Every Child Matters Academy Trust
Managing Medical Needs and Infection Control in Schools and Child Care Settings

Managing Medical Needs and Infection Control in Schools and Child Care Settings

The following gives guidance on the strategy for managing medicines, medical needs and dealing with infections within the workplace/school setting. Annual Care plans need to be completed by the individual services/schools working with Children and Young People and Families.

Individual services have put a copy of the relevant care plans in their information section within the document.

Where appropriate a copy of the care plan should be held in school or child care setting. This is to enable school staff to be aware of any signs and symptoms a child may have and the correct procedure to deal with these if required.

This policy has been developed by BMBC and, as the Trust's Health and Safety Advisors, it has been adopted from BMBC. This policy will be reviewed in the Spring term 2027 or sooner if advised of any changes by BMBC's Health and Safety department.

Approved by the Resources Committee on 10th March 2026.

Signed: Chair_____ CEO_____

This guidance consists of:

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What are the arrangements for Managing Medical Needs in Schools and Settings?

Management of medical needs refers to the arrangements and provisions made for pupils

1. Introduction

who have conditions, illnesses, infections and/or disabilities which may require action on behalf of the school either through the provision of information and guidance or emergency/intermediary treatment to deal with medical issues.

Each school or setting needs to determine what their school arrangements are in terms of making adjustments in the premises and work activities to cater for pupils with medical needs, administration of medicines, identifying and dealing with infectious diseases and providing emergency intermediary treatment to deal with medical issues.

What are the risks?

Failure to have arrangements in place for the management of medicines could result in a serious medical emergency, increased spread of infection, increased danger to vulnerable pupils and others affected by their actions and/or a misadministration of medicine.

Existing regulations

In general the Health and Safety at Work etc Act 1974 places a duty upon the employer to ensure the health, safety and welfare of persons not in their employment but may be affected by their work activities.

Under part 4 of the Disability Discrimination Act (DDA) 1995, responsible bodies for schools (including nursery schools), must not discriminate against disabled pupils in relation to their access to education and associated services – a broad term that covers all aspects of school life including school trips, clubs and activities.

The National Curriculum Inclusion Statement 2000 emphasises the importance of providing effective learning opportunities for all pupils in terms of:

- Setting suitable learning challenges
- Responding to pupils' diverse needs
- Overcoming potential barriers to learning

2. Responsibilities

First and foremost, the Headteacher will make it clear to parents that they are responsible for ensuring their child is well enough to attend school. If a child is acutely unwell they must be kept at home.

Administration of Medicines

There is no legal duty that requires staff to administer medicines. However, anyone caring for children including teachers, other school staff and day care staff in charge of children, has a common law duty of care to act like any reasonable prudent parent. Staff need to make sure that children are healthy and safe. In exceptional circumstances, the duty of care could extend to administering medicine and/or taking action in the event of an emergency. This duty extends to staff leading activities taking place off site such as visits, outings or field trips.

Where the Headteacher authorises the administration of prescription medicines in school, the advice in arrangement 1 should be followed.

Where the Headteacher authorises the administration of non-prescription medicines in school, the advice in arrangement 2 should be followed.

Should the Headteacher decide that prescribed medicines ***shall not*** be administered to any pupil under any circumstances by school staff; the Headteacher *will communicate this to parents/carers*. Where it is essential that medication is taken during the school day, parents/carers will be expected to come into school to administer the medicine to their child.

Appendix 1 contains advice and information cards on common medical problems experienced in schools and child care settings which must be implemented by the school when the Headteacher feels that it is necessary and appropriate to the needs of their pupils.

The information contained in each section is intended to provide an overview of the medical condition and to provide information which is felt useful and relevant for the school setting. However, it is not exhaustive and therefore, links have been provided to relevant websites and organisations who can provide more extensive information and support in dealing with medical issues. This information may be useful when formulating individual Health Care Plans (see below).

Self Administration

It is good practice to support and encourage children, who are able, to take responsibility to manage their own medicines from a relatively early age. The age at which children are ready to take care of, and be responsible for, their own medicines, varies. As children grow and develop they should be encouraged to participate in decisions about their medicines and to take responsibility.

Older children with a long-term illness should, whenever possible, assume complete responsibility under the supervision of their parent. Health professionals need to assess, with parents and children, the appropriate time to make this transition.

If children can take their medicines themselves, staff may only need to supervise. The health care plan should say whether children may carry, and administer (where appropriate), their own medicines, bearing in mind the safety of other children and medical advice from the prescriber in respect of the individual child.
Where pupils, parents and Headteachers deem it appropriate for the pupil to self-administer medicines, consent form AM2 should be completed.

Storage of Medicines

Medicines will be stored strictly in accordance with product instructions paying particular note to temperature and the original container in which dispensed. Never transfer medicines from their original containers.

Staff will ensure that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine, the method and frequency of administration, the time of administration, and side effects and the expiry date.

Where a child needs two or more prescribed medicines, each will be in a separate container.

Children will be informed where their own medicines are stored and who holds the key.

All emergency medicines such as asthma inhalers and adrenaline pens will be readily available to children and will not be locked away. The Headteacher should determine whether pupils can carry their own inhalers and communicate this to parents/carers and employees. This should also be documented in individual health care plans.

Other non-emergency medicines will be kept in a secure place not accessible to children.

A few medicines need to be refrigerated. They can be kept in a refrigerator containing food but must be kept in an airtight container and clearly labelled. There will be restricted access to a refrigerator holding medicines. It is acceptable for a staff room fridge to be used as storage as long as medical items are clearly labelled.

The school/setting will make special access to emergency medicine that it keeps. However, it is also important to make sure that medicines are kept securely and only accessible to those for whom they are prescribed.

Disposal of Medicines

Staff should not dispose of medicines. Parents/carers are responsible for ensuring that date-expired medicines are returned to the pharmacy for safe disposal. They will be asked to collect them at the end of each term. If medicines aren't collected they will be taken to a local pharmacy for safe disposal.

Sharps boxes will always be used for the disposal of needles. Collection and disposal should be arranged with the clinical waste disposal contractor (e.g. Cannon Hygiene) or the Local Authority.

Individual Health Care Plans

Parents/carers have the prime responsibility for their child's health and should provide schools and settings with detailed information about their child's medical condition.

Individual health care plans must be amended to include reference to oral medication if administration is required for a period of eight days or more.

Individual health care plans need to include any restrictions on a child's ability to participate in school activities such as PE/ cooking.

Consideration must be given to who it is necessary to issue Health Care Plans to such as:

- Class Teachers
- SMSAs
- School transport escorts
- Those taking school visits and journeys

Form AM5 contains a template General Individual Health Care Plan which should be completed for children who have a known medical condition which the school needs to have detailed information about. The medical needs action cards may also include a specific Health Care Plan for certain medical conditions which the Headteacher may prefer to use.

Additionally, for those pupils who have a medical need which may impede their ability to safely evacuate the premises in the event of an emergency, a Personal Emergency Evacuation Plan (PEEP) may need to be developed and implemented.

Infection Control Arrangements

Each school should have a copy of and display the Health Protection Agency (HPA) guidance on infection control in schools and other childcare settings. It gives guidance on the most common infectious diseases and the recommended action to take in the event of an outbreak occurring. This document can be downloaded from the HPA website using the following link: Guidance on Infection Control in Schools and other Child Care Settings

It should be noted that taking preventative measures such as following good hygiene practice are the best ways to prevent the spread of infections. Therefore, good hand-hygiene should be demonstrated and reiterated to children.

Further information can be obtained from the HPA website. Additionally, appendix 2 provides some useful points of contact.

Staff should have access to protective disposable gloves and will follow precautions on the COSHH assessment for clinical waste and body fluids when dealing with such substances and disposing of dressings or equipment.

Medical Facilities

The Education (School Premises) Regulations 1999 require every school to have a room appropriate and readily available for use for medical or dental examination and treatment and for the caring of sick or injured pupils. It ***must*** contain a wash basin and be reasonably near to a water closet. It ***must not*** be teaching accommodation. If this room is used for other purposes as well as for medical accommodation, the Headteacher must consider whether dual use is satisfactory or has unreasonable implications for its main purpose.

Training Arrangements

Staff managing the administration of medicines and those who administer medicines will receive appropriate training and support from healthcare professionals. This shall be recorded on consent form AM3.

The Authority accepts that teachers have a general professional duty to safeguard the health and safety of the pupils in their care. Whilst this does not imply a duty to administer medication, appropriate staff may voluntarily undertake this duty as long as they receive training to enable them to do so. The Headteacher should, therefore, identify which staff are willing to be trained and make the necessary arrangements with the School Health Service.

There should be enough volunteers to cover holidays, illnesses and other absences. A contingency plan should be in place for circumstances when there are no members of trained volunteer staff present on a particular day for the administering of the treatment.

Liabilities and Insurance

Employees who are not medical healthcare professionals will be supported by their school and the Local Authority in carrying out healthcare activities such as:

- Administering First Aid in an emergency by employees with a valid first aid certificate
- Providing assistance to a user in administering a nebuliser, an inhaler and oxygen when following a written care plan
- Administering injections where the necessary training has been undertaken (e.g. Epipen training)

- Administering oral medication which has been prescribed and directed by a medical professional provided the relevant consents have been obtained.
- Administering oral medication as directed and authorised by a parent or carer provided the relevant consents have been obtained.

For queries about any other health care activities, the insurance section should be contacted on 01226 773149.

Home to School Transport

The local authority has a duty to ensure that pupils are safe during journeys. Most pupils with medical needs do not require supervision on school transport, but the Local Authority will provide appropriate trained escorts if they consider them necessary.

Prior to transport commencing, the Schools' Transport service routinely request information about the pupils' medical conditions from parents/carers and this enables them to develop an individual health care plan. This information will be provided to and kept with the escort assigned to the child. The schools' transport service will organise any specific training required, such as the use of epipens.

Eating and drinking is not permitted on vehicles to minimise the risk of children having allergic reactions to some food groups.

Parents, school escorts and Headteachers should liaise regularly to ensure the pupil's medical files are updated with any changes in their condition or medical treatment.

School Visits, Journeys and Off-site Education or Work Experience

It is good practice for schools to encourage children with medical needs to participate in safely managed visits. Schools and settings should consider what reasonable adjustments they might make to enable children with medical needs to participate fully and safely on visits. This might include revising relevant visits and journeys risk assessments so that planning arrangements will include the necessary steps to include children with medical needs and incorporate additional safety measures such as additional supervision, such as a parent or another volunteer accompanying a particular child. Arrangements for taking any necessary medicines will also need to be taken into consideration. Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures. A copy of any health care plans should be taken on visits in the event of the information being needed in an emergency.

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

Additional risk assessments may need to be carried out for pupils who, as part of Key Stage 4 provision are educated off-site through another provider to ensure that the relevant provisions are made for them at their place of study/work. The school is responsible for ensuring that a work place provider has a health and safety policy which covers each individual student's needs. Parents/carers and pupils must give their permission before relevant medical information is shared on a confidential basis with employers.

Sporting Activities

Most children with medical conditions can participate in physical activities and extra-curricular sport. There should be sufficient flexibility for all children to follow in ways appropriate to their own abilities. However, any restrictions on a child's ability to participate

in PE should be recorded in their individual health care plan. All adults should be aware of issues of privacy and dignity for children with particular needs.

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

Emergency Preparedness

Within the schools' resilience arrangements, it may be necessary to consider which medications need to be taken to the evacuation point in case children have a medical emergency or if staff will not have access to the premises for a lengthy period of time.

The Role of the School Health Service

There are some children with a medical need which may require dedicated support and advice from specialist health professionals. Advice is provided within the guidance on the most common medical conditions and how to manage them. However, it is not possible to incorporate every individual medical need / eventuality. For example there may be children who have:

- palliative care needs;
- cancer;
- cystic fibrosis;
- had surgery and are rehabilitating as they return to school.

In these circumstances individual health care plans should be drawn up to identify the level of support that is needed at school. Those who may need to contribute to any health care plan are:

- the school health service or other health care professionals;
- the Headteacher;
- the parent(s) or carer(s);
- the child (if sufficiently mature);
- relevant teacher(s), care assistant or support staff (if applicable);
- School staff who have agreed to administer medication / procedures.

Schools should normally use the School Health Service, as a first point of contact if they require specific advice on individual medical needs of a child within school. This will enable arrangements and procedures to be put in place to ensure that adequate support is available for both the school and the child. However, schools requiring advice on diabetes should contact the diabetes nurses directly, since it is such a specialised area. The specialist diabetes nurses are part of the children's community nursing team.

The School Health Service consists of the nursing team who are either based at New Street Health Centre or at the local Health Centre. School nurses are involved in health promotion and education. They encourage children to understand their development and care for their health, making choices which promote their well-being. They offer support to children, parents and teaching staff on a wide range of health-related issues. These include diet, exercise, sexual health, emotional well-being etc. In addition, the school nurse can provide access to information and support on a range of medical issues.

Each school has a named nurse. If a school needs to contact them or find out the name of the school nurse, they should contact New Street Health Centre on (01226) 433130.

The Children's Community Nursing Team are based on The Children's Ward at Barnsley District General Hospital. They provide care and support to children with:

- Allergies;
- Asthma / respiratory conditions;
- Cystic Fibrosis;
- Cancer;
- Diabetes;
- Palliative care needs;
- Some children who have had surgery;
- Special needs children who require specialist support.

Record keeping

The following records must be kept:

- Relevant Parental consent forms for the administration of medicines and emergency medical action (AM1, AM2 and AM4) found in appendix 3.
- Training records in the administration of emergency medical action (AM3) found in appendix 3.
- Any necessary additional risk assessment forms (e.g. school visits and journeys, participation in sporting activities, etc.)
- Any specific Individual Health Care Plans which have been developed either from the general template AM5 found in appendix 3 or from the annexes in the Medical Needs Information and Action Cards found in appendix 1.
- Any Personal Emergency Evacuation Plan (PEEP) which has been developed for a pupil with specific medical needs.

Key Monitoring Requirements

- Determine the schools' arrangements for the administration of medicines and implement the requirements of arrangement 1 or arrangement 2 as necessary
- Determine which information and action cards (appendix 1) are relevant to the pupils in the school and implement the requirements of these arrangements
- Assess the needs of pupils who have specific medical needs and develop an individual health care plan using an appropriate format
- Implement a system to ensure that the relevant consent and medical record forms are completed and that staff know which forms should be completed and where they are located.
- Include arrangements for pupils who have specific medical needs in the relevant risk assessments e,g, school visits and journeys, PE, off-site education and work experience
- Display the HPA Guidance on Infection Control Poster and communicate the requirements of this to the relevant staff members
- Liaise with other agencies as appropriate in order to maintain and share up-to-date medical information where the relevant consent has been sought from parents/carers.

Arrangement 1: Administering Prescription Medicines

It is the Headteacher's in consultation with the Governors' decision whether to authorise the administration of prescription medicines in school. If it is authorised, the following points should be observed:

1. Parents/carers should provide full written information about their child's' medical needs in the form of a Parental Request/Consent Form AM1 or an individual Health Care Plan (AM5).
2. Short-term prescription requirements should only be brought to school if it is detrimental to the child's health not to have the medicine during the school day. If the period of administering the medicine is eight days or more, there must be an individual Health Care Plan (AM5).
3. The school/setting will not accept medicines that have been taken out of the container as originally dispensed nor make changes to prescribed dosages.
4. The school/setting will not accept medicines that have not been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber unless it is done as part of an individual Health Care Plan. The school will inform parents of this.
5. Some medicines prescribed for children are controlled by the misuse of Drugs Act. Members of staff are authorised to administer a controlled drug in accordance with the prescriber's instructions. A child may have a prescribed controlled drug in their possession. The school/setting will keep controlled drugs in a locked non-portable container to which only named staff will have access. A record of access to the container will be kept. Misuse of a controlled drug is an offence and will be dealt with under the school's behaviour policy.
6. Medicines should always be provided in the original container as dispensed by a pharmacist and should include the prescriber's instructions for administration. In all cases this should include:
    - Name of child
    - Name of medicine
    - Dose
    - Method of administration
    - Time/frequency of administration
    - Any side effects
    - Expiry date
7. A minimum of two people should be responsible for administering medicine to a child.
8. The dosage, method of administration and frequency of administration should be double-checked by each person prior to administering the medicine, to ensure that the correct dose is given.
9. Each time a child is given medication a record will be made on form AM1 by the person who administered the medication
10. In cases where pupils can be trusted to manage their own medication it will be encouraged and staff will observe/supervise this. The Headteacher will ensure that parental consent AM2 form has been completed and returned to school before medication is administered.
11. If a child refuses to take medication school staff will not force them to do so. The Headteacher will make an informed decision on the action to be taken based on the arrangements agreed with the parent.

The school setting will refer to the DfES guidance document ‘Managing Medicines in Schools and Early Years Settings’ when dealing with any other particular issues relating to managing medicines.

Arrangement 2: Administering Non - Prescription Medicines

1. No child under 16 should be given prescription or non-prescription medicines without their parents/carers written consent.

2. Staff should obtain written parental/carer consent for each medicine that is to be administered in school. A parental/carer consent to administer non-prescription medication form and a prescription medication form can be found in appendix AM1 and AM2 of this document.

3. A separate form is required for each medication. The consent form should document that the child has no known adverse reaction to the medication to be administered.

4. The medicine should either be supplied by the parent/carer and stored in a safe and secure place in school.

5. A record will be kept stating the medication dosage, time administered, by whom and the reason.

6. Before administering a non-prescription medicine, schools should check that the instructions on the medicine are in line with what is being requested (e.g. dose and frequency on the consent matches the guidance on the box for the child's age).

7. Expiry dates should be checked before administering or applying medicines.

8. No pupil under the age of 16 will be administered aspirin (unless prescribed by a doctor).

Appendix 1:

Medical Needs Information and Action Cards

Contents

Anaphylaxis

ANNEX 1: Care pathway for school child with an allergy/anaphylaxis

ANNEX 2: Protocol and care plan on the management of a child who suffers from a severe allergic reaction

ANNEX 3: Action plan for an anaphylactic reaction

Asthma

ANNEX 1: Asthma management care plan

Athletes Foot

Diabetes

ANNEX 1: Care pathway for school child with diabetes.

ANNEX 2: Guidelines for blood glucose monitoring in schools.

Epilepsy

ANNEX 1: Guidelines for administration of rectal diazepam/buccal midazolam in epilepsy and febrile convulsions for non-medical/non-nursing staff in school/early years setting and respite care.

Headlice

ANNEX 1: Parent information leaflet

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ANNEX 1: Procedure for managing incidents of incontinence in primary children

Infectious Diseases

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Medical Jewellery

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Anaphylaxis

Definition of Anaphylaxis

Anaphylaxis is an extreme allergic reaction requiring urgent medical treatment. The whole body is affected, usually within minutes of exposure to the allergen. The most common type of allergen is food, in particular peanuts, nuts, sesame, fish, shellfish, dairy products and eggs. Wasp and bee stings, natural latex (rubber) and certain drugs can also cause an allergic reaction.

Any allergic reaction, including the most extreme form, anaphylactic shock, occurs because the body's immune system over reacts in response to the presence of a foreign body, which is wrongly perceived as a threat. In anaphylactic shock, blood vessels leak, breathing (bronchial) tissues swell and the blood pressure drops causing choking.

In its most severe form the condition can be life-threatening; however it can be treated with medication. Furthermore once the cause of the allergy is known it can, wherever possible, be avoided.

Symptoms of Anaphylaxis

Symptoms can vary and may depend on how or what type of contact has taken place with the substance causing the allergy. Symptoms can be split into two categories as detailed below:

Mild Symptoms

- urticarial rash (nettle rash/hives);
- itching and/or sneezing;
- flushed face or neck;
- swollen face/puffy eyes.

Moderate/Severe Symptoms

- swollen lips;
- hoarse voice/feeling of lump in the throat;
- cough;
- vomiting and diarrhoea;
- difficulty in breathing/or swallowing;
- swollen tongue;
- feeling of faintness;
- blue colour of the lips or face;
- loss of consciousness;
- breathing stops, no pulse felt, heart stops.

Not all the symptoms may be experienced. Some people find their reaction is always mild. For example, a tingling or itchy mouth and nothing more, which may be treated with oral antihistamine (Piriton). However if there is a marked difficulty in breathing or swallowing, and/or a sudden weakness or floppiness, these symptoms should be regarded as serious requiring immediate treatment.

Medication and Control

In the most severe cases of anaphylaxis, children are normally prescribed a device for injecting adrenaline by a qualified medical practitioner. The device is called an Epipen which looks like a fountain pen. It is pre-loaded with the correct dose of adrenaline and is normally injected into the fleshy part of the thigh. Adrenaline acts quickly to constrict blood vessels, relax smooth muscles in the lungs to improve breathing, stimulate the heartbeat and help stop swelling around the face and lips.

The needle is only revealed after the injection has been administered. 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 purely on a voluntary basis and should not, in any case, be undertaken without training from an appropriate health professional. Following the administration of an Epipen it should be disposed of in accordance with the protocol/Health Care Plan.

For some children the timing of the injection may be crucial. There needs to be a health care plan in place which clearly sets out suitable procedures for each individual child so that swift action can be taken in an emergency.

Following the administering of the Epipen an ambulance should be called and the parents of the child contacted. If there is no medical improvement in the child within five minutes a second Epipen should be given.

Storage of the Epipen

The child may be old enough to carry their 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.

The Management of Anaphylaxis within the School

When a child is diagnosed with anaphylaxis information will be passed on to the School Health Service, Child's GP or Health Visitor through a referral and information form. The School Health Service will then liaise with the school to allay fears surrounding the child's diagnosis of anaphylaxis. It is also expected that the parent(s) or carer(s) of the child will inform the school or if appropriate the school they are to be admitted to, that the child is known to suffer from a severe allergic reaction. When the problem is identified, it is important to ensure that as far as is possible the child is treated normally. Annex 1 to the section outlines an example of a care pathway.

If a child is likely to suffer a severe allergic reaction all school staff should be aware of the condition and know who is responsible for administering the emergency treatment and where it is stored. An example of an action plan can be found at Annex 3 to this section which could be displayed on the classroom wall or staff rooms, etc.

Staff Training

Specific training will be arranged and delivered by the appropriate staff within the School Health Service within four weeks of the School Health Service being notified of the diagnosis.

The training is to inform school/nursery staff on the specifics of allergy and anaphylaxis. This training can involve parents, school staff identified by the Headteacher and appropriate health professionals. If parents are unable to attend, the School Nurse/Health Visitor will contact the parents to inform them of the staff trained and procedures. Forms AM3 and AM4 will need to be completed and signed to provide indemnity for staff.

Training will need to be updated annually for all school staff in order to maintain the indemnity involved in the administration of Epipen. Update sessions may also be required if the child's circumstances change or staff change.

The Protocol and Health Care Plan for the Individual Child

For dealing specifically with an individual child who suffers from anaphylaxis an Individual Health Care Plan must be drawn up and accepted by the parents, the school and the School Health Service.

This will deal with all of the following:

- definition of allergy;
- emergency procedure to be adopted;
- treatment;
- food management;
- staff training;
- precautionary measures;
- staff indemnity;
- consent and agreement.

A sample protocol Health Care Plan for dealing specifically for anaphylaxis is attached at Annex 2 to this section. It is important to stress that the precise content of the protocol Health Care Plan will be dependent on the individual circumstances of each child. The Health Care Plan should be completed at the training session and copies sent to appropriate parties eg. school/nursery/School Health/Barnsley District General Hospital and parents.

Administration of the Epipen

Details of the medical procedure for using the Epipen Injector are outlined in Annex 2 to this section.

Day to day policy measures within school

School Meals

Food management and an awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school are important factors to be considered. The catering supervisor should also be aware of the child's particular requirements. It is reasonable to expect that parents will provide the child with an appropriate packed lunch and clear guidance on sweets/snacks.

School Visits

For outdoor activities/visits and journeys the school should ensure that the medical needs of a child who suffers from anaphylaxis have been addressed and the child's medication is taken on the visit. It may be appropriate for the child to be accompanied by a parent or an appropriately trained volunteer helper.

This policy was approved by the Resources Committee on_____

Chair of the Committee_____ CEO_____

ANNEX 1

CARE PATHWAY FOR SCHOOL CHILD WITH AN ALLERGY/ANAPHYLAXIS

Child diagnosed with anaphylaxis

↓

Referral and information sheet

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School Nurse/Community children's Nurse

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Arrange training in school as soon as possible after notification of diagnosis.

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Complete care plan and check indemnity

↓

Distribute care plans to relevant parties

↓

Review annually

ANNEX 2

PROTOCOL AND CARE PLAN ON THE MANAGEMENT OF A CHILD WHO SUFFERS FROM A SEVERE ALLERGIC REACTION

1 BACKGROUND

1.1 It is known that * may suffer an anaphylactic reaction if he/she eats or comes into contact with

If this occurs he/she is likely to need medical attention and, in an extreme situation, his/her condition may be life threatening. However, medical advice is that attention to his/her diet, and in particular the exclusion of nuts, together with the availability of his/her emergency medication, is all that is necessary. In all other respects, it is recommended that his/her education should carry on as normal.

1.2 The arrangements set out below are intended to assist *s parents and the school in achieving the least possible disruption to his/her education, but also to make appropriate provision for his/her medical requirements.

2 DETAILS

2.1 The Headteacher will arrange for his/her teacher and other staff in school to be briefed about *'s condition and about other arrangements contained in this document.

2.2 The school staff will take all reasonable steps to ensure that * does not eat any food items unless they have been prepared/approved by the parents.

2.3 *Parents will remind him/her regularly of the need to refuse any food items, which might be offered to him/her by other pupils.

2.4 In particular, * parents have the opportunity to provide for her:

2.5 If there are any proposals which mean that * may leave the school site, prior discussions will be held between school and *'s parents in order to agree appropriate provision and safe handling of his/her medication on the day.

2.6 Wherever the planned curriculum involves cookery or experimentation with food items, prior discussion will be held between the school and parents to agree measures and suitable alternatives.

2.7 The school will hold, under secure conditions, appropriate medication clearly marked for use by designated school staff or qualified personnel and showing an expiry date.

All used/expired medication must be replaced by *'s parents prior to commencement of the next attending school day.

3 ALLERGY REACTION

3.1 In the event of * showing symptoms of anaphylaxis, which are:

as described by his/her mother, then the following steps should be taken;

ALERT ANOTHER staff member, who will summon an ambulance using 999 and stating **"CHILD EXPERIENCING SEVERE ANAPHYLACTIC REACTION"**. Then a trained staff member will collect the EPIPEN from storage then return to administer the EPIPEN AUTO INJECTOR into *'s thigh, in accordance with medical instructions received in the training session.

PARENTS TO BE INFORMED ON TEL NO:

THEN

The teacher, upon recognising the symptoms of anaphylaxis (nausea, swelling, rash etc) will administer

Symptoms usually subside within one hour following the administration of Piriton and * should be closely observed during this time.

The syrup may make * sleepy.

Following recovery, *'s parents should be informed of what occurred.

IF symptoms do not subside, or increase in severity and he/she becomes wheezy, dizzy, has difficulty breathing, drowsy, collapses or becomes unconscious:

THEN place * in the recovery position, stay with him/her and do not leave him/her alone at any time.

DETAILS OF THE MEDICAL PROCEDURE FOR USING THE EPIPEN INJECTOR

PULL OFF GREY SAFETY CAP.

PLACE THE BLACK TIP ON THE MID OUTER ASPECT OF *S THIGH (ALWAYS THE THIGH) AT A RIGHT ANGLE.

PRESS HARD TO THIGH, HOLD IN PLACE FOR A COUNT OF 10.

REMOVE EPIPEN AND PLACE IN SHARPS BIN FOR AMBULANCE MEN.

MASSAGE INJECTION SITE FOR 10 SECONDS.

IF NO IMPROVEMENT IN CONDITION AFTER 5 MINUTES AND NO MEDICAL ASSISTANCE HAS ARRIVED 2ND EPIPEN TO BE ADMINISTERED.

Care should be taken to avoid accidental injury to the administering person. If this occurs, they should go to the nearest Accident & Emergency Department immediately for treatment.

3.2 The administration of EPIPEN is safe for *, and even if it is given through mis-diagnosis, it will do him/her no harm.

3.3 On the arrival of qualified ambulance service, the teacher in charge will appraise them of the medication given to *.

3.4 After the incident a debriefing session will take place, with all members of staff involved. School can contact the School Health Service for advice and support.

3.5 Parents will ensure replacement of any used medication prior to the commencement of the next school day.

4 TRANSFER OF MEDICAL SKILLS

4.1 Volunteers from school staff;

have undertaken training to administer emergency medication.

Name of qualified person giving training:

4.2 A training session was attended on by members of school staff named (4.1) , it explained in detail *'s condition, the symptoms of anaphylactic reaction and the procedures for the administration of medication.

4.3 Further advice is available to the school staff/volunteers at any point in the future where they feel the need for further assistance. The medical training will be repeated at the beginning of the academic year by the school health advisor who can be contacted on 01226 433100.

4.4 Barnsley Metropolitan Borough Council provides a staff indemnity for any school staff volunteers who agree to administer medication to a child in school, given the full agreement of parents and school, in accordance with medical guidelines.

(Harvey. J. 1999)

5 The Care Plan has been agreed and understood:

Name: Signature: Date:

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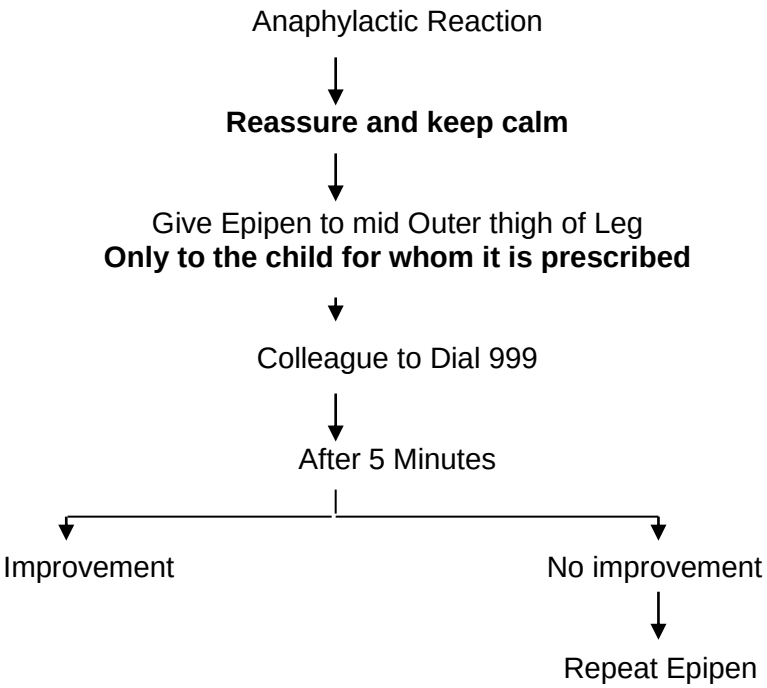
ANNEX 3

ACTION PLAN FOR AN ANAPHYLACTIC REACTION

MILD	1	Rash	)	**GIVE**
	2	Itching and/or sneezing	)	**PIRITON**
	3	Flushed face or neck	)	
	4	Swollen face/puffy eyes	)	
	5	Swollen lips	)	
	6	Hoarse voice, or a lump in the throat	)	
MODERATE	7	Cough	)	**GIVE**
	8	Vomiting and diarrhoea	)	**EPIPEN**
	9	Difficulty in breathing and swallowing	)	
	10	Swollen tongue	)	**AND**
			)	
SEVERE	11	Feeling of faintness	)	**INHALER**
	12	Blue colour to the lips and face	)	**IF**
	13	Loss of consciousness	)	**PRESCRIBED**
	14	Breathing stops, no pulse felt and heart stops	)	



<u>Always</u>
Observe
Stay calm
Reassure child
Stay with child
Call 999 and inform parents.

ANNEX 4

USEFUL TELEPHONE NUMBERS RE-ALLERGIES

Anaphylaxis campaign Registered charity Web-site	PO Box 275, Farnborough, Hampshire GU14 6SX 01252-542029 http://www.anaphylaxis.org.uk/
British Allergy Foundation Registered charity Web-site	Deepdene House 30 Bellegrove Road, Kent DA16 3PY 020-8303-8583 www.allergyfoundation.com
SOS Talisman (ID jewellery)	Talisman Corner, 21 Grays Corner, Ley Street, Ilford, Essex IG2 7RG 020-8554-5579
Supermarket “Free From” lists	Asda 0113-243-5435 Marks and Spencer 020-7268-1234 Tesco 0800-505555 Co-op 0800-317827
School Nursing/Health Team	01226-433130

Asthma

General information on Asthma

Where a child who suffers from asthma attends school, every effort should be made to encourage and help the child to participate fully in aspects of school life.

This can be achieved by helping staff and other pupils to understand asthma and avoid any stigma or misconceptions which are sometimes attached to the condition.

Asthma is a condition that affects the child's airways. Asthma symptoms include coughing, wheezing, a tight chest, and getting short of breath. However not every child will get all these symptoms.

Children with asthma have airways that are almost always red and sensitive (inflamed). These airways can react badly when someone with asthma has a cold or other viral infection or comes into contact with an asthma trigger. Common triggers include colds, viral infections, house-dust mites, pollen, cigarette smoke, furry or feathery pets, exercise, air pollution, laughter and stress.

When someone with asthma comes into contact with a trigger that affects their asthma, the airways do three things. The airway lining starts to swell, it secretes mucus, and the muscles that surround the airway start to get tighter. These three effects combine to make the tubes very narrow, which makes it hard to breathe in and out normally. This is called an asthma attack and it is at this point that a child will need to take a dose of their reliever medication. The affected child may be distressed and anxious, and, if they experience several consecutive attacks the child's skin and lips may become blue.

Medication and Control

Asthma varies in severity. Avoiding known triggers where appropriate and taking the correct medication can usually control asthma effectively. However, some children with asthma will have to take time off school or have disturbed sleep due to asthma symptoms.

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 they may also prevent symptoms if they are used in anticipation of a trigger, e.g. exercise).

Within the school environment, asthma medication is usually given through the use of inhalers. It is good practice to allow children with asthma to take charge of and use their inhaler from an early age with minimal support. This should be recorded on form AM2.

A small number of children, particularly the younger ones, may use a spacer device with their inhaler. Spacers make metered dose inhalers (spray inhalers) easier to use and more effective.

Each child's needs and the amount of assistance they require will differ. Staff are encouraged to offer assistance when needed although this is purely on a voluntary basis. The Authority will provide indemnity for staff who volunteer to administer medication to pupils with asthma. Form AM3 should be used for this purpose.

Storage of Medication

Children with asthma must have immediate access to their reliever inhalers when they need them. Delay in taking reliever treatment, even for a few minutes, can lead to a severe attack and in very rare cases can prove fatal. Children who are able to use their inhalers themselves should usually be allowed to carry them with them in their pocket or pouch.

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 pupils name.

At break time, in PE lessons and on school trips the inhaler should still be accessible to the child.

Reliever inhalers must never be locked up or kept in a central room away from the child. It is advisable for all children to have a spare inhaler kept by the school in an accessible place in case their own runs out, they forget to bring it to school or lose their inhaler.

Children should not take medication which has been prescribed for another child, however if a child took a puff of another child's inhaler there are unlikely to be serious adverse effects.

Some children may be shy about taking their inhaler in front of others.

Parents should always be informed if their child is taking their inhaler more often that they usually would.

Asthma attacks
Common signs of an asthma attack

- **Cough,**
- **Shortness of breath,**
- **Wheezing,**
- **Chest tightness**
- **Being unusually quiet**
- **Difficulty in talking/walking.**

If a child has an asthma attack the school should follow the following procedure:

(i) Ensure that the reliever inhaler (blue) is taken immediately; repeat the dose every few minutes. If possible use the blue reliever aerosol via a spacer device. Give 4-6 puffs spaced out evenly over a few minutes.

(ii) Stay calm and reassure the child. Listen carefully to what the child is saying. Although it's comforting to have a hand to hold, staff should not put their arm around a child's shoulder as this is restrictive; reassure the child.

(iii) Help the child to breathe by ensuring tight clothing is loosened. Encourage the child to breathe slowly and deeply whilst sitting upright or leaning forward slightly, in the most comfortable position for them. (Lying flat is not recommended). Offer the child a drink of water;

(iv) Minor attacks should not interrupt the involvement of a pupil in school: they can return the child to class when they are better;

Never leave a pupil having an asthma attack alone. If they do not have their inhaler and/or spacer on them, send another teacher or pupil to get it.

(v) Inform the child's parents about the attack as soon as possible within that school day.

Emergency Situation

In an emergency situation, school staff are required under common law, duty of care, to act as a prudent parent would.

Medical advice must be sought and/or an ambulance called if:

- the reliever has no effect after ten minutes;
- the child is either distressed or unable to talk;
- Breathing is faster than usual and / or the child is using their tummy muscles to breathe;
- the child is getting exhausted;
- they are pale or blue around the lips;
- you have any doubts at all about the child's condition.

Continue to give reliever medication every few minutes until help arrives. Don't worry about overdosing since too much blue inhaler is more beneficial than too little.

A child should always be taken to hospital in an ambulance. School staff should not take them in their car as the child's condition may deteriorate quickly.

Annex 1 to this section details an example of an asthma management / care plan for a child. However, it should be noted that not all children who suffer from asthma will have one since it is dependent on the severity and stability or their asthma which will have previously been assessed.

Asthma in PE and School Sports

Full participation in PE and sports should be the goal for everyone and should be accessible to all pupils at school, including those with asthma. Exercise and activity is good for everyone and the majority of pupils should be able to take part in most sports, exercise and activity. However, many children with asthma may experience asthma symptoms during exercise.

For some exercise is the only trigger, whilst others it is one of many triggers.

A small minority of pupils with difficult to control asthma may find it difficult to participate fully in exercise because of the nature of the asthma; however, there have been changes to P.E.and exercise in schools and other opportunities to try alternative ways of exercising.

Children with exertional symptoms will normally restrict themselves and care should be taken not to push them, especially when they have symptoms.

Teachers taking PE classes have an important role in supporting and encouraging pupils with asthma. They should:

- make sure that they know which children have asthma;
- be encouraging and supportive to children with asthma;

- remind children whose asthma is triggered by exercise to take a dose of reliever medication a few minutes before they start the class;

- encourage children with asthma to do a few short sprints over a five minute period to warm up, in particular before rushing into sudden activity when the weather is cold;

- make sure children bring reliever inhalers with them on all off-site activities;

- make sure that children who say they need their asthma medication take their reliever inhaler and rest until they feel better;

- speak to the parents if they are concerned that a child has undiagnosed asthma;

- make time to speak to parents to allay their concerns or fears about children with asthma participating in PE;

- children should not be forced to take part if they feel unwell. If a child has to sit out because of the asthma, try to keep them as involved as possible.

Record Keeping

When a child is admitted to school it is expected that the parent(s) or carer(s) would inform the school that their child suffers from asthma.

The School Health Service also asks parent(s) or carer(s) to fill in School Entry Health Needs Assessment questionnaires, the purpose of which is to highlight any health needs of individual children.

From this information the school should keep a register of all children who suffer from asthma. All school staff should be aware of which children have asthma within the school. The relevant consent form(s) should be completed for the administration of asthma medication.

If medication changes parents are expected to inform the school. A member of school staff should have responsibility for maintaining the register ensuring that any spare reliever inhalers are not out of date (they usually have a two year expiry date).

School Trips

No children should be excluded from taking part in day trips and overnight stays because of their asthma unless advised to do so,

Day Trips – The child's reliever inhaler should be taken with them on the trip. If the child is able to take charge of their inhaler they should be allowed to carry it with them in their pocket or pouch. If the child is too young or immature to take personal responsibility for it a member of staff should carry it.

Residential Trips – The child's reliever inhaler should be available at all times throughout the trip, and should be carried by themselves or a member of staff. The preventer inhaler usually, brown, orange or purple is normally only needed twice a day and arrangements should be made for either the child to carry the inhaler or for it to be kept in the first aid box.

Further advice and guidance can be found on the Asthma UK website asthma.org.uk where you can find resources specifically developed for schools and school aged children.

Schools can also contact the Asthma Specialist Nurse:

Jackie Eaton
Office Tel: 01226 432519
Mobile Tel: 07767425910
Email; Jacqueline.eaton@nhs.net

Zena Thomas
Office Tel: 01226 432519
Mobile Tel: 07788 416057
Email: zena.thomas@nhs.net

ANNEX 1

ASTHMA MANAGEMENT CARE PLAN FOR:

It should be noted that not all children who suffer from Asthma will have an individual management / care plan. It will be dependent on the severity and stability of each child's asthma.

IF..... **HAS**:

- increased cough;
- increased wheeze;
- increased breathlessness;
- or if he / she is needing to use the Reliever (blue inhaler) more than 3-4 hourly.

WHAT TO DO:

- give 4 - 6 puffs of Reliever (blue inhaler) using a spacer device if available;
- each puff should be separate and spaced out evenly over a few minutes;
- wait 10 minutes. If condition returns to normal the child can go back to class;
- If no improvement give 1 puff of Reliever (blue inhaler) every 30 seconds. Up to 10 doses.
- call child's parents or seek medical advice.

MEDICAL ALERT / EMERGENCY

IF THE CHILD IS:

- breathing faster than usual;
- using his / her tummy muscles to breathe;
- having difficulty in speaking (due to asthma symptoms);
- having difficulty in walking (due to asthma symptoms);
- pale or blue around the lips;
- appears distressed and exhausted.

WHAT TO DO:

- DIAL 999 - YOU MUST SEEK MEDICAL HELP;
- give 1 puff of the RELIEVER (blue inhaler) every 30 seconds up to 10 doses, using a spacer device, if available;
- stay with the child until ambulance arrives;
- keep giving reliever as outlined above until help arrives;
- other treatment; .....

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Athletes Foot

Definition

Athlete's foot is a common persistent infection of the foot usually caused by a fungus. It causes irritation and discomfort, mainly between the toes. The skin becomes inflamed and cracked and may bleed.

The fungus that causes it lives on dead skin, hair and toenails and thrives in a warm moist environment. It can be spread by sharing damp towels and also by picking it up from other people's shed skin scales.

Treatment

Treatment is simple and effective and is always advisable. There are various creams, powders and sprays available, which can be bought over the counter at the pharmacist.

Prevention

Children should generally be advised not to share towels, shoes etc, whether someone has athletes foot or not. For the person who is affected, the best precaution against them spreading it, is to wear rubber flip-flops where other people are walking around in bare feet. This would obviously be applicable to the side of the swimming pool, although a gym shoe or plimsoll would be more appropriate for activities such as PE or dance.

Children with athlete's foot should not be excluded from swimming.

Diabetes

Introduction

Diabetes is a condition in which the amount of glucose (sugar) in the blood is too high because the body's pancreas has stopped producing insulin. This is called type 1 diabetes. However we are now seeing small numbers of children develop type 2 diabetes which is when the body is still producing insulin but not using it effectively. This tends to coincide with a child being over weight and/or a strong family history of type 2 diabetes.

Children with diabetes normally need to have daily insulin injections, 3-6 times per day, to control their blood glucose level. Some children and young people receive their insulin via an insulin pump. This is becoming more common and will certainly increase over time.

Diabetes cannot be cured, but it can be treated effectively. The aim of the treatment is to keep the blood glucose level close to the normal range, so that it is neither too high (hyperglycaemia) nor too low (hypoglycaemia - also known as a hypo).

Treating Diabetes

Most children with diabetes will be treated by a combination of insulin and a balanced diet, with the recommendation of regular physical activity.

Insulin

Insulin has to be injected unless on an insulin pump. It is a protein that would be broken down in the stomach if it was swallowed like a medicine.

Children and young people with diabetes may require different insulin regimes, from taking insulin three and up to six times per day. This may involve having insulin injections at lunch time and in these instances it will be documented in the child's individual Health Care Plan held in school, outlining the storage and safe keeping of insulin and where it is to be administered, e.g. the medical room.

If a young child requires to have an insulin injection at school, the parent may need to visit school to administer the insulin injection and if there is a volunteer in school, that person can be trained and deemed competent by a member of the Children's Diabetes Team to administer insulin to that child. A training package is available.

Having more injections of insulin does not mean that a particular child's diabetes is not well controlled. The main aim is to give them a more flexible insulin regime to suit their individual lifestyle.

Most children can give their insulin from a very early age with minimal supervision. It is unlikely that children under the age of eleven will require insulin injections whilst at school.

A care pathway for children with diabetes can be found at Annex 1 to this section.

Food

The child and family will have educated by the paediatric dietician about healthy eating and suitable food choices. The diet for a child with diabetes is a healthy eating diet, low in sugar and low in fat with reasonable amounts of carbohydrates. The occasional treat is acceptable.

Eating times

Meals and snacks should be eaten at regular intervals following a plan discussed by the family and their dietician. The child needs to eat at regular times in order to maintain stable blood glucose levels. A missed or delayed meal / snack could lead to hypoglycaemia.

Snacks may need to be eaten in class, but if the times coincide they may be best eaten at break time to avoid any fuss. If it is felt that the class should understand why the child is having a snack, the child should be asked how they feel about having their diabetes explained to the class.

It is important to know the times when the child needs to eat and make sure that they keep to these times. They may need to be near the front of the queue (and at the same sitting each day) for the midday meal.

Blood glucose testing

All children with diabetes will need to monitor their blood glucose levels whilst in school. 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. Most children will be able to do this themselves and will simply need a suitable place to carry it out. If a young child is unable to monitor their blood glucose levels a volunteer can be trained to do so by a member of the Children's Diabetes Team. A training package is available. Form AM3 should be used for this purpose. Annex 2 to this section outlines guidance for blood glucose monitoring.

Blood glucose testing involves pricking the finger, using a special finger - pricking device to obtain a small drop of blood. This is then placed on a reagent strip, which is read by a small, electronic blood glucose meter. A test takes about a minute in total.

Snacks

Snacks may need to be eaten in class, but if the times coincide they may be best eaten at break times to avoid any fuss. This will be discussed at the school meeting facilitated by a member of the Children's Diabetes Team

The choice of food will depend on the individual child but could include:

- roll / sandwich
- cereal bar
- one individual mini pack of dried fruit
- a portion of fruit
- two biscuits, e.g. garibaldi, ginger biscuits

Hypoglycaemia (Hypo)

Hypoglycaemia is the most common short-term complication in diabetes and occurs when blood glucose levels fall too low.

Hypos are especially likely to happen before meals. This can happen as a result of:

- too much insulin
- not enough food to fuel an activity
- too little food at any stage of the day
- a missed meal or delayed meal or snack
- cold weather
- a child vomiting

How to recognise a hypo

Hypo's fall into three categories; mild, moderate and severe. These will have been discussed at the school meeting and will be detailed in the individual child's health care plan, produced by a member of the Children's Diabetes Team.

Hypos happen quickly, but most children will have warning signs that will alert them, or people around them, to a hypo. The following symptoms, either individually or combined, may be indicators of a hypo in a child with diabetes.

- hunger
- sweating
- drowsiness
- glazed eyes
- pallor
- trembling or shakiness
- headache
- lack of concentration
- irritability
- mood changes especially angry or aggressive behaviour

Each child may experience different symptoms and this should be discussed when drawing up the individual health care plan. If a child is feeling hypo they should never be sent anywhere unaccompanied.

Treating a mild hypo

A normal blood sugar is between 4-7 mmols/l. Anything 4 or below should be treated as hypo. If a child has a hypo, if they are able to, they need to test their blood glucose level. If not, treat as a hypo.

It is important that a fast acting sugar, such as 3 glucose tablets or 100mls of ordinary coke or Lucozade is taken immediately. Alternatively, for a mild hypo a small glass of fruit or five sweets (e.g. jelly babies) can be eaten. This will have been discussed at the school meeting and will be detailed in the individual child's Health Care Plan, produced by a member of the Children's Diabetes Team.

The child should not be left alone during a hypo, nor be sent off to get food. The food must be brought to the child. If the child's recovery takes longer than what is outlined in the care plan or in cases of emergency an ambulance should be called.

If the child has a moderate hypo, conscious but drowsy, the management of this will have been discussed at the school meeting and will be detailed in the child's Health Care Plan.

Unconsciousness

In the unlikely event of a child losing consciousness, they should not be given anything by mouth - not even Hypostop (concentrated glucose gel). They should be placed in the recovery position (lying on their side with the head titled back). An ambulance should then be called, informing them the child has diabetes. The child will come around eventually and should not come to any immediate harm if they are kept in the recovery position.

Diabetes and PE

Diabetes shouldn't stop children with the condition from enjoying any kind of physical activity, or being selected to represent school in team games, provided they have made some simple preparations.

Preparations are needed because all forms of physical activity, such as swimming, football, gymnastics and walking, use up glucose. If the child does not eat enough before starting an activity, their blood glucose level will fall too low and they will experience a hypo.

The more strenuous and prolonged the activity, the more food will be needed beforehand, and possibly during and afterwards.

Before an activity it is important for the child to have an extra snack. If the activity is after lunch, it may be easier for the child to have a slightly larger lunch.

During an activity there should be glucose tablets or a sugary drink nearby in case the child's blood glucose level drops too low, which could lead to a hypo. Also if the activity is off the main school campus back up supplies of hypostop will need to be available.

After an activity the child may need to eat some starchy food, such as a sandwich or a packet of crisps, but this will depend on the timing of the activity (for example, it may be followed by lunch) and the level of exercise taken. While it is important that staff keep watch over all the children, the child with diabetes need not be singled out for special attention. This could make them feel different and may lead to embarrassment.

Children with diabetes should not use their condition as an excuse for not participating in any physical activity. If this does happen regularly, school should speak to the parent(s) or carer(s).

OTHER CONSIDERATIONS

Sickness

If the child is unwell, their glucose levels may rise. This can happen even if the child just has a cold. High blood glucose levels may cause them to be thirsty, and need to go to the toilet more frequently. If staff notice this during the day, they should report it to the child's parent(s) or carer(s) immediately. The child may need to go home to enable parents to take more appropriate action, eg, to give extra insulin as previously discussed with the Children's Diabetes Team.

If the child vomits at school, start them sipping on a sugary drink, eg Lucozade, and call their parent(s) or carer(s). Should the child continue to vomit, treat this as an emergency and call an ambulance. This will have been discussed and will be outlined in more detail in the child's individual Health care Plan.

SCHOOL TRIPS

Day Trips

Going on a day trip should not cause any problems, as the feeding routine will be much like that at school.

The child with diabetes should take their insulin and injection kit, in case of any delays in their usual injection time. The child will have to eat some starchy food following the injection, so should have some extra starchy food with them. They should also take with them their usual hypo treatment. This will have been discussed at the school meeting beforehand.

Overnight stays

With overnight stays, the child's routine will include insulin injections and blood glucose monitoring. Schools will need to ensure that either the child is able to do their own injections or that there is a member of staff who is willing to take responsibility for helping with injections and blood glucose testing.

If any medical equipment has been lost or forgotten, the paediatric department or Accident and Emergency department at the nearest hospital, must be contacted for help.

The Children's Diabetes Team will visit school before the planned overnight stays to discuss the management of the child's diabetes whilst away from home.

For further information and guidance please contact the Diabetes Specialist Nurse:

Denise Gibson
Office Tel: 01226 432519
Email: denise.gibson@nhs.net

ANNEX 1

CARE PATHWAY FOR SCHOOL CHILD WITH DIABETES.

Child diagnosed with diabetes

referral and information sheet

arrange training in school within a week of diagnosis

devise a health care plan and check indemnity

distribute care plan to relevant parties

review when child changes school or if specifically requested.
(annual reviews to be introduced in the near future)

ANNEX 2

GUIDELINES FOR BLOOD GLUCOSE MONITORING IN SCHOOLS

Training will be given to the relevant teachers / nursery nurses by the paediatric diabetes specialist nurse. All equipment to be labelled with the child's name and stored safely when not in use.

1 The procedure should be carried out in a designated area e.g. medical room. Prepare area - Paper towels / Disposable gloves / Cotton wool / Blood glucose meter / Test strips / Disposable bag / Finger pricking device and lancet.

2 Child / young person to wash their hands using warm soapy water.

3 Person carrying out / assisting the child should wash and dry their hands and wear disposable gloves.

4 Finger pricking to be carried out as previously agreed in the care plan.

5 Blood to be placed on test strip, then to be monitored according to the individual machine.

6 Cotton wool to be placed on finger until bleeding ceases.

7. Lancet to be placed in sharps bin

8 Result to be recorded in accordance with the care plan.

9 All disposable materials to be disposed of in accordance with the yellow bag system.

10 Dispose of gloves in yellow bag, wash and dry hands thoroughly.

11 It is recommended that each child is to take their blood glucose monitoring kit home each weekend for cleaning.

Epilepsy

Introduction

Epilepsy is defined as having a tendency to have seizures. They are sometimes called 'fits'. Seizures come from a temporary disruption of electrical activity in the brain. What happens during a seizure will depend on where in the brain the epileptic activity begins and how widely and rapidly it spreads. A good source of information and guidance on the management of epilepsy in school is the epilepsy action website: http://www.epilepsy.org.uk/ where many resources are available to download.

Management of Epilepsy in Schools

The Authority recognises that pupils who suffer from epilepsy may require urgent medical treatment. However, there are options available to the Headteacher regarding the level of emergency medical action the school is prepared to administer.

Option One

Where a child is due to be admitted to the school who suffers from epilepsy or who is diagnosed with epilepsy at a later date the parent(s) or carer(s) and the Authority will be notified in writing that the school staff will not administer the emergency medical procedure (Rectal Diazepam or Buccal Midazolam) which is carried out to treat children who suffer from a prolonged seizure.

The Headteacher will ensure that there is an agreed protocol/Health Care Plan in place at school for any child who suffers from epilepsy and make arrangements for the epilepsy specialist nurse to deliver an awareness session to school staff on epilepsy.

If the situation arises where a child experiences a major seizure the school will:

a) call for an ambulance;
b) immediately contact the parent(s) or carer(s)

First Aid Posters are available from the epilepsy action website by following this link: http://www.epilepsy.org.uk/info/seizures/first-aid

Option Two

Where a child is either admitted to the school who suffers from epilepsy or is diagnosed with epilepsy at a later date the Headteacher will implement the following procedure

- inform the Authority;
- inform all staff;
- (If emergency medication is prescribed) request volunteers to administer the following emergency medication:
  - Rectal Diazepam
  - Buccal Midazolam
  - Both Rectal Diazepam and Buccal Midazolam

- implement the agreed individual care plan;
- ensure all staff administering the emergency medication receive the appropriate training and legal indemnity as set out on Form AM3;

- ensure that the provision of care can be maintained for the school day;
- ensure staff record the use of Rectal Diazepam/Buccal Midazolam in the nursing cardex (special school) or on Form AM1.

In circumstances where seizures do not stop after first dose of emergency medication has been given the school will:

a) give the child a second dose if this is written in the protocol/care plan;
b) call for an ambulance regardless of whether a second dose is given;
c) Immediately contact the parent(s) or carer(s).

Seizures

There are about 40 different types of seizure, some of which are more common in children. The most common seizure school staff will come across are as follows:

Tonic-clonic Seizures (previously known as grand-mal)

Children who have tonic-clonic seizures lose consciousness and fall to the ground. Their body goes stiff and their limbs jerk. When their seizure is over, their consciousness returns but they may be very confused and tired. It is important that you stay with them at this point, to make sure that they are alright.

Absence Seizures

During an absence seizure (previously known as a petit-mal) the child will briefly lose consciousness but will not lose muscle tone or collapse. Sometimes their eyes will flicker. The person stops what they are doing and may stare, blink or look vague for just a few seconds. Because of this, absence seizures can sometimes be mistaken for daydreaming or inattention. Absence seizures are most common between the ages of six and 12 years old. While these episodes may seem unimportant they can happen hundreds of times a day. You may be able to help your students who have absence seizures by providing written information at the end of a lesson, and helping them catch up on things missed. There is no first aid needed for absence seizures. Usually the pupil will be able to continue with what they were doing before the seizure although they may need reminding.

Myoclonic Seizures

When a child has a myoclonic seizure the muscles of any part of their body jerks. These jerks are common in one or both arms and can be a single movement or the jerking may continue for a period of time. Myoclonic seizures happen most often in the morning and teachers need to bear in mind that a child may be tired or lack concentration if they start school after having one of these. There is no first aid needed for myoclonic seizures unless the child has been injured in which case usual first aid procedures are used.

Complex Partial Seizures

A complex partial seizure can be difficult to recognize. It can appear to the onlooker that the person is fully aware of what they are doing, but they may appear to act strangely, for example, plucking at their clothing, swallowing or scratching or just wandering aimlessly. The specific symptoms of a complex partial seizure depend on which area of the brain the seizure is occurring in. It is important to remember that a person experiencing a complex partial seizure cannot control their behavior, and their consciousness is altered so they cannot follow instructions and may not respond at all.

Complex partial seizures can be misinterpreted as bad behavior. In fact, the child will not know what has happened and will not remember what they were doing before the seizure started.

Although there is no real first aid needed, it is important not to restrain the young person unless they are in immediate danger. This is because they may not recognize you.

Atonic Seizures

Atonic seizures cause a child to momentarily lose muscle tone and suddenly collapse. Injuries can easily occur; particularly head injuries as the pupil will often fall forwards and will not be able to put out their hands for protections during the fall. Safety headgear is sometimes worn by pupils who have frequent seizures. There is no first aid needed for atonic seizures unless the child has been injured in which case usual first aid procedures are used.

Social Needs in the Classroom

Pupils with epilepsy should be included as far as possible in all school activities. Extra precautions and supervision may be needed for some activities and sports, residential visits and on transport. This should be considered and included within the pupils individual care plan.

Triggers

For many pupils, seizures happen without warning. Others may know of certain 'trigger' factors. These should be discussed, written in the pupils care plan and communicated to the relevant parties. There are many different triggers but some are more relevant to school settings than others.

Photosensitive epilepsy is a form of epilepsy in which seizures are triggered by flickering or flashing lights. Only about five percent of all people with epilepsy have this form of the condition, and it is most common in children and young people aged between seven and 19. Seizures are most commonly triggered by certain frequencies of flash or flicker. High contrast patterns such as black and white stripes, sunlight through blinds or reflection from water can be a trigger.

Computer and interactive whiteboards are usually not a problem as they either seem to flicker at a rate too fast to trigger a seizure or not at all. Conventional 'cathode ray' TV screens could trigger in someone with photosensitive epilepsy, but viewing the screen from at least 2.5 meters' away will minimise the risk.

Stress can make a pupil with epilepsy more likely to have seizures. For young people, stress about exams and assessment can be reduced by making sure any special consideration or access arrangements (such as extra time, separate invigilation or rest breaks) are organised well in advance. Information about applying for special considerations/adjustments in exams is contained in the epilepsy action document 'Epilepsy Policy for Schools'.

Emergency Medication

Sometimes a pupil with epilepsy can experience a longer seizure or a series of seizures without regaining consciousness. If this continues for 30 minutes it is called 'status epilepticus' and is a medical emergency as it could lead to brain damage and ultimately can be fatal.

The pupil's individual healthcare plan with contain details of any medication such as rectal diazepam or buccal midazolam which may have been prescribed to bring the person out of a prolonged seizure or series of seizures.

Emergency medication should only be given according to the instructions on the healthcare plan. There is no legal duty on teachers to give emergency medication but they can volunteer to be trained.

For further information and guidance please contact the Epilepsy Specialist Nurse:

Phil McNulty
Office Tel: 01226 433130
Email: phil.mcnulty@barnsleypct.nhs.uk

Head lice

Introduction

Head lice are small insects that live on the human head, hair, eyebrows and beards. They have six legs and no wings. They are a greyish brown colour and when fully grown roughly 3mm long. Having no wings, the head lice cannot fly or jump and cannot swim.

Head lice are very common, especially among school age children. Transmission is via head to head contact and it has nothing to do with personal hygiene. It takes one full minute to crawl from one head to another.

To live the louse needs to keep warm and is usually found very close to the scalp. It feeds twice a day by sucking the blood off its host through the scalp.

The female can lay up to eight eggs per night in sacs glued to hair close to the scalp. They are the size of a grain of sugar, dull in colour and are very well camouflaged, making them difficult to spot in dry hair. They take seven to ten days to hatch.

The empty egg sacs (nits) are white and shiny and are much more noticeable. Once hatched the louse takes just seven to ten days to become fully grown and able to mate.

Although there appears to be a particularly high incidence of head lice among primary school children they are a problem for the whole community.

Managing the problem of head lice within school

In managing the problem of head lice the school should encourage promoting the prevention of them by working with the School Health Service and raising awareness with parents through health education.

Routine head inspections by school nurses are no longer performed. It has proved much more effective in combating the problem to increase community awareness by health education and by offering parents enough help and advice to detect and treat head lice promptly and effectively within the home.

It should be noted that school staff do not have legal rights to carry out head inspections. Furthermore the school cannot exclude an infected child.

There is a very helpful leaflet which has been designed by the School Health Service detailing the facts about head lice, showing how to detect them and how to treat them. This can be found at Annex 1 to this section. The school should distribute the leaflet to parents periodically and not only when parents or school staff have raised concerns or where there is an ‘outbreak’ in school. It should be integrated within the management of other school health problems rather than addressed as a separate topic.

Schools are no longer advised to send out ‘alert letters’ following an outbreak of head lice. The reasons are:

- it would be inconsistent with the advice given on highly transmissible diseases;
- schools could be sending a succession of these letters : the number of letters being issued diminishes their effect;
- it creates a parental perception that there is a constant problem for their child and;
- it may encourage parents to use an insecticidal lotion inappropriately.

If there is a continuing problem regarding head lice with a particular family or child, the school nurse is available to give further advice and information to parents or individuals - including a home visit if that is deemed appropriate.

School nurses offer home appointments, clinic appointments, and school based appointments to meet with parents and discuss the wet combing technique and general information around treatment and prevention of head lice.

In addition they offer awareness sessions for parents in the form of coffee mornings and parent evenings.

Where parents repeatedly fail to take any action in dealing with head lice on their child the school should consult the Authority with a view to reporting the parents to Social Services on the grounds of neglect.

For further information and guidance please contact the Head of School Nursing:

Ann Meynell
Office Tel: 01226 433130
Email: ann.meynell@swyt.nhs.uk

HEAD LICE

The Facts about Head Lice

* Head lice are small insects (about the size of a sesame seed when fully grown) that live very close to the scalp.

* Nits are not the same as lice. Nits are the empty egg cases which stick to the hair.

* You only have head lice if you find a living moving louse (not a nit).

* Anybody can get head lice - adults and children.

* Head lice don't care if the hair is dirty or clean, short or long.

* A lot of infections are caught from close family and friends in the home and community, not at school.

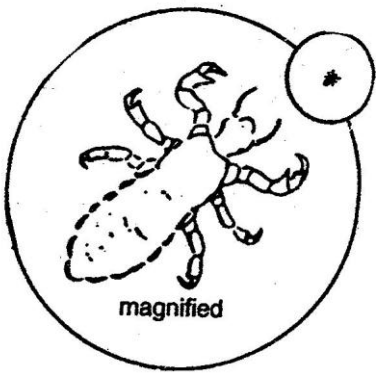
* Head lice can walk from one head to another, if the heads are pressed together for some time. They do not fly, jump or swim.

* Regular hair care may help to spot lice early.

* The best way to stop infection is for families to check their heads regularly using detection combing.

How to detect head lice

Actual size
1.3mm long



You will need:

A PLASTIC DETECTOR COMB
(These are available from your pharmacist - ask for help if there are none on display)

1) Wash the hair well and rinse, apply lots of conditioner but do not rinse.

2) Ensure that there is **good lighting** - daylight is best.

3) First, comb the hair with an ordinary comb. Then, using the detector comb, begin at the top of head and making sure that the comb is touching the scalp, slowly draw the comb towards the ends of the hair.

4) Check the teeth of the comb carefully.

5) Repeat steps (3) and (4), working your way around the head from the top of the scalp to the ends of the hair.

If there are head lice, you will find

one or more on the teeth of the comb

6) If you find lice, or something which you are unsure about, stick it to a piece of paper with clear sticky tape and take it to your GP or local pharmacist.

The best way to stop infection is to do detection combing regularly.

NEVER use insecticidal liquids, lotions or shampoos to PREVENT infection, or just in case.

How to treat head lice

DO NOT TREAT UNLESS YOU ARE SURE YOU HAVE FOUND **A LIVING, MOVING LOUSE**

Ask your GP or pharmacist
which head louse lotion or liquid to use
Do NOT use head louse shampoo

In a well ventilated room....

1) Apply the lotion or liquid to **dry** hair

2) Part the hair near the top, put a few drops of the lotion or liquid on to the scalp and rub in some more of the lotion or liquid. Do this again and again until the whole scalp is wet. You don't need to take the lotion or liquid any further than where you would put a ponytail band. Take care not to get the lotion or liquid in the eyes or on the face.

You should use at least one small bottle of lotion or liquid per head, more if the hair is thick

3) Let the lotion or liquid dry on the hair naturally. Keep well away from naked flames, cigarettes or other sources of heat. Do NOT use a hair dryer.

4) Leave on the hair for 12 hours or overnight. Then, wash and rinse as normal.

5) Repeat the entire treatment seven days later, using second bottle of the same lotion or liquid.

6) Check the head two days after the second treatment. If you still find living, moving lice ask your School Nurse for advice.

Your School Nurse is .....

Contact Tracing

You need to find where the lice came from or you may be reinfected. The source is probably a family member or close friend, who probably does not know they have lice.

Use the check list below to make sure you get in touch with everyone who has been in close (head to head) contact with the infected person. All the people on your list should check themselves and their families for head lice using detection combing. Anyone who is infected with living, moving lice should be treated straight away.

Contact check list:

	Name (s)	Contacted
Parents		
Grandparents		
Brothers / Sisters		
Sons / Daughters		
Aunts / Uncles		
Cousins		
Nieces / Nephews		
Friends		
Lodgers		
School / Nursery		
Babysitter		
Clubs		
Guide / Scouts		
Other		

The problem Won't Go Away?

DID YOU ...

... Use enough lotion or liquid?
... Apply it correctly?
... Let it dry naturally?
... Leave it on for 12 hours?
... Use a second bottle 7 days after the first?
… Check all your close family and friends?
... Check adults as well as children?
... Treat all infected contacts at the same item?

REMEMBER

It doesn't matter how many nits you have, or how itchy your scalp is - if you can't find a living, moving louse, you don't have lice.

Infectious Diseases

Children are more prone to infection than adults and from time to time advice may be required on the occurrence of particular symptoms or signs in children such as rashes, jaundice or diarrhoea. If a health problem has been identified within school, the school nurse and/or the LEA should be provided with the necessary information for its management. This includes:

- the numbers involved;
- the affected children/staff names and contact details;
- their age and class;
- the symptoms;
- the dates of onset and absence, symptoms etc.

Further action will then fall into two broad categories -

(i) Issues may be dealt with by the school nurse/LEA and will include problems not requiring specific intervention nor having the potential to spread within the school.

(ii) Issues which may require more specialised advice or further co-ordinated action. These include problems which indicate a potential outbreak of an infectious disease or which relate to a potentially serious condition. These should be referred to the Authority who will then consult with the Department of Public Health. However should staff not be available at the Authority, schools must contact Public Health direct on (01226) 777010 who will then co-ordinate any further action required. This may well involve professionals in education, environmental health and health services.

The South Yorkshire Health Protection Service has developed guidance on The Management and Control of Infectious Diseases. This is available to download from the HPA website by following this link: The Management and Control of Infectious Diseases

Alternatively the school can contact the Health Schools Team on (01226) 720335 who will in turn liaise with the Health Protection Agency.

Incontinence

The majority of instances of incontinence are most frequent in those children who have just been admitted to nursery. The Authority's Policy on admission to nursery units does not include any requirements that a child be toilet trained, therefore admission cannot be refused if the school becomes aware that the child is not toilet trained. However, it is necessary to differentiate between an incidence of incontinence which is accidental opposed to repeated occurrences which are due to lack of training and/or delayed development.

In the case of an accident it is expected that schools will continue to deal with the incident as part of their duty of care for the child. However, it is necessary to draw staff's attention to the Health and Safety aspects of dealing with bodily fluids. Advice is provided at Annex 1 to this section.

Problems occur where there has been a lack of toilet training by the parent(s) or carer(s) and/or delayed development resulting in repeated incidents whilst the child is attending nursery unit. Where this is the case parents should be advised that it is causing a problem for the nursery unit staff. Schools should manage such a situation as they determine appropriate with their knowledge of the child and family. This will involve the school and the parents working together to resolve the problem.

Whilst the child cannot be refused admission to the nursery unit or prevented from continuing to attend it would not be unreasonable for the parent to support the school by providing nappies and baby wipes. The child should not be penalised for a delay in the ability to learn bladder/bowel control.

Where there is a medical problem it is likely that the school would have been made aware of the difficulty by other professionals and the school should seek the advice of the School Nurse and the Admissions Section.

For SEN pupils with CSA/TA support, managing incidents of incontinence will be part of their job description.

It would be sensible for the school to have two persons present when changing a child where this is possible. The purpose of this would be to assist each other and to minimise the potential for accusations of abuse. However, it is recognised that there will be occasions where this is not practicable and therefore school staff will be expected to exercise their judgement.

In respect of older disabled children or older children who have special educational needs the parent(s) or carer(s) should be asked who, i.e. either male or female member of staff they would like to assist in changing their child. In cases where older children are more mentally able it is advisable to ask which gender of staff they would prefer to assist in changing them. This information should be detailed in the Health Care Plan and staff should protect the dignity of children as far as possible.

If it is necessary to dispose of soiled nappies or other items on a continuing basis this must be dealt with under the regulations covering the disposal of clinical waste using the yellow bag system. Yellow bags can be purchased from the Smithies depot and are used to identify to the waste collection service that the contents are body waste or fluids. Arrangements need to be made for the yellow bag to be collected from school separately from the normal school waste/ rubbish. This service can be provided by the Waste Management department at a charge by telephoning Smithies Depot on 774207.

ANNEX 1

PROCEDURE FOR MANAGING INCIDENTS OF INCONTINENCE IN PRIMARY CHILDREN

Dealing with incontinence in pupils must be managed with the same precautions that apply to any bodily fluid.

1 The changing of a pupil's clothing and necessary washing should take place in a private area and if possible two persons should be present.

2 Any area designated for this purpose should have facilities for washing and drying the child.

3 Members of staff carrying out this procedure should wear disposable gloves and an apron.

4 For the children just admitted into nursery unit the school should ask for a change of clothing to be kept at school.

5 Parents must always be told that there has been an incident and that it was necessary to wash / dry the child.

6 Soiled clothing should be put in a plastic bag and returned to parents for washing or for the disposal of it.

7 Dirty nappies should be placed in a plastic bag and sealed (sellotape or staples) which in turn should be placed in the yellow bag to identify the contents as containing bodily waste.

8 At the end of the procedure wash and dry hands and dispose of the apron and gloves.

Verrucas

General Information on Verrucas

A verruca is a wart which is commonly found on the sole of the foot. It is usually painless and will sometimes disappear without treatment given time. However if it rubs against the shoe, or is on a weight-bearing part of the foot it may be painful. If it is painful or if it is spreading it may require treatment. Verrucas are usually acquired from contaminated floors in swimming pools and communal showers.

The virus that causes a verruca is very slow growing, and from the point of infection up to the development of a verruca there is quite a long time delay. Therefore, only to take precautions with children who have developed an obvious verruca, is not likely to stop the spread of the virus since other children may have the virus on their foot even though it has not yet become apparent.

Children's activities may obviously be limited if they have a bad verruca that is causing them pain. In such cases medical treatment should be sought. However, aside from that situation, precautions such as the wearing of verruca socks, plimsolls and banning children from swimming hinder the full participation of children in activities. These precautions are unnecessary and not advisable.

Emergency Medical Jewellery

There are a small number of children in schools who have a medical condition which requires the permanent wearing of medical jewellery. Such items provide essential information in the event of the pupil having an accident or requiring treatment relating to their medical condition.

If these items are attached to the child's body there is no reason why they cannot be removed and attached safely to an item of clothing which the child is wearing for P.E.

The P.E. staff should make an informed decision to which part of their clothing constitutes a safe but secure position.

Furthermore they should be aware of any children who have a medical condition and be familiar with what action to take in the event of an accident or incident requiring immediate treatment relating to their medical condition.

Norovirus

What is norovirus?

Norovirus is actually a name given to a group of viruses, and it is the most common viral cause of gastrointestinal illness in the UK. Inadequate hygiene is the main reason why this virus can be spread so quickly. Sufferers can experience both diarrhoea and vomiting at the same time, and if hands are not sufficiently washed, the virus can be transferred to anyone and anything the sufferer touches. This is why you often hear of outbreaks occurring in crowded, contained places such as cruise ships and hospitals.

Common names of the illness caused by noroviruses are winter vomiting disease, viral gastroenteritis, and acute non-bacterial gastroenteritis, also colloquially known as "stomach flu"—a broad name that refers to gastric inflammation caused by a range of viruses and bacteria.

How is it spread?

Norovirus is transmitted directly from person to person and indirectly via contaminated objects, water and food. They are highly contagious, with as few as one to ten virus particles being able to cause infection. Transmission occurs through ingesting contaminated food and water and by person-to-person spread. Transmission is through fecal-oral, can be aerosolized when those stricken with the illness vomit and can be aerosolized by a toilet flush when vomit or diarrhea is present; infection can follow eating food or breathing air near an episode of vomiting, even if cleaned up. The viruses continue to be shed after symptoms have subsided and shedding can still be detected many weeks after infection

Diagnosing, treating and preventing norovirus

When a person becomes infected with norovirus, the virus begins to multiply within the small intestine. After approximately 1 to 2 days, norovirus symptoms can appear. The principal symptom is acute gastroenteritis that develops between 24 and 48 hours after exposure, and lasts for 24–60 hours. The condition is usually self-limiting, and characterized by nausea, vomiting, diarrhoea, and abdominal pain; and in some cases, loss of taste. General lethargy, weakness, muscle aches, headache, and low-grade fever may occur.

Since the virus is transferred through diarrhoea, diagnosis is usually confirmed by testing a stool sample. This is probably more likely to happen during an outbreak. Otherwise, since it is such a common cause of gastroenteritis, testing samples is not usually needed.

As with any kind of gastrointestinal illness, personal hygiene is crucial to reducing the spread of infection. This includes washing hands thoroughly after going to the toilet and also disinfecting the toilet, seat, flush handle etc. Avoid preparing or serving food and try to stay at home until your symptoms have passed. It is advised that in schools, bars of soap are done away with in favour of soap dispensers.

As with general diarrhoea, dehydration is one of the main risks, especially with young children so keeping up fluid intake is essential.

Advice to Parents

If a child falls ill with symptoms including nausea, vomiting and diarrhoea, parents should be urged to take the following action:

- NOT send their children to school when they fall ill
- Ensure their child washes his or her hands frequently and thoroughly, particularly after using the toilet and before handling food
- Disinfect any surfaces or objects that could be contaminated with a norovirus using a bleach-based household cleaner
- Flush away any infected faeces or vomit in the toilet and keep the surrounding toilet area clean and hygienic
- Wash any clothing or linens which could have become contaminated with a norovirus with hot, soapy water.

Anyone with a stomach bug that may have been caused by a norovirus should avoid direct contact with others and preparing food for others until at least 48 hours after the symptoms have gone.

There is no specific treatment for a norovirus apart from letting the condition run its course. Eating foods that are easy to digest such as soup, rice, pasta and bread is advised. Drinking plenty of water will help to replace the fluids that are lost through diarrhoea and vomiting and prevent dehydration.

School Closure

In some severe cases it may be determined that a school closure is required to;

- Stop the spread of infection between pupils and staff
- Allow the school to have a 'deep clean' to sanitise contaminated surfaces/objects
- Allow for enough staff to recover to re-open the school to pupils who are well.

For advice on school closures, the Health Protection Agency (HPA) (South Yorkshire Health Protection Unit) should be contacted on 0114 2428850.

School closures where they are advised by the HPA are the decision of the Head Teacher in conjunction with the Chair of Governors and the Infrastructure for Learning Department who will coordinate the closure.

Appendix 2:

Useful Points of Contact

Diabetes Specialist Nurse
Denise Gibson 432519
Denise.gibson@nhs.net

Asthma Specialist Nurse
Zena Thomas
0122 6432519 mobile. 07788416057
Zena.thomas@nhs.net

Epilepsy Specialist Nurse
Phil McNulty
01226 355
Phil.mcnulty@barnsleypct.nhs.uk

School Nursing Team
Ann Meynell
01226 433130
Ann.meynell@swyt.nhs.uk

Health Visiting Service
Anita McCrum
01226 433256
Anita.mccrum@swyt.nhs.uk

Healthy Setting 0 to 19yrs Team
Sue Copeland
01226 775088

Appendix 3

Consent Forms and Medical Records

AM1 Parental consent forms for the administration of medicines to children

AM2 Parental consent forms for the self-administration of medicines to children

AM3 Record of training in administering medical/emergency procedures

AM4 Consent to administer medical/emergency procedure

AM5 Template Individual Health Care Plan

PARENTAL CONSENT FORM FOR THE ADMINISTRATION OF MEDICINES

SECTION 1

PUPIL NAME .....

CLASS No/ TEACHER .....

DATE OF REQUEST

SECTION 2

PARENT CONTACT NUMBER .....

DAY TIME EMERGENCY CONTACT NUMBER .....

PARENT(S) OR CARER(S) NAME

SECTION 3

NAME OF MEDICATION .....

IS THIS MEDICINE:

PRESCRIBED		NON PRESCRIBED	

CONDITION OR ILLNESS EG EAR INFECTION .....

DATE PRESCRIBED .....

DETAILS OF DOSAGE .....

TIME/FREQUENCY OF DOSAGE .....

DATE COURSE OF MEDICATION FINISHES .....

If the medication is prescribed for 8 days or more, an individual health care plan should be completed.

SECTION 4

DECLARATION BY THE PARENT/LEGAL GUARDIAN

I consent to my child being administered the prescribed medicine in accordance with the information above*. I understand that It is the School Policy not to force children to take their medicine if they refuse to do so. In the event of this occurring, the nominated contact will be notified.*

I confirm that my child has no known adverse reaction to this medication and understand that the LEA, Governing Body of the school and the staff cannot accept responsibility for any adverse reaction my child may suffer as a consequence of being administered the prescribed medication at my request.

Signed: _____ Date: _____.

Relationship to child: _____

AM1 (CONTINUED)

SECTION 5

APPROVAL FOR REQUEST YES / NO

HEADTEACHER_____ **DATE**_____

RECORD OF PRESCRIBED AND NON PRESCRIBED MEDICINES ADMINISTERED TO CHILDREN OR SELF ADMINISTERED AS PER PAGE 1

DATE	TIME	MEDICINE & DOSAGE	ADMINISTERED BY	WITNESSED BY

PARENTAL CONSENT FORM FOR THE SELF-ADMINISTRATION OF MEDICINES

SECTION 1

PUPIL NAME .....

CLASS No/ TEACHER .....

DATE OF REQUEST

SECTION 2

PARENT CONTACT NUMBER .....

DAY TIME EMERGENCY CONTACT NUMBER .....

PARENT(S) OR CARER(S) NAME

SECTION 3

NAME OF MEDICATION .....

IS THIS MEDICINE:

PRESCRIBED		NON PRESCRIBED	

CONDITION OR ILLNESS (e.g. ear infection) .....

DATE PRESCRIBED .....

DETAILS OF DOSAGE .....

TIME/FREQUENCY OF DOSAGE .....

DATE COURSE OF MEDICATION FINISHES (if applicable) .....

If the medication is prescribed for 8 days or more, an individual health care plan should be completed.

IF THERE ARE NO SPECIAL STORAGE ARRAGEMENTS, WOULD YOU LIKE YOUR CHILD TO CARRY THEIR MEDICINE WITH THEM FOR USE AS NECESSARY?

YES **NO**

SECTION 4

DECLARATION BY THE PARENT/LEGAL GUARDIAN

I consent to my child self-administering the prescribed medicine in accordance with the information above.

I understand that the LEA, Governing Body of the school and the staff cannot accept responsibility for any adverse reaction my child may suffer as a consequence of being administered the prescribed medication at my request.

Signed: _____ Date: .

Relationship to child: _____

AM2 (CONTINUED)

SECTION 5

APPROVAL FOR REQUEST **YES / NO**
APPROVAL FOR CHILD TO SELF-ADMINISTER IF APPLICABLE **YES / NO**
APPROVAL FOR CHILD TO CARRY OWN MEDICINES IF APPLICABLE **YES / NO**

HEADTEACHER_____ **DATE**_____

Dear Parent (s)/Carer(s)

NOTIFICATION OF SELF ADMINISTRATION OF NON PRESCRIPTION MEDICINE

I would inform you that your child: _____

has received medication as detailed below, in accordance with your request that was agreed with the school.

Name of Medication: _____

Details of Dosage: _____

Date and time(s) medication administered: _____

Condition or illness: _____

_____

Name of person administering/supervising self-administration of medicine:

_____

Yours sincerely

The Headteacher

RECORD OF TRAINING IN ADMINISTERING MEDICAL/EMERGENCY PROCEDURES

This form is to be used where there has been a parental request for school staff to administer a medical procedure/emergency medical procedure. Training will be provided in the relevant procedure(s) by the appropriate health professional(s).

Training will be provided with the agreement of parent / carer/ responsible medical professional / Headteacher / and Barnsley Local Education Authority, on the understanding that:

- Staff undergo training on a voluntary basis.
- Staff are employees of the Barnsley Local Education Authority or Governing Bodies in Barnsley VA Schools or are carers approved by the Barnsley NHS Primary Care Trust/Barnsley District General Hospital NHS Trust.
- Staff agree to regular review and update their skills under instruction from a trainer approved by the responsible medical professionals.

Date of awareness session: _____

Nature of medical procedure to be undertaken: _____

_____

Pupils Name: _____

Year Group/Class: _____

Please check that the pupils address, emergency contact name and number and parents contact details are up to date in the school records.

Name of GP: _____

Address: _____

_____

Telephone no: _____

Date training undertaken:	
Training provided by:	
And approved by:	

Name of Nominated Staff	Signature
1	I have understood the training that has been provided and feel competent in carrying out the task.
2	I have understood the training that has been provided and feel competent in carrying out the task.
3	I have understood the training that has been provided and feel competent in carrying out the task.
4	I have understood the training that has been provided and feel competent in carrying out the task.
5	I have understood the training that has been provided and feel competent in carrying out the task.
6	I have understood the training that has been provided and feel competent in carrying out the task.
7	I have understood the training that has been provided and feel competent in carrying out the task.
8	I have understood the training that has been provided and feel competent in carrying out the task.
9	I have understood the training that has been provided and feel competent in carrying out the task.
10	I have understood the training that has been provided and feel competent in carrying out the task.

11	
	I have understood the training that has been provided and feel competent in carrying out the task.
12	
	I have understood the training that has been provided and feel competent in carrying out the task.

DECLARATION BY SUPERVISING DOCTOR/NURSE

I declare that the above named individuals have attended an awareness session under my supervision. They have been made aware of the medical condition and procedure and have been given the appropriate training and level of understanding to administer medical procedures as detailed in the Care Plan and Teaching Pack where appropriate.

Name: _____ Status: _____

Signed: _____ Date: _____

AM4

CONSENT TO ADMINISTER MEDICAL/EMERGENCY PROCEDURE

PARENT/CARER'S DECLARATION

I consent to my child receiving the medical procedure detailed in their Individual Care Plan by the individuals what have been training and are detailed on form AM3. I will notify the school immediately of any change in circumstances/regime.

I fully understand that unless the administering member(s) of staff negligently fail to administer the medical procedure in compliance with the approved training/instruction he/she has received, or any subsequent training/instruction he/she has received, that BMBC, the Governing Body of the School and the staff cannot accept any responsibility for any adverse reaction or medical complication my child might suffer as a consequence of receiving this medical procedure, which I have requested them to undertake on my behalf.

Signed: _____

Relationship to child: _____

Date: _____

HEADTEACHER'S DECLARATION

I confirm the Chairperson of the Governing Body will be informed of the above details.

Signed: _____

(Headteacher)

Date: _____

AM5

INDIVIDUAL HEALTH CARE PLAN

This care plan can be used to document arrangements for general health conditions. However, please be aware that more relevant template health care plans may be available within the medical needs information and action cards appendices to this Strategic Assurance Standard.

SECTION 1	
CHILDS NAME	
CLASS No/ TEACHER	
DATE OF BIRTH	
MEDICAL DIAGNOSIS/ CONDITION	
DATE	
REVIEW DATE	

SECTION 2	
PARENT CONTACT NUMBER	
DAY TIME EMERGENCY CONTACT NUMBER	
PARENT(S) OR CARER(S) NAME	

SECTION 3	
CLINIC/ HOSPITAL CONTACT NAME & NUMBER	
GP CONTACT NAME & NUMBER	

SECTION 4	
DESCRIBE MEDICAL NEEDS AND GIVE DETAILS OF CHILDS SYMPTOMS	
POSSIBLE TRIGGERS	
DAILY CARE REQUIREMENTS/ MEDICINES (e.g. before sport/ at lunchtimes)	
DESCRIBE WHAT CONSTITUTES AN EMERGENCY FOR THE CHILD AND THE ACTION TO TAKE IF THIS OCCURS	

FOLLOW-UP CARE	
WHO IS RESPONSIBLE IN AN EMERGENCY (state if different for off-site activities)	
IS SPECIFIC TRAINING IN ADMINISTERING MEDICAL/EMERGENCY PROCEDURES NECESSARY?	YES NO IF YES PLEASE COMPLETE FORM AM3

SECTION 5

INDICATE IF ANY ADDITIONAL RISK ASSESSMENTS HAVE BEEN PROCUDED AND FOR WHICH ACTIVITIES (e.g. P.E.)	
DO ANY SPECIFIC STAFF HAVE A COPY OF THIS CARE PLAN? (e.g. transport services, school cook)	
ANY OTHER ASSOCIATED FORMS WITH THIS CARE PLAN (e.g. AM1)	

SECTION 7 PARENT/CARER'S DECLARATION

The above information is, to the best of my knowledge, accurate at the time of writing. I will inform the school/setting immediately in writing if there are any changes in my child's condition, medical/emergency arrangements or the contact details given.

I give consent for this information to be shared with relevant non-parent carers as detailed in section 5.

I will complete any associated consent forms for the administration of medicines and/or emergency/medical procedures.

Signed: _____ Date: _____.

Relationship to child: _____