Woodlands Primary School

Medical Needs Policy

Policy for Supporting Pupils with Medical Needs in School

Status:	Current	
Date Adopted by Governing body:	10/07/2024	
Ratified by Governing Body:	10/07/2024	
Updated by Matthew Kitley	July 2024	
Review by Governing Body:	July 2026	2 years

Policy for Supporting Pupils with Medical Needs in School

Contents

1. Pupils with Medical Needs

There are many types of medical needs. In schools, the medical conditions in children, which most commonly cause concern, are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). Details of these conditions can be found in Annex A.
Pupils with medical needs fall into two main categories.

1.1. Short Term Medical Needs

These include children who need to take medication at school for some time during their school life. Mostly, this will be for a short period only; to finish a course of antibiotics or apply a lotion. Allowing pupils to do this will minimise the time they need to take off school. Medication should only be taken in school when absolutely necessary. Much medication can be prescribed in dose frequencies which enable it to be taken outside school hours, and parents will be encouraged to ask the prescribing doctor/dentist about this.

1.2. Long Term Medical Needs

The school will need to know about the details of these conditions either before the child starts school or immediately the condition develops. In these cases, the school will carry out a full risk assessment and then if safe to do so will draw up an individual health care plan in conjunction with the child's parents and relevant health professionals. This would also rely on a member of staff volunteering to carry out necessary administration of medicine or clinical procedures.

The school is committed, where possible, to include these pupils in school and to take necessary action to enable them to access a broad and balanced curriculum. However, staff are not required to administer medicine or to carry out clinical procedures. If a risk assessment allows, staff may volunteer but will only be taken up on this if the headteacher is willing and able to take responsibility for competency.

2. Responsibilities & Expectations

The Headteacher and school staff must treat all medical information confidentially. The Headteacher will agree with the parent or guardian who should have access to records and other information about a pupil.

2.1. Expectations of the Parents

- 2.1.1. Parents should supply the Headteacher with sufficient information about their child's medical condition and treatment, or special care needed at school.
- 2.1.2. They should, jointly with the head, reach agreement on the school's role in helping with their child's medical needs. Information regarding a child's health will be shared with other members of staff in order that the school can ensure the best care for a pupil. Parents are responsible for their child's medication and should ensure that they are disposed of, where necessary, and that medication is collected and checked at the end of each term.
- 2.1.3. Parents should keep their children at home when they are acutely unwell. Information regarding infectious diseases in school can be found in Annex B.

2.2. Expectations of the Governors

- 2.2.1. The Governors are responsible for ensuring that correct procedures are followed.
- 2.2.2. They should provide appropriate training for willing staff to enable them to support pupils with medical needs in school. This training should be arranged in conjunction with the Health Authority or other health professionals. The Governors must ensure that such training has given staff sufficient understanding, confidence and expertise, and a health care professional should confirm this proficiency.
- 2.2.3. The Governors must ensure that insurance arrangements provide full cover for staff acting within the scope of their employment.[1]

2.3. Expectations of the Headteacher

- 2.3.1. The Headteacher must implement the policy in practice and should maintain and

[1] This will normally be covered as part of the employer's public liability insurance. Governors must provide written confirmation of insurance cover for staff who provide specific medical support.

develop relevant procedures.

2.3.2. The Headteacher must ensure that staff who volunteer to support pupils with medical needs in school are given training and support, where necessary.

2.3.3. The Headteacher will be responsible for making the day to day decisions about administering medication.

2.3.4. The Headteacher must make sure that all parents are aware of the school's policy and procedures for dealing with medical needs.

2.3.5. In conjunction with parents, the Headteacher will agree what support the school can provide. If there are concerns regarding the school's ability to meet a child's needs following a risk assessment, the Headteacher will seek advice from the school nurse or doctor, the child's doctor or other health professionals.

2.4. Expectations of Teachers and Other School Staff

2.4.1. Staff should be aware of pupils with medical needs in school. They should understand the nature of the condition, and when and where pupils may need extra attention. This information should be provided by the child's parents and health professionals.

2.4.2. Staff should be aware of the likelihood of an emergency arising and what action to take if one occurs. Staff are expected to use their best endeavours at all times.[2]

2.4.3 Staff are not expected to administer medicine or to carry out clinical procedures. If a risk assessment allows, staff may volunteer but will only be taken up on this if the headteacher is able to take responsibility for competency

3. Medication in School

Before any medication can be administered, there must be prior written agreement from parents or guardians for any medication, prescribed or non-prescription, to be given to a child.

3.1. School Staff Giving Medication

3.1.1. Teachers' conditions of employment do not include giving medication or supervising a pupil taking it. Teachers who volunteer to undertake this role must first seek agreement from the Headteacher.

3.1.2. Any member of staff who does volunteer to accept responsibility for administering prescribed medication to a pupil should have proper training and guidance. He/she must also be aware of possible side effects and what to do if they occur.

3.2. Procedure for Administering Medication

The Headteacher accepts responsibility, in principle, for school staff giving or supervising children taking prescribed medication during the school day.

3.2.1. Any member of staff giving medicine to a pupil should check:

- ⇒ The pupil's name
- ⇒ Written instructions provided by parents or doctor
- ⇒ Prescribed dose
- ⇒ Expiry date

3.2.2. If there are doubts about any of the procedures, the member of staff should check with the parents or health professional before taking further action.

3.2.3. Staff should complete and sign a record each time they give medication to a pupil; this can be found as Annex C.

3.2.4. A child who refuses to take medication should not be forced to do so. The school should inform the child's parents as a matter of urgency. If necessary, the school should call the emergency services.

3.3. Non-Prescription Medication

The school will consider each case separately with a risk assessment but will not generally administer non prescription medicine without a doctor's letter.

3.4. Storage and Access to Medication in School

The Headteacher is responsible on a day to day basis for ensuring that medicines are stored safely. Medicines are generally stored in a secure place not accessible to pupils. Some medications may be harmful to anyone for whom they are not prescribed. Where the school agrees to administer this type

[2] In an emergency, generally, the consequences of taking no action are likely to be more serious than those of trying to assist.

of medication, the governors have a duty to ensure that the risks to the health of others are properly controlled.[3]

3.4.1. The school will not store large volumes of medication and parents may be asked to bring in a required dose each day.

3.4.2. Where the school does need to store medicines, the contained should be labelled with the following:

- ⇒ Name of pupil
- ⇒ Name and dose of the drug
- ⇒ Frequency of administration

3.4.3. If a child needs two or more prescribed medicines, each should be in a separate container.

3.4.4. Pupils should know where their medication is stored and how they may access it[4]. Asthma inhalers will be readily available to pupils and should be carried in a bumbag or stored in the teachers cupboard in clearly labelled containers and taken with the child when they leave the immediate vicinity of the classroom.

3.5. Disposal of Medicines

3.5.1. School staff should not dispose of medicines.

3.5.2. Parents should collect medicines held at school at the end of each term.

3.5.3. Parents are responsible for the disposal of date-expired medicines.

3.6. Hygiene/Infection Control

3.6.1. All staff should be familiar with normal precautions of avoiding infection and must follow basic hygiene procedures.

3.6.2. Staff should have access to disposable gloves and take particular care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment.[5]

3.7. Record Keeping

3.7.1. Parents are responsible for supplying information about medicines that their child needs to take at school, and for letting the school know of any changes to the prescription or the support needed. The parents or doctor should provide written details including:

- ⇒ Name of medication
- ⇒ Dose
- ⇒ Method of administration
- ⇒ Time and frequency of administration
- ⇒ Other treatment
- ⇒ Any side effects

Forms for recording these details can be found in Annex D.

4. School Visits

4.1. Where safety permits, the school will encourage pupils with medical needs to participate in school trips.

4.2. Additional safety measures for outside trips and arrangements for taking any necessary medication will need to be considered in advance.[6]

4.3. Staff supervising excursions must make themselves aware of any medical needs and relevant emergency procedures.

4.4. If staff are concerned about whether or not they can provide for a pupil's safety, or the safety of other pupils on a trip, they should refer the matter to the Headteacher.[7]

5. Sporting Activities

Most pupils with medical conditions can participate in extra-curricular sport or in the PE curriculum. The school supports the view that, for many, physical activity can benefit their overall social, mental and physical health and well-being.

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[3] This duty derives from the Control of Substances hazardous to Heath Regulations 1994 (COSHH)

[4] Medicines may be stored in a refrigerator containing food, but must be in an airtight container and clearly labelled. The school must then restrict access to a refrigerator holding medicines.

[5] Further guidance is available on the DfEE publication HIV and Aids: A Guide for the Education Service

[6] Staff must ensure that medication is taken on the visit – this includes the asthma inhaler wallet

[7] Further information on school trips can be found in the DFE circular 22/94 Safety in Outdoor Activity Centres

5.1. Any restrictions on a pupil's ability to participate in PE should be included on their individual health care plan.
5.2. Some pupils may need to take precautionary measures before or during exercise and/or need to be allowed immediate access to their medication. Teacher supervising sporting activities should be aware of relevant medical conditions and emergency procedures.

6. Staff Training

6.1.1. The Headteacher will ensure that staff are made aware of pupils with medical needs in school and that the Health Care Plans are discussed at regular intervals.[8]

6.1.2. The Headteacher & governors must ensure that staff who volunteer to support pupils with medical needs in school are given training, where necessary. This training should be arranged in conjunction with the Health Authority or other health professionals. The Governors must ensure that such training has given staff sufficient understanding, confidence and expertise, and a health care professional should confirm this proficiency.

6.1.3. School staff should never give medication without appropriate training from health professionals.

7. Health Care Plans

7.1. The main purpose of an individual health care plan for a pupil with medical needs is to identify the level of support that is needed at school. A written agreement with parents clarifies for staff, parents and the pupil the help that the school can provide and receive. Individual health care plans will be updated annually, or if the needs of the pupil change. A form for recording health care plans can be found as Annex E.

7.2. People contributing to the plan will include

- ⇒ The Headteacher
- ⇒ The parent of guardian
- ⇒ The child
- ⇒ The teachers and other staff
- ⇒ Any school staff who have agreed to administer medication or be trained in emergency procedures
- ⇒ The school health service, the child's GP to other health care professionals

7.3. The information will be coordinated and disseminated by The Special Education Needs Coordinator.[9] Lists of pupils with medical needs will be maintained by the school office and copies placed in the school registers. These will be updated termly.

8. Emergency Procedures

All staff should know how to call the emergency services and who is responsible for carrying out emergency procedures in the event of need. Guidance on calling an ambulance can be found in the emergency procedure cards available by the telephone in the school office. A copy can be found in Annex F

8.1. A pupil who is taken to hospital by ambulance should be accompanied by a member of staff who should remain until the pupil's parent arrives. This will generally be the Headteacher.

8.2. Staff should not take a pupil to hospital in their own vehicle.

8.3. In a non-emergency situation, where a child is being taken for medical treatment for eg at a local GP practice, a second adult must accompany the driver.[10]

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[8] 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

[9] Staff will need to make supply teachers aware of pupils with medical needs in their class.

[10] The driver of the vehicle must ensure that he/she is covered by public liability vehicle insurance.

Annex A
Asthma, epilepsy, diabetes and anaphylaxis – common concerns

ASTHMA
What is Asthma?
People with asthma have airways which narrow as a reaction to various triggers. The triggers vary between individuals but common ones include viral infections, cold air, grass pollen, animal fur and house dust mites. Exercise and stress can also precipitate asthma attacks in susceptible people. The narrowing or obstruction of the airways causes difficulty in breathing and can be alleviated with treatment.

Asthma attacks are characterised by coughing, wheeziness and difficulty in breathing, especially breathing out. The affected person may be distressed and anxious and, in severe attacks, the pupils skin and lips may become blue.

About one in seven children has asthma diagnosed at some time and about one in twenty children have asthma which requires regular medical supervision.

Medication and Control

We keep 2 emergency inhalers in school – one in the main school office and another in the Y5/Y6 medical cabinet. Emergency inhalers can only be used for/by a pupil who is on the school Asthma Register. A school First Aider would need to be present during the use of an emergency inhaler. After this the school inhaler would be sterilized.

There are several medications used to treat asthma. Some are for long term prevention and are normally used out of school hours and others relieve symptoms when they occur (although these may also prevent symptoms if they are used in anticipation of a trigger, e.g. exercise).

Most pupils with asthma will relieve their symptoms with medication using an inhaler. It is good practice to allow children with asthma to take charge of and use their inhaler from an early age, and many do.

A small number of children, particularly the younger ones, may use a spacer device with their inhaler with which they may need help. In a few severe cases, children use an electrically powered nebulizer to deliver their asthma medication.

Each pupil's needs and the amount of assistance they require will differ.

Children with asthma must have immediate access to their reliever inhalers when they need them. Pupils who are able to use their inhalers themselves should usually be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the pupil's name. Inhalers should also be available during physical education and sports activities or school trips.

It is helpful if parents provide schools with a spare inhaler for their child's use in case the inhaler is left at home accidentally or runs out. Spare reliever inhalers must be clearly labelled with the pupil's name and stored safely.

The medication of any individual pupil with asthma will not necessarily be the same as the medication of another pupil with the same condition. Although major side effects are extremely uncommon for the most frequently used asthma medications, they do exist and may sometimes be made more severe if the pupil is taking other medication.

Pupils should not take medication which has been prescribed for another pupil. If a pupil took a puff of another pupil's inhaler there are unlikely to be serious adverse effects. However, schools should take appropriate disciplinary action if inhalers are misused by the owner or other pupils.

Pupils with asthma should be encouraged to participate as fully as possible in all aspects of school life, although special consideration may be needed before undertaking some activities. They must be allowed to take their reliever inhaler with them on all off-site activities. Physical activity will benefit pupils with asthma in the same way as other pupils. They may, however, need to take precautionary measures and use their reliever inhaler before any physical exertion. Pupils with asthma should be encouraged to undertake warm up exercises before rushing into sudden activity especially when the weather is cold. They should not be forced to take part if they feel unwell.

The health care plan should identify the severity of a pupil's asthma, individual symptoms and any particular triggers, such as exercise or cold air.

If a pupil is having an asthma attack, the person in charge should prompt them to use their reliever inhaler if they are not already doing so. It is also good practice to reassure and comfort them whilst, at the same time, encouraging them to breathe slowly and deeply. The person in charge should not put his/her arm around the pupil, as they may restrict breathing. The pupil should sit rather than lie down. If the medication has had no effect after 5-10 minutes, or if the pupil appears very distressed, is unable to talk and is becoming exhausted, then medical advice must be sought and/or an ambulance called.

EPILEPSY

What is Epilepsy?

People with epilepsy have recurrent seizures, the great majority of which can be controlled by medication. Around one in 130 children in the UK has epilepsy and about 80% of them attend mainstream schools. Parents may be reluctant to disclose their child's epilepsy to the school. A positive school policy will encourage them to do so and will ensure that both the pupil and school staff are given adequate support.

Not all pupils with epilepsy experience major seizure (commonly called fits). For those who do, the nature, frequency and severity of the seizure will vary greatly between individuals. Some may exhibit unusual behaviour (for example, plucking at clothes, or repetitive movements), experience strange sensations, or become confused instead of, or as well as, experiencing convulsions and/or loss of consciousness.

Seizures may be partial (where consciousness is not necessarily lost, but may be affected), or generalised (where consciousness is lost). An example of some types of generalised seizures are:-

- **Tonic Clonic Seizures**
  During the tonic phase of a tonic clonic seizure the muscles become rigid and the person usually falls to the ground. Incontinence may occur. The pupil's pallor may change to a dusky blue colour. Breathing may be laboured during the seizure. During the clonic phase of the seizure there will be rhythmic movements of the body which will gradually cease. Some pupils only experience the tonic phase and others only the clonic phase. The pupil may feel confused for several minutes after a seizure. Recovery time can vary - some require a few seconds, where others need to sleep for several hours.

- **Absence Seizures**
  These are short periods of staring, or blanking out and are non-convulsive generalised seizures. They last only a few seconds and are most often seen in children. A pupil having this kind of seizure is momentarily completely unaware of anyone/thing around him/her, but quickly returns to full consciousness without falling or loss of muscle control. These seizures are so brief that the person may not notice that anything has happened. Parents and teachers may think that the pupil is being inattentive or is day dreaming.

- **Partial Seizures**
  Partial seizures are those in which the epileptic activity is limited to a particular area of the brain.

- **Simple Partial Seizures (when consciousness is not impaired)**
  This seizure may be presented in a variety of ways depending on where in the brain the epileptic activity is occurring.

- **Complex Partial Seizures (when consciousness is impaired)**
  This is the most common type of partial seizure. During a temporal lobe complex partial seizure the person will experience some alteration in consciousness. They may be dazed, confused and detached from their surroundings. They may exhibit what appears to be strange behaviour, such as plucking at their clothes, smacking their lips or searching for an object.

Medication and Control

The symptoms of most children with epilepsy are well controlled by modern medication and seizures are unlikely during the school day. The majority of children with epilepsy suffer fits for no known cause, although tiredness and/or stress can sometimes affect a pupil's susceptibility. Flashing or flickering lights, video games and computer graphics, and certain geometric shapes or patterns can be a trigger for seizures in some pupils. Screens and/or different methods of lighting can be used to enable photosensitive pupils to work safely on computers and watch TVs. Parents should be encouraged to tell schools of likely triggers so that action can be taken to minimise exposure to them.

Pupils with epilepsy must not be unnecessarily excluded from any school activity. Extra care and supervision may be needed to ensure their safety in some activities such as swimming or working in science laboratories. Off-site activities may need additional planning, particularly overnight stays. Concern about any potential risks should be discussed with pupils and their parents, and if necessary, seeking additional advice from the GP, paediatrician or school nurse/doctor.

Some children with tonic clonic seizures can be vulnerable to consecutive fits which, if left uncontrolled, can result in permanent damage. These children are usually prescribed Diazepam for rectal administration. Teachers may naturally be concerned about agreeing to undertake such an intimate procedure and it is important that proper training and guidance is given. For advice on intimate/invasive treatment see Chapter 4. Diazepam causes drowsiness so pupils may need some time to recover after its administration. For information on the administration of rectal Diazepam see Form 7.

When drawing up health plans, parents should be encouraged to tell schools about the type and duration of seizures their child has, so that appropriate safety measures can be identified and put in place.

Nothing must be done to stop or alter the course of a seizure once it has begun except when medication is being given by appropriately trained staff. The pupil should not be moved unless he or she is in a dangerous place, although something soft can be placed under his or her head. The pupil's airway must be maintained at all times. The pupil

should not be restrained and there should be no attempt to put anything into the mouth. Once the convulsion has stopped, the pupil should be turned on his or her side and put into recovery position. Someone should stay with the pupil until he or she recovers and re-orientates.

Call an ambulance if the seizure lasts longer then usual or if one seizure follows another without the person regaining consciousness, or where there is any doubt.

DIABETES

What is Diabetes?

Diabetes is a condition where the person's normal hormonal mechanisms do not control their blood sugar levels. About one in 700 school-age children has diabetes. Children with diabetes normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly.

Medication and Control

The diabetes of the majority of school-aged children is controlled by two injections of insulin each day. It is unlikely that these will need to be given during school hours. Most children can do their own injections from a very early age and may simply need supervision if very young, and also a suitable, private place to carry it out.

Children with diabetes need to ensure that their blood glucose levels remain stable and may monitor their levels using a testing machine at regular intervals. They may need to do this during the school lunch break or more regularly if their insulin needs adjusting. Most pupils will be able to do this themselves and will simply need a suitable place to do so.

Pupils with diabetes must 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. If a meal or snack is missed, or after strenuous activity, the pupil may experience a hypoglycaemia episode (a hypo) during which his or her blood sugar level falls to too low a level. Staff in charge of physical education classes or other physical activity sessions should be aware of the need for pupils with diabetes to have glucose tablets or a sugary drink to hand.

Hypoglycaemic Reaction

Staff should be aware that the following symptoms, either individually or combined, may be indicators of a hypo in a pupil with diabetes:

- Hunger
- Sweating
- Drowsiness
- Pallor
- Glazed eyes
- Shaking
- Lack of concentration
- Irritability

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

If a pupil has a hypo, it is important that a fast acting sugar, such as glucose tablets, a glucose rich gel, a sugary drink or a chocolate bar, is given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the pupil has recovered, some 10-15 minutes later. If the pupil's recovery takes longer, or in cases of uncertainty, call an ambulance.

Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and schools will naturally wish to draw any such signs to the parents' attention.

ANAPHYLAXIS

What is Anaphylaxis?

Anaphylaxis is an extreme allergic reaction requiring urgent medical treatment. When such severe allergies are diagnosed, the children concerned are made aware from a very early age of what they can and cannot eat and drink and, in the majority of cases, they go through the whole of their school lives without incident. The most common cause is food - in particular nuts, fish, dairy products. Wasp and bee stings can also cause allergic reaction. In its most severe form the condition can be life-threatening, but it can be treated with medication. This may include antihistamine, adrenaline inhaler or adrenaline injection, depending on the severity of the reaction.

Medication and Control

In the most severe cases of anaphylaxis, people are normally prescribed a device for injecting adrenaline. The device looks like a fountain pen and is pre-loaded with the correct dose of adrenaline and is normally injected into the fleshy part of the thigh. The needle is not revealed and the injection is easy to administer. It is not possible to give too large a dose using this device. In cases of doubt it is better to give the injection than to hold back. Responsibility for giving the injection should be on a purely voluntary basis and should not, in any case, be undertaken without training from an appropriate health professional.

For some children, the timing of the injection may be crucial. This needs to be clear in the health care plan and suitable procedures put in place so that swift action can be taken in an emergency.

The pupil may be old enough to carry his or her own medication but if not, a suitable safe yet accessible place for storage should be found. The safety of other pupils should also be taken into account. If a pupil is likely to suffer a severe allergic reaction all staff should be aware of the condition and know who is responsible for administering the emergency treatment.

Parents will often ask for the school to ensure that their child does not come into contact with the allergen. This is not always feasible, although schools should bear in mind the risk to such pupils at break and lunch times and in cookery, food technology and science classes and seek to minimise the risks whenever possible. It may also be necessary to take precautionary measures on outdoor activity or school trips.

Allergic Reactions

Symptoms and signs will normally appear within seconds or minutes after exposure to the allergen. These may include:

- A metallic taste or itching in the mouth
- Swelling of the face, throat, tongue and lips
- Difficulty in swallowing
- Flushed complexion
- Abdominal cramps and nausea
- A rise in heart rate
- Collapse or unconsciousness
- Wheezing or difficulty breathing

Each pupil's symptoms and allergens will vary and will need to be discussed when drawing up the health care plan.

Call an ambulance immediately particularly if there is any doubt about the severity of the reaction or if the pupil does not respond to the medication.

Annex B
Infectious diseases
Guidance on infection control in schools from the Department of Health
To minimise the risk of transmission of infection to other children and staff:

RASHES AND SKIN	Recommended period of time to be kept away from school (once child is well)	Comments
Athletes foot	None	
Chickenpox	For five days from onset of rash	It is not necessary to wait until spots have healed or crusted.
Cold sores (Herpes simplex virus)	None	Many healthy children and adults excrete this virus at some time without have a 'sore'
German measles (rubella)	Five days from onset of rash	The child is most infectious before the diagnosis is made and most children should be immune due to immunisation so that exclusion after the rash appears will prevent very few cases.
Hand, foot and mouth disease	None	Usually a mild disease not justifying time off school
Impetigo	Until lesions are crusted and healed	Antibiotic treatment by mouth may speed healing. If lesions can reliably be kept covered exclusion may be shortened.
Measles	Five days from onset of rash	Measles is now rare in the UK
Molluscum contagiosum	None	A mild condition
Ringworm (Tinea)	None	Proper treatment by the GP is important. Scalp ringworm needs treatment with an antifungal by mouth
Roseola	None	A mild illness, usually caught from well persons
Scabies	Until treated	Outbreaks have occasionally occurred in schools and nurseries. Child can return as soon as properly treated. This should include all the persons in the household.
Scarlet Fever	Five days from commencing antibiotics	Treatment recommended for the affected child
Slapped cheek or Fifth disease (Parvovirus)	None	Exclusion is ineffective as nearly all transmission takes place before the child becomes unwell.
Warts and verrucae	None	Affected children may go swimming but verrucae should be covered

DIARRHOEA AND VOMITING ILLNESS	Recommended period to be kept away from school (once child is well)	Comments
Diarrhoea and/or vomiting (with or without specified diagnosis)	Until diarrhoea and vomiting has settled (neither for the previous 24 hours)	Usually there will be no specific diagnosis and for most conditions there is no specific treatment. A longer period of exclusion may be appropriate for children under age 5 and older children unable to maintain good personal hygiene
E.coli and Haemolytic Uraemic Syndrome	Depends on the type of E.coli seek FURTHER ADVICE from the Consultant in Communicable Disease Control (CCDC)	
Giardiasis	Until diarrhoea has settled (neither for the previous 24 hours)	There is a specific antibiotic treatment
Salmonella	Until diarrhoea and vomiting has settled (neither for the previous 24 hours)	If the child is under five years or has difficulty in personal hygiene, seek advice from the
Shigella (Bacillary dysentery)	Until diarrhoea has settled (neither for the previous 24 hours	If the child is under five years or has difficulty in personal hygiene, seek advice from the CCDC

RESPIRATORY	Recommended period to be kept away from school (once	Comments

	child is well)	
Flu (influenza)	None	Flu is most infectious just before and at the onset of symptoms
Tuberculosis	CCDC will advise on action	Generally requires quite prolonged, close contact for spread. Not usually spread from children
Whooping cough (pertussis)	Five days from commencing antibiotic treatment	Treatment (usually with erythromycin) is recommended though non-infectious coughing may continue for many weeks

Others	Recommended period to be kept away from school (once child is well)	Comments
Conjunctivitis	None	If an outbreak occurs consult Consultant in Communicable Disease Control
Glandular fever	None	
Head lice (nits)	None	Treatment is recommended only in cases where live lice have definitely been seen.
Hepatitis A		There is no justification for exclusion of well older children with good hygiene who will have been much more infectious prior to the diagnosis. Exclusion is justified for five days from the onset of jaundice or stools going pale for the under fives or where hygiene is poor.
Meningococcal meningitis/ septicaemia	The CCDC will give specific advice on any action needed	There is no reason to exclude from schools siblings and other close contacts of a case
Meningitis not due to Meningococcal infection	None	Once a child is well infection risk is minimal
Mumps	Five days from onset of swollen glands	The child is most infectious before the diagnosis is made and most children should be immune due to immunisation.
Threadworms	None	Transmission is uncommon in schools but treatment is recommend for the child and family
Tonsilitis	None	There are many causes, but most cases are due to viruses and do not need an antibiotic. For one cause, streptococcal infection, antibiotic treatment is recommended.

HIV/AIDS	HIV is not infectious through casual contact. There have been no recorded cases of spread within a school or nursery.

HEPATITIS B AND C	Although more infectious than HIV, hepatitis B and C have only rarely spread within a school setting. Universal precautions will minimise any possible danger of spread of both hepatitis B and C.

HANDS-WASHING AND GOOD HYGIENE PROCEDURES

- Effective hand-washing is an important method of controlling the spread of infections, especially those that cause diarrhoea and vomiting.
- Always wash hands after using the toilet and before eating or handling food using warm, running water and a mild, preferably liquid soap. Toilets must be kept clean.
- Rub hands together vigorously until a soapy lather appears and continue for at least 15 seconds ensuring all surfaces of the hands are covered.
- Rinse hands under warm running water and dry hands with a hand dryer or clean towel (preferably paper).
- Discard disposable towels in a bin. Bins with foot-pedal operated lids are preferable.
- Encourage use of handkerchiefs when coughing and sneezing.
- If a food handler has diarrhoea or vomiting the CCDC's advice should be sought urgently.

CLEANING UP BODY FLUID SPILLS - UNIVERSAL PRECAUTIONS

- Spills of body fluids: Blood, faeces, nasal and eye discharges, saliva and vomit must be cleaned up immediately.
- Wear disposable gloves. Be careful not to get any of the fluid you are cleaning up in your eyes, nose mouth or any open sores you may have.

- Clean and disinfect any surfaces on which body fluids have been spilled. An effective disinfectant solution is household bleach solution diluted 1 in 10 but it must be used carefully.
- Discard fluid-contaminated material in a plastic bag along with the disposable gloves. The bag must be securely sealed and disposed of according to local guidance.
- Mops used to clean up body fluids should be cleaned in a cleaning equipment sink (not a kitchen sink), rinsed with a disinfecting solution and dried.
- Ensure contaminated clothing is hot laundered (minimum 60ºC).

Annex C

REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

The school will not give your child medicine unless you complete this form and the Headteacher has agreed that the school staff can administer the medication.

DETAILS OF PUPIL

Surname	
Forename	
Address	
Date of Birth	
Class	
Condition/Illness	

MEDICATION

Name/Type of Medication	
How long will you take this medication?	
Date dispensed	
Dosage and method	
Timing	
Special precautions	
Side effects	
Can your child take this medication him/herself?	
Procedures to take in an emergency	Contact parent or …….

CONTACT DETAILS

I understand I must deliver the medication personally to the Headteacher/Office and accept this is a service which the school is not obliged to undertake

Name:_____ **Daytime Telephone Number**: _____

Signed: _____ **Date**: _____ **Relationship to pupil**: _____

Record of Medication Administered In School

Name of Pupil: _____

Date	Time	Medication Given	Dose Given	Signature	Witnessed By

Risk Assessment

Health Care Needs Risk Assessment (Form 4) - STRICTLY CONFIDENTIAL

Child Name:	Date of Birth:
Class Teacher:	Year Group:
Health Representative:	
Professionals involved in this Risk Assessment (i.e. Specialist Nurse or Community Children's nurse, Physiotherapist, OT, (community) Paediatrician):	
Date of Assessment:	
Previous assessment date:	
Reassessment due:	
Is an individual health care plan (HCP) required? Yes/No	
Signatures Head teacher: Parents: Other professionals involved in completing the assessment:	
Section A - Pupil Information Profile	
Health Care Needs / Disability:	
Comments / Areas of Concern including ability to participate in activities such as PE / Practical lessons:	
Is the condition chronic / progressive / life limiting / life threatening? (Please circle if appropriate)	

Does the pupil have any medication which may need to be administered by school staff (not covered by the schools Administration of Medication Policy)? Yes / No

If so, please identify including times of administration and any special instructions, risks or hazards to the child or staff administering. Risks / Control measures indentified will require action to resolve and may result in a HCP.

If the child has medication where will the medication be stored?

Is this location locked? Yes / No

Is this location readily accessible at all times if medication is required? Yes / No
Explain:

Where will administration of the medication be recorded and by whom?

Please note any concerns re: the administration of medication including route, timing, any possible side effects or indications to not administer:

Section B - Airway and Breathing

Does the pupil have any problems in this area? Yes / No (If No go to next section)

Does the pupil require support to maintain their own airway?

Never Sometimes At all times

Support Required: (Circle all applicable)

Suction:

Oxygen: Emergency only Continuous (?) Dependant

Ventilation:

Tracheostomy:

Basic Life Support: (Circle all applicable)

Nebuliser: Regular Occasional

Inhalers: Regular Emergency

Does it interfere with any of these activities? (Circle all applicable)

Science Swimming Indoor PE Outdoor PE Outdoor activity Transport

Does the pupil have any allergies? Yes / No

Please give details:

Section C - Cardiovascular
Is the pupil known to have any heart or circulatory problems? Yes / No (If No go to next section)
Does the child have medication or technology based support for their cardiovascular problems? Yes / No Please give details:
Do the child's problems affect bleeding / clotting? Yes / No Please give details:
Are there any activities which may need to be modified or monitored to ensure this child's safety? Yes / No Please give details:

Section D - Neurological

Is the pupil known to have any neurological problems (i.e. seizures, brain injury or damage, neurological disorder or syndrome) Yes / No (If No go to the next section)

Does the child have history of seizures?

Never Occasional Frequent

Please identify type and frequency of seizure including date of last seizure?

Does the child have medication or treatment related to this problem (including rescue medication)? Yes / No
If so please complete section K - Medication.

Are there any warning signs or triggers for a seizure for this child? Yes / No
Please explain:

Following a seizure what is the child's usual recovery pattern?

Does the child have any other symptoms or problems (i.e. slurred speech, numbness or loss of sensation, ataxic gait,) Yes / No
Please give details:

Section E - Gastrointestinal problems and Feeding needs

Does the pupil have any gastrointestinal or feeding problems? Yes / No

(if No go to the next section)

Is the child able to feed and drink adequate quantities orally? Yes / No
Please explain:

Does the pupil require any help with eating or drinking (including use of thickening agents or supplements)? Yes / No
Please explain:

Is there a risk of the child choking?

Never Occasional Frequent

Does the child have a NG, PEG or gastrostomy button? Yes / No (Please circle all which apply)

If Yes which does the pupil require: (Please circle all which apply)

Liquids Feeding Medication

If so are they administered by bolus or feeding pump? (Please circle)

Please identify medications related to gastrointestinal problems and also any medications administered enterally with relevant information re: administration in section K – Medication.

Does the pupil have any gut disturbances such as vomiting / diarrhoea / constipation / passing blood? (Please circle all which apply) Yes / No
Please explain:

Does the pupil have a colostomy or ileostomy? Yes / No
Please explain:

Does the pupil have any known food allergies? Yes / No
If yes please give details of foods and reactions:

Does the pupil have any medication which may need to be administered? If so please complete section K – Medication.

F - Urinary and Renal Needs

Does the pupil require intervention in order to pass urine (i.e. indwelling catheter, suprapubic catheterisation or intermittent catheterisation or Mitrofanoff)? Yes / No
Please explain:

Does the pupil have other urinary problems which require monitoring (i.e. Diabetes Insipidis)? Yes / No
Please explain:

If medication to be administered please complete section A.

Section G - Infection Control / maintaining skin integrity

Is there an action which needs to be taken to maintain the safety of the child or others around the child? Yes / No (if No then go on to the next section)

Is the child particularly at risk of infection due to low immunity from immune disorder or treatment which has affected the immune system? Yes / No
Please explain:

Is the pupil known to have an infection or been in recent contact with anyone with an infectious condition (i.e. MRSA, HIV, Hepatitis, Chicken Pox, Tuberculosis, Meningitis, Clostridium Dificile)? Yes / No
Please list:

Does the pupil have any skin conditions which require treatment or management? (i.e. eczema, psoriasis, pressure areas, rashes) Yes / No
Please list:

Does the pupil have medications that need to be administered? Yes / No

If so please complete Section K - Medication.

Section H - Communication
What is the child's usual method of communication?
Does the child have any signs or gestures that are important for their safety and wellbeing?
Is the pupil generally cooperative? Yes / No If No please explain:
How does the pupil learning disability effect their communication? Please explain:
Section I- Mobility and transferring
Does this child have a handling plan which addresses their handling needs during the administration of medication or treatment? Yes / No If no, the manual handling plan needs to be updated to include this risk.
Section J - Pain
Does the pupil have any chronic pain that is controlled with medication or any other intervention?
Does the pupil appear to be in pain? Yes / No

Risk Scoring

Using the Australia/New Zealand (AS/NZS 4360/1999) risk management standard, which is internationally recognised, a summary of the potential 'grades' of risk issues, based on the risk score, is given below:

Grade	Definition	Risk Score
RED	Extereme Risk	15-25
AMBER	High Risk	8-12
YELLOW	Moderate Risk	4-6
GREEN	Low Risk	1-3

The table represents the possible combined risk scores based on a measurmenet of both the probability and impact of risk issues. A combination of likelihood and severit score provides the combine **risk score**.

Probability x Impact = Risk Score

For example where: Probability = Possible (3) x Impact = Major (4) **= Risk Score of 12**

This risk score can now be compared to the risk matrix above and a 'colour' or 'grade' can be determined. In the example above, a risk score of 12 would be graded as 'amber' (moderate). Consequentally, the employer can then prioritise mitigation actions based on an understanding of the nature of the risk presented.

Risk Scoring Matrices

Probability Matrix

Probability Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen	Do not expect it to happen but it is possible it may do so	Might happen occasionally	Will probably happen but it is not a persisting issue	Will undoubtedly happen, possibly frequently
Frequency Time-frame	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Frequency Will it happen or not?	<0.1%	0.1 to 1%	1 to 10%	10 to 50%	>50%

Impact Matrix

Impact Score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of client, staff or public (physical / psychological harm)	Minimal injury requiring no / minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days RIDDOR/agency reportable incident	Major injury leading to long-term incapacity / disability Requiring time off work for >14 days	Incident leading to death Multiple permanent injuries or irreversible health effects

Assessment Summary

Hazard and possible impacts	Who or what is at risk?	Existing controls in place	Risk Rating Red / Amber / Yellow / Green	Additional controls required	Any action points Including training needs?	Action point lead person

WOODLANDS PRIMARY SCHOOL

Annex F

EMERGENCY PLANNING
REQUEST AN AMBULANCE

Dial 999 and be ready with the following information:

2. Your telephone number

3. Give your location as follows:

WOODLANDS PRIMARY SCHOOL
WINDING WAY
SALISBURY
SP2 9DY

4. Give your name

5. Give the pupil's name and date of birth (or age)

6. Give a brief description of the pupil's symptoms

7. Collect child's medical card from their file in locked cupboard

8. Entrance - they should enter the school via the emergency gates, which will be open for them with a member of staff directing

REMEMBER TO SPEAK CLEARLY AND SLOWLY AND BE READY TO REPEAT INFORMATION IF REQUIRED

WOODLANDS PRIMARY SCHOOL

Annex H

Useful Contacts and Helpless

Action for Sick Children
Argyle House
29-31 Euston Road
London NW1 2SD
0171 833 2041

Action for ME and Chronic Fatigue
PO Box 1302
Wells
BA5 2WE
0891 122976

The Anaphylaxis Campaign
PO Box 149
Fleet Hampshire
GU13 9XU
01252 318723

British Diabetic Foundation
10 Queen Anne Street
London
W1M 0BD
Helpline 0171 636 6112

British Epilepsy Association
Anstey House
40 Hanover Square
leeds
LS5 1BE
Helpline 0800 309030

Cancerlink
17 Britannia Street
London
WC1X 9JN

Cystic Fibrosis Trust
Alexandra House
5 Blyth Road
Bromley
Kent
BR1 3RS
0181 464 7211

Hyperactivity Children's Support Group
71 Whyke Lane
Chichester
West Sussex
PO19 2LD
01903 725182

MENCAP
117-123 Golden Lane
London
EC1Y 0RT
0171 454 0454

National Asthma Campaign
Providence House
Providence Place
London
N1 0NT
0345 010203

National Eczema Society
163 Eversholt Street
London
NW1 1BU
0171 388 4097

SCOPE
The Cerebral Palsy Helpline
PO Box 833
Milton Keynes
MK13 6DR
0800 626216