Because asthma varies from child to child, it is impossible to provide emergency guidance that will apply uniformly in every single case. However, the guidelines given in Appendix 6 may be helpful. Schools may wish to copy the information and display it as emergency guidance.

9. Diabetes

What is Diabetes?
Diabetes is a condition where the amount of glucose in the blood is too high because the body cannot use it properly.

What Causes it?
Diabetes is a disorder caused when the pancreas produces an insufficient amount of the hormone insulin or when insulin production is absent. There are two main types of diabetes which are discussed briefly below:

Type 1 Diabetes
Type 1 diabetes develops when the insulin-producing cells have been destroyed and the body is unable to generate any of the substance. It is treated with insulin either by injection or pump, a healthy diet and regular physical activity. The majority of affected children have Type 1 diabetes.

Type 2 Diabetes
Type 2 diabetes develops when the body does not produce enough insulin or the insulin that is produced does not work properly.

This type of diabetes is treated with a healthy diet and regular physical activity, though medication (and/or insulin) is often required.

In both instances each child may experience different symptoms and these should be discussed when drawing up the healthcare plan

What is the Treatment for the Condition?
For most children diabetes is controlled by injections of insulin each day. Some children may require multiple injections, though it is unlikely that they will need to be given injections during school hours.

In some cases, the child's condition may be controlled by an insulin pump. Most children can manage their own injections, however, if doses are required at school then supervision may be required and a suitable, private place to inject will need to be identified.

It has become increasingly common for older children to be taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime and then insulin with breakfast, lunch and 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. The child is then responsible for administering injections and the regime to be followed would be detailed in the individual healthcare plan.

It is essential that children with diabetes make sure that their blood glucose levels remain stable. They may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs to be adjusted. The majority of older children will be able to undertake this task without assistance

and will simply need a suitable place to do it. However, younger children may need adult supervision to carry out the test and/or interpret the results.

When members of staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional, usually a specialist nurse with clinical responsibility for the treatment of the particular child.

What Arrangements are in Place at our School?
Healthcare Plan
A healthcare plan will be needed for pupils with diabetes. Information about these plans is given on page 11 and Appendix 3.

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. Members of staff need to be made aware that if a child should miss a meal or snack he/she could experience a hypoglycaemic episode (commonly known as a 'hypo') during which the blood glucose level falls too low. It is, therefore, important that staff should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand. After strenuous activity a child may experience similar symptoms, in which case the teacher in charge of physical education or other sessions involving physical activity should be aware of the need to take appropriate action.

What are the Signs of a Hypoglycaemic Episode?
Staff should be aware that the following symptoms, either individually or in combination, may be an indicator of low blood sugar:

- Hunger
- Sweating
- Drowsiness
- 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 individual healthcare plans.

Emergency Action
If a child experiences a 'hypo', it is very important that he/she is not left alone and that a fast-acting sugar, such as glucose tablets, a glucose rich gel or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.
An ambulance should be called if:

- the child's recovery takes longer than 10-15 minutes
- the child becomes unconscious

Hyperglycaemia
Some children may experience hyperglycaemia, which is a high glucose level.

The underlying cause of hyperglycaemia will usually be from loss of insulin producing cells in the pancreas or if the body develops resistance to insulin.

More immediate reasons for it include:

- Missing a dose of diabetic medication, tablets or insulin
- Eating more carbohydrates than the body and/or medication can manage
- Being mentally or emotionally stressed
- Contracting an infection

The symptoms of hyperglycaemia include thirst and the passing of large amounts of urine. Tiredness and weight loss may indicate poor diabetic control. If these symptoms are observed members of staff should draw these signs to the attention of parents. If the child is unwell, is vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and he/she will require urgent medical attention.

Further information on this condition can be found on the Diabetes UK website.

10. Epilepsy

Epilepsy is characterised by a tendency for someone to experience recurrent seizures or a temporary alteration in one or more brain functions.

What Causes it?
An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons and can result from a wide variety of disease or injury.

Triggers such as anxiety, stress, tiredness and illness may increase the likelihood that a child will have a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. The latter is called photosensitivity and is very rare. Most children with epilepsy can use computers and watch television without any problem.

What are the Signs of the Condition?
Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience.

What the child experiences depends on whether all of the brain is affected or the part of the organ that is involved in the seizure. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected; a child may appear confused, wander around and be unaware of their surroundings. They could also display unusual, such as plucking at

clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

Most seizures last for a few seconds or minutes, and stop of their own accord. In some cases, seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves.

After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while others may need to sleep for several hours.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear `blank' or `staring', and sometimes there will be fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class.

What is the Treatment for the Condition?
The great majority of seizures can be controlled by anti-epileptic medication. It should not be necessary to take regular medicine during school hours.

What Arrangements are in Place at our School?
Healthcare Plan
An individual healthcare plan is needed when a pupil has epilepsy.
Parents and health care professionals should provide information to the school's Medication Coordinator so that it can be incorporated into the individual healthcare plan, detailing the particular pattern of an individual child's epilepsy. If a child experiences a seizure whilst at school, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – for example visual/auditory stimulation, anxiety or upset.
- any unusual 'feelings' which the child reported prior to the seizure
- the parts of the body demonstrating seizure activity, such as limbs or facial muscles
- the time when the seizure happened and its duration
- whether the child lost consciousness
- whether the child was incontinent

The above information will help parents to give the child's specialist more accurate information about seizures and their frequency. In addition, it should form an integral part of the school's emergency procedures and relate specifically to the child's individual healthcare plan. The healthcare plan should clearly identify the type or types of seizures, including descriptions of the seizure, possible triggers and whether emergency intervention may be required.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or participating in science lessons. The Medication Coordinator should discuss any safety issues with the child and parents as part of the healthcare plan, and these concerns should be communicated to members of staff.

Emergency Action

Information regarding emergency management is given in Appendices 8 and 9. Appendix 8 covers the procedures to be followed with regard to first aid for all seizures, whilst Appendix 9 covers procedures to be followed if the casualty is known to have epilepsy and has been prescribed rectal diazepam.

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured him/herself badly
- the child has problems breathing after a seizure
- a seizure lasts longer than the period identified in the child's healthcare plan
- a seizure lasts for five minutes and members of staff do not know how long the seizures usually last for a particular child
- there are repeated seizures, unless this is usual for the child, as described in the child's health care plan

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. Putting something soft under the child's head during a convulsive seizure will help to protect it from injury.

Nothing should be placed in the child's mouth. After a convulsive seizure has stopped, the pupil should be placed in the recovery position and a member of staff should stay with him/her until the child has fully recovered.

Status Epilepticus

Status epilepticus is a condition described as one continuous, unremitting seizure lasting longer than five minutes or recurrent seizures without regaining consciousness between them for greater than five minutes. It must always be considered a medical emergency.

A five-minute seizure does not in itself constitute an episode of status and it may subsequently stop naturally without treatment. However, applying emergency precautions after the five-minute mark has passed will ensure that prompt attention will be available if a seizure does continue. Such precautions are especially important if the child's medical history shows a previous episode of status epilepticus.

Any child not known to have had a previous seizure should receive medical assessment as soon as possible. Both medical staff and parents need to be informed of any events of this nature.

Emergency Medication
Two types of emergency medication are prescribed to counteract status, namely:

- Buccal (oromucosal) midazolam. This is the most common treatment for prolonged acute convulsive seizures, which is placed via syringe into the buccal cavity (the side of the mouth between the cheek and the gum).
- Rectal diazepam, which is given rectally (into the bottom). This is an effective emergency treatment for prolonged seizures.

These drugs are sedatives which have a calming effect on the brain and are able to stop a seizure. In very rare cases, these emergency drugs can cause breathing difficulties so the person must be closely watched until they have fully recovered.

Training in the administration of buccal midazolam and rectal diazepam is essential and is provided by the specialist nurse with clinical responsibility for the treatment of the particular child. Special training should be updated annually.

Administration of Buccal Midazolam and Rectal Diazepam
Any child requiring rectal buccal midazolam or diazepam should have his/her medication reviewed every year. As an additional safeguard, each child requiring buccal midazolam or rectal diazepam should have his/her own specific healthcare plan that will focus exclusively on this issue. All interested parties should be signatories to this document. An example is reproduced in Appendix 10.

Buccal midazolam and rectal diazepam can only be administered in an emergency if an accredited first-aider, trained in mouth to nose/mouth resuscitation, is easily accessible (that is only one or two minutes away). At least one other member of staff must be present as well.

Arrangements should be made for two adults to be present for such treatment, a least one of whom is the same sex as the child; this minimises the potential for accusations of abuse. The presence of two adults can also make it much easier to administer treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.

Staying with the child afterwards is important as buccal midazolam and diazepam may cause drowsiness. Moreover, those who administer buccal midazolam and rectal diazepam should be aware that there could be a respiratory arrest.

If breathing does stop a shake and a sharp voice should usually start the child breathing again; if this does not work it will be necessary to give mouth to mouth resuscitation.

11. Unacceptable Practice

The DfE's statutory guidance makes it very clear that governing bodies should ensure that the school's 'Policy on Supporting Pupils with Medical Conditions' is explicit about what practice is not acceptable. Though most schools have for many years implemented exemplary practice to ensure that children with medical needs are fully supported, it is, nevertheless, recommended that they retain the information

listed below which is taken from the DfE document. If nothing else, it will enable governors to demonstrate unequivocally to a scrutinising authority that they are not adhering to or advocating practices that are deemed unacceptable, prejudicial or which promote social exclusion.

Although school staff should use their discretion and judge each case on its merits whilst referencing the child's individual healthcare plan, it is not considered acceptable practice to:

- prevent children from easily accessing their inhalers and medication and administering their medication when and where necessary
- assume that every child with the same condition requires the same treatment
- ignore the views of the child or their parents; or ignore medical evidence or opinion (although this may be challenged)
- send children with medical conditions home frequently or prevent them from staying for normal school activities, including lunch, unless this is specified in their individual healthcare plans
- if the child becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable
- penalise children for their attendance record if their absences are related to their medical condition, such as hospital appointments
- prevent pupils from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively
- require parents, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their child, including assisting with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs
- prevent children from participating, or create unnecessary barriers which would hinder their participation in any aspect of school life, including school trips by, for example, requiring parents to accompany the child

12. Complaints

Similarly to the stance adopted above, the DfE's statutory guidance requires that governing bodies ensure that the school's policy is crystal clear. It needs to set out how complaints concerning the support provided to pupils with medical conditions may be made and how they will be handled.

Should parents or pupils be dissatisfied with the support provided they should discuss their concerns directly with the school. If, for whatever reason, this does not resolve the issue, they may make a formal complaint via the school's existing complaints procedure.

13. Appendices

Appendix 1	Administration of Medication Pupils- Agreement between Parents and School (parental consent form)
Appendix 2	Parental Request for Child to Carry and Self-administer Medicine
Appendix 3	School Healthcare Plan for a Pupil with Medical Needs
Appendix 4	Individual Staff Training Record – Administration of Medication
Appendix 5	Record of Medication Administered in School
Appendix 6	Emergency Action in the Event of an Asthma Attack
Appendix 7	Emergency Action: Allergic Reaction/Anaphylaxis
Appendix 8	Emergency Action: Epilepsy - First Aid for all Seizures
Appendix 9	Emergency Action: First Aid for Children Known to Have Epilepsy and Prescribed Rectal Diazepam
Appendix 10	Individual Care Plan for the Administration of Rectal Diazepam
Appendix 11	Record of Use of Rectal Diazepam
Appendix 12	Register of Children who have Allergies

Appendix 1

Administration of Medication to Pupils Agreement between Parents and School

A parent must supply a written request in order for medication to be administered to pupils during school hours. In some circumstances the school may consider administering certain 'over the counter' medication and each request received by a parent to do so will be assessed individually. This is at the discretion of the head teacher.

It is also important to keep the administration of medication to a minimum and parents are requested to consider the possibility of administering the daily doses out of school hours. If this is not possible the following consent form must be completed and returned to the school:

Note: Medicines must be kept in the original container as dispensed by the pharmacy.

Part 1 – To be Completed by Parent/Carer	
To the Headteacher: Anne-Marie Grimes	**School: Swansfield Park Primary School**
My child *(name)* _____ Date of birth:_____ Class_____ has the following medical condition_____ I wish for him/her to have the following medicine administered by school staff, as indicated below:	
Name of Medication:	
Dose/Amount to be given:	
Time(s) at which to be given:	
Means of administration:	
How long will the child require this medication to be administered?	
Known side effects and any special precautions (please attach details)	
Procedures to take in case of emergency (please attach details)	
Emergency Contact 1 Name:_____ Telephone *Work*: _____ *Home*: _____ *Mobile*: _____ Relationship: _____	***Emergency Contact 2*** Name:_____ Telephone *Work*: _____ *Home*: _____ *Mobile*: _____ Relationship: _____

I undertake to deliver the medicine personally to the Headteacher or Medication Coordinator and to replace it whenever necessary. I also undertake to inform the school immediately of any change of treatment that the doctor or hospital has prescribed.

Name:_____Signature:_____

Relationship to child:_____ Date: _____

Part 2 - To be completed by Headteacher/Medication Coordinator

Confirmation of agreement to administer medicine

It is agreed that *(child)* _____ will receive (*quantity and name of medicine)* _____every day at (*time medicine to be administered, for example, lunchtime or afternoon break)* _____.

(Child) _____ will be given medication or supervised whilst he/she takes it by (*name of member of staff)* _____.

This arrangement will continue until_____ *(either the end date for the course of medicine or until the parents instruct otherwise).*

Name:_____Signature:_____
Headteacher/Medication Coordinator

School:_____Swansfield Park Primary School

Appendix 2

Parental Request for Child to Carry and Self-administer Medicine

This form must be completed by a parent/carer

To: Headteacher: Anne-Marie Grimes	
School: Swansfield Park Primary School	
Name of child:	Class:
Address:	
Name of Medication:	
Procedures to be taken in an emergency:	
Contact Information	
I would like my child to keep his/her medicine on him/her for use, as necessary. Name:_____ Signature: _____ Daytime Tel no(s):_____ Date:_____ Relationship to child:_____	

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

Appendix 3

Healthcare Plan for a Pupil with Medical Needs

Details of Child and Condition	
Name of child:	Add photo here
Date of birth:	
Class/Form:	
Medical Diagnosis/Condition:	
Triggers:	
Signs/Symptoms:	
Treatments:	
Has the Parental Consent Form been completed? *Yes/No* *(Medication cannot be administered without parental approval)*	
Date:	Review Date:
Medication Needs of Child	
Medication:	
Dose:	
Specify if any other treatments are required:	
Can the pupil self-manage his/her medication? *Yes/No* If *Yes*, specify the arrangements in place to monitor this: Indicate the level of support needed, including in emergencies: *(some children will be able to take responsibility for their own health needs)*	

Known side-effects of medication:
Storage requirements:
What facilities and equipment are required? *(such as changing table or hoist)*
What testing is needed? *(such as blood glucose levels):*
Is access to food and drink necessary? *(where used to manage the condition):* *Yes/No* Describe what food and drink needs to be accessed
Identify any dietary requirements:
Identify any environmental considerations *(such as crowded corridors, travel time between lessons):*
Action to be taken in an emergency *(If one exists, attach an emergency healthcare plan prepared by the child's lead clinician):*
Staff Providing Support
Give the names of staff members providing support *(State if different for off-site activities):*
Describe what this role entails:
Have members of staff received training? *Yes/No* (*details of training should be recorded on the Individual Staff Training Record, Appendix 4)*
Where the parent or child have raised confidentiality issues, specify the designated individuals who are to be entrusted with information about the child's condition:

Detail the contingency arrangements in the event that members of staff are absent:
Indicate the persons (or groups of staff) in school who need to be aware of the child's condition and the support required:
Other Requirements
Detail any specific support for the pupil's educational, social and emotional needs *(for example, how absences will be managed; requirements for extra time to complete exams; use of rest periods; additional support in catching up with lessons or counselling sessions)*

Emergency Contacts	
Family Contact 1 Name:_____ Telephone *Work*:_____ *Home*:_____ *Mobile*:_____ Relationship:_____	***Family Contact 1*** Name:_____ Telephone *Work*:_____ *Home*:_____ *Mobile*:_____ Relationship:_____
Clinic or Hospital Contact Name:_____ Telephone: *Work*:_____	***GP*** Name:_____ Telephone: *Work*:_____
Signatures	
Signed _____ *(Headteacher)*	*Signed* _____ *(Medication Coordinator)*

Appendix 4

Individual Staff Training Record – Administration of Medication

Name: _____ Job:_____ School: Swansfield Park Primary School

Type of training received	**Date completed**	**Training Provided by**	***Trainer's Signature*** *I confirm that this employee has received the training detailed and is competent to carry out any necessary treatment.*	**Employee's Signature confirming receipt of training**	**Suggested review date**

Appendix 5

Record of Medication Administered in School

SWANSFIELD PARK PRIMARY SCHOOL

Date	Pupil's Name	Time	Name of Medication	Dose Given	Any Reactions	Signature of Staff	Print Name

Emergency Action: Asthma – First Aid

Ensure that the reliever medicine is taken promptly:

A reliever inhaler (usually blue) should quickly open up narrowed air passages; try to make sure it is inhaled correctly. Preventative medicine is of no use during an attack; it should be used only if the child is due to take it.

Stay calm and reassure the child:

Attacks can be frightening and it is important to stay calm and do things quietly and efficiently:

- listen carefully to what the child is saying and what he or she wants (the child has probably been through it before)
- try tactfully to take the child's mind off the attack
- do not put arms around the child's shoulder as this is restrictive

Help the child to breathe:

- encourage the child to try and breathe slowly and breathe out for longer (in an attack people tend to take quick shallow breaths)

- allow the child to take his or her favoured position. Most people find it easier to sit fairly upright or lean forwards slightly. They may want to rest their hands on their knees to support their chest. They must not lie flat on their backs.

- loosen clothing around the neck and offer the child a drink of warm water as the mouth becomes dry with rapid breathing

If any of the following apply call a doctor urgently:

- the reliever has no effect after five to ten minutes

- the child is distressed or unable to talk

- the child is getting exhausted

- there are any doubts at all about the child's condition

If a doctor is not immediately available call an ambulance

Repeat doses of reliever as required (every few minutes, if necessary, until it takes effect)

Do not be afraid of causing a fuss. Doctors prefer to be called early so that they can alter the medication.

After the attack:

- minor attacks should not interrupt a child's concentration and involvement in school activities; normal activity should be encouraged as soon as the attack is over

Emergency Action:
Epilepsy - First Aid for all Seizures

- Ensure that the child is out of harm's way. Move the child only if there is danger from sharp or hot objects or electrical appliances. Observe these simple rules and let the seizure run its course

- Check the time the child starts to fit

- Cushion the head with something soft (a folded jacket would do) but do not try to restrain convulsive movements

- Do not try to put anything at all between the teeth

- Do not give anything to drink

- Loosen tight clothing around the neck, remembering that this could frighten a semi-conscious child and should be done with care

- Arrange for other children to be escorted from the area, if possible

- Call for an ambulance if:

  - a seizure shows no sign of stopping after a few minutes
  - a series of seizures take place without the individual properly regaining consciousness

- As soon as possible, turn the child onto his/her side in the semi-prone (recovery/unconscious) position, to aid breathing and general recovery. Wipe away saliva from around the mouth

- Be reassuring and supportive during the confused period which often follows this type of seizure. If rest is required, arrangements should be made for this purpose

- If there has been incontinence cover the child with a blanket to prevent embarrassment. Arrange to keep spare clothes at school if this is a regular occurrence

If a child is known to have epilepsy:

- It is not usually necessary for the child to be sent home following a seizure, but each child is different. If the Headteacher feels that the period of disorientation is prolonged, it might be wise to contact the parents. Ideally, a decision will be taken in consultation with the parents when the child's condition is first discussed, and a Healthcare Plan drawn up

- If the child is not known to have had a previous seizure medical attention should be sought

- If the child is known to have diabetes this seizure may be due to low blood sugar (a hypoglycaemic attack) in which case an ambulance should be summoned immediately

Emergency Action: Epilepsy

First Aid for Children Known to Have Epilepsy and Prescribed Rectal Diazepam

- Ensure that the child is out of harm's way. Move the child only if there is danger from sharp or hot objects or electrical appliances. Observe these simple rules and let the seizure run its course.
- Check the time the child starts to fit
- Cushion the head with something soft (a folded jacket would do) but do not try to restrain convulsive movements
- Do not try to put anything at all between the teeth
- Do not give anything to drink
- Loosen tight clothing around the neck, remembering that this could frighten a semi-conscious child and should be done with care
- Arrange for other children to be escorted from the area, if possible
- Rectal diazepam must only be given to a child with a prescription that a Consultant Paediatrician has endorsed and updated annually
- Rectal diazepam must only be administered in an emergency by an appropriately trained member of staff in the presence of at least one other member of staff
- Rectal diazepam must only be administered if a trained First Aider is on site
- If the child has been convulsing for five minutes and there is no suggestion of the convulsion abating, the first dose of rectal diazepam should be given. The medication should indicate the name of child, the date of birth, date of expiry, contents and the dosage to be administered
- If after a further five minutes

  (a) a seizure shows no sign of stopping or
  (b) a series of seizures takes place without the individual properly regaining consciousness, then call an ambulance

- As soon as possible, turn the child onto his/her side in the semi-prone (recovery/unconscious) position to aid breathing and general recovery. Wipe away saliva from around the mouth
- Be reassuring and supportive during the confused period which often follows this type of seizure. Many children sleep afterwards and if rest is required, arrangements could be made for this purpose
- If there has been incontinence cover the child with a blanket to prevent embarrassment. Arrange to keep spare clothes at school if this is a regular occurrence
- A child should be taken home after a fit if he/she feels ill

Appendix 9

Individual Care Plan for the Administration of Rectal Diazepam

This care plan should be completed by or in consultation with the medical practitioner

(Please use language appropriate to the lay person)

Details of Child and Condition	
Name:	Class:
Date of birth:	
Identify the seizure classification and/or description of seizures which may require rectal diazepam *(Record all details of seizures, for example goes stiff, falls, convulses down both sides of body, convulsions last 3 minutes etc. Include information re: triggers, recovery time etc. If in status epileptics, note whether it is convulsive, partial or absence)*	
Usual duration of seizure?	
Other useful information:	
Diazepam Treatment Plan	
When should rectal diazepam be administered? *(Note here should include whether it is after a certain length of time or number of seizures)*	

Initial dosage: how much rectal diazepam is given initially? *(Note recommended number of milligrams for this person*)
What are the usual reactions to rectal diazepam?
What action should be taken if there are difficulties in the administration of rectal diazepam *such as constipation/diarrhoea?*
Can a second dose of rectal diazepam be given? *Yes/No* If ***Yes***, after how long can a second dose of rectal diazepam be given? (*state the time to have elapsed before re-administration takes place)* How much rectal diazepam is given as a second dose? *(state the number of milligrams to be given and how many times this can be done after how long)*
When should the person's usual doctor be consulted?
When should 999 be dialled for emergency help? • if the full prescribed dose of rectal diazepam fails to control the seizure *Yes/No* • Other (Please give details)
Who Should: • administer the rectal diazepam? *(ideally someone should be trained in at least 'Emergency Aid,' preferably 'First Aid at Work'):* • witness the administration of rectal diazepam? *(this should normally be another member of staff of the same sex):*

Who/where needs to be informed?
Parent_____ Tel: _____
Prescribing Doctor:_____ Tel: _____
Other:_____ Tel: _____
Precautions: under what circumstances should rectal diazepam not be used? *(for example, Oral Diazepam already administered within the last…….minutes)*

All occasions when rectal diazepam is administered must be recorded on the "Record of Use of Rectal Diazepam" log sheet (Appendix 10)

This plan has been agreed by the following:

Prescribing Doctor

Name_____Signature_____Date_____

Authorised person(s) trained to administer rectal diazepam

Name_____Signature_____Date_____

Name_____Signature_____Date_____

Parent

Name_____Signature_____Date_____

Headteacher/Medical Coordinator

Name_____Signature_____Date_____

This form should be available at every medical review of the patient and copies held by the GP and the school.

Expiry date of this form:_____

Copy holders to be notified of any changes by: _____

Appendix 10

Record of Use of Rectal Diazepam

Name of Child:_____ **Class:**_____

Date:					
Recorded by:					
Type of seizure:					
Length and/or number of seizures:					
Initial dosage:					
Outcome:					
Second dosage (if any):					
Outcome:					
Observations:					
Parent informed:					
Prescribing doctor informed:					
Other information:					
Witness:					
Name of Parent re-supplying dosage:					
Date delivered to school:					