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Hele's School Policy No:		Person/Group responsible:	**Deputy Principal (Support)**
Review Period:	**Annual**	Last review date:	**January 2022**

EDUCATIONAL ESTABLISHMENTS

Introduction

1. This document is based upon the Department for Education and Skills and the Department of Health guidance booklet: **"Managing Medicines in Schools and Early Years Settings"** (DfES/DH March 2005 – Reference 1448-2005DCL-EN – available at www.teachernet.gov.uk or http://publications.teachernet.gov.uk). Page and paragraph numbers, where given below, refer to this DfES/DH guidance booklet. The Children & Families Act 2014 states that governing bodies must make arrangements for supporting pupils at school with medical conditions.

2. **Further guidance**, for example on curriculum activities such as physical education and outdoor pursuits, may be found in other Plymouth City Council publications. The **religious practices** of some faiths may also impact upon the administration of medicines: some examples are given in Appendix D to this document; guidance where required should be sought from the parents and faith groups themselves.

Responsibilities and Legal Framework

3. Hele's School is **responsible** for the health and safety of children **while in their care**; in undertaking this duty of care, they are **dependent** on the accurate information from and cooperation of parents, as well as the support of health professionals.

4. **No member of staff should be compelled** to give medical treatment to a pupil (see page 6, paragraph 16 and page 35, paragraph 6 of the DfES/DH guidance booklet); **however**, teachers have a general legal duty to act in loco parentis. **All those caring for children**, including teachers, other school staff and day care staff in charge of children, have a **common law duty of care** to act like any reasonably prudent parent. This duty also extends to staff leading activities taking place off site, such as visits, outings or field trips.

5. Hele's School staff may, with appropriate training, assist with the administration of medication provided by parents and health professionals; however, **staff** (i.e. staff who are not health professionals themselves) **should not prescribe and administer medicines**. For instance, requests for paracetamol in the case of children's headaches or other pains should be politely refused and the problem referred to the parent through the school's or setting's usual communication processes.

6. It is hoped that through a combination of parental cooperation, the support of the City Council and the help of the School Health Service, staff will see the management of medicines as part of their pastoral role.

7. Hele's School is under a duty to **increase access** and should be aware of the circumstances in which children with medical needs are protected under the Disability Discrimination Act (DDA) 1995. The general guidance on inclusion, as outlined in the National Curriculum Inclusion Statement 2000, refers to the key principles of responding to children's diverse needs and **overcoming potential barriers to learning** (see page 5, paragraphs 8-12 of the DfES/DH guidance booklet).

8. Children with medical needs have the **same rights of admission** to school as other children and cannot be removed from school for medical reasons, except "in certain circumstances, e.g. where there is a risk to health and safety of staff and other pupils" (see page 35, paragraph 8 of the DfES/DH guidance booklet). Pupils with medical conditions should be properly supported so that they have full access to education including school trips and PE (see Medical Needs Policy).

9. Legislation and regulations relevant to schools and settings in dealing with children's medical needs, include:

   - Medicines Act 1968
   - Misuse of Drugs Act 1971 and associated regulations
   - Health and Safety at Work etc Act 1974
   - Education Act 1996
   - Management of Health and Safety at Work Regulations 1999
   - The Education (School Premises) Regulations 1999
   - SEN and Disability Act (SENDA) 2001
   - Control of Substances Hazardous to Health Regulations (COSHH) 2002 • Children & Families Act 2014

10. Further details of the acts and regulations are given in Annex A (Legal Framework) of the DfES/DH guidance booklet.

General Guidance on the Administration of Medicines

11. Children with medical needs and requiring medicines may be identified as falling into one of **three categories**: there will be some pupils capable of self-administering treatment e.g. paracetamol for period pains, while some will require a certain level of supervision and others will need the medicine to be administered to them. Staff, with advice from the medical services if required, may note into which of these three categories each pupil will fall, as this could be helpful when dealing with a health care plan, an agreement to administer medicines or any forms recording medicines administered. For examples of recommended forms, see Section 6 ("Documentation") below and Annex B to this document.

12. Medicines must be **prescribed by a registered medical practitioner** and should not be given unless **parents have requested their use and signed the consent form**. Where medicines have

been brought into school before parents have been able to complete a consent form, verbal or written permission must be sought form the parent. The general rule is that students should not bring non-prescribed medicines to school, if non-prescribed medicines are brought to school parents must complete and sign a consent form.

13. The practice of parents giving children small quantities of **proprietary medicines** to cope with minor ailments when away from home, as well as occasions when parents are convinced that **homeopathic remedies** are helpful to their children, may require further discussion with parents. Although these situations are unlikely to be potentially life-threatening or harmful, where proprietary medicines or homeopathic remedies are taken, it is still essential that parents sign the consent form (**AMEE 5** in Appendix B) and provide all the necessary information.

14. Medicines should only be taken to school when essential; **it is helpful, where clinically appropriate, if medicines are prescribed in dose frequencies which enable them to be taken outside school hours**. The medicines Standard of the National Service Framework (NSF) for Children recommends that:

    - prescribers consider the use of medicines which need to be administered only once or twice a day so that they can be taken outside school hours
    - prescribers consider providing two prescriptions for a child's medicine; one for home and one for use in the school or setting, avoiding the need for repackaging or relabelling of medicines: an example of this might also be reliever inhalers for asthma. (NB Providing two prescriptions would be inappropriate in the case of antibiotics.) If repackaging occurs, parents must ensure that medicines are clearly labelled with dosage and other essential instructions, and provided in the minimum quantity for the school or setting day.

15. Hele's School should **check** that medicines held on a child's behalf are '**in date**' and **clearly labelled** with the child's name and the recommended dosage. If medicines become out of date, **parents** should dispose of them in an approved way: any medicines not collected by parents should be taken to a local pharmacy for safe disposal.

16. The duty to ensure that the risks to others are properly controlled is set out in the Control of Substances Hazardous to Health Regulations 2002 (COSHH). All medicines, unless managed by individual students themselves, should be **stored in separate containers in a safe place** when not in use, in accordance with the product instructions and clearly labelled with the name of the child and details of dosage. "A safe place" means lockable storage and rooms in which drugs are kept should **not normally** be **accessible to students**. Storing drugs in a fridge in a staff room not used by students would be acceptable, unless security procedures relevant to controlled drugs are appropriate. **Controlled drugs**, which can be extremely dangerous if taken in the wrong quantities or by other children, should be kept in a locked, non-portable container, accessible only to staff nominated by the head teacher as the appropriate guardian, and records should be kept for audit purposes. Whenever possible and appropriate, children should know where their medicines are stored and who holds the key.

17. Further details of prescribed medicines, controlled drugs and non-prescription medicines may be found in Chapter 1 (Developing Medicines Policies) of the DfES/DH guidance booklet.

18. Emergency medicines such as asthma inhalers and adrenaline pens should not be locked away and should be **readily available** to children requiring them. In a large educational establishment this may mean having the medicines available in a number of different locations, so that they are accessible within five minutes from any area.

19. When **adrenaline pens** are prescribed (normally by the child's paediatrician) Hele's School should be informed and may request training for the relevant school staff who have agreed to help in their administration. With the support of the School Nursing Service, a health care plan will be drawn up and opportunities provided for annual training updates.

20. If required, **sharps boxes**, which must always be used for the disposal of needles, should be provided by parents, who may obtain boxes on prescription from the child's GP or paediatrician and should collect boxes for disposal. Schools and early years settings should be aware of the need to maintain **security of sharps boxes**, which are potential targets for theft. It is also important to remember that any individual suffering a **needle-stick injury** should go straight to Accident and Emergency

A Summary of Parental Responsibility

21. Parents have the **prime responsibility** for their child's health and should provide schools and settings with the **necessary information** about their child's medical condition. For example, parents should ensure that a copy of the health care plan provided by the child's GP or relevant professional is made available to the school or setting, and must ensure that the school is informed of any change in condition, prescription or staff training need.

22. Parents, as defined in section 576 of the Education Act 1996, include any person who is not a parent of a child but has **parental responsibility for or care of a child**. It only requires one parent to agree or to request that medicines are administered. **Where parents disagree** over medical support, the disagreement must be resolved by the courts: the school or setting should continue to administer the medicine in line with the consent given and in accordance with the prescription, unless and until a court decides otherwise.

23. If a child is on regular medication it may be necessary for **two sets** of similar medicines to be kept; one at home and one at school. The child's GP or paediatrician should be willing to prescribe this, at parental request.

24. **Close co-operation** between parents, health professionals and the school is essential. However, the primary responsibility to make arrangements rests with parents, including being prepared to make alternative provision should any arrangements fail.

25. Further details regarding parental responsibility may be found in Chapter 2 (Roles and Responsibilities) of the DfES/DH guidance booklet.

Training

26. The provision of **advice, support and training**, on request, on specific issues to do with the administration of medicines as well as on more general issues, is accessed via the School Nursing Service: trade unions and other professional associations offer training but, in particular, epipen, Midazolam and Stesolid training should be provided by the School Nursing Service .

27. Although the majority of medicines are given by mouth in liquid form or as tablets, training is recommended. Asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis) are medical conditions that commonly cause most concern and need for training in schools and settings. General guidance on these conditions and the administration of medicines is to be found in Appendix C to this document (which is based upon Chapter 5 of the DfES/DH guidance booklet, revised and updated by local health professionals). The School Nursing Service (in the case of schools) and the Health Visiting Service (in the case of early years settings) will provide **specific training** for school or setting staff, **on request**.

28. First aid training for school staff should cover aspects of the administration of medicines which could present a risk, in order that contingency plans can be prepared for the event of an accident or emergency.

29. Training should cover the need for confidentiality.

30. Staff should not give prescription medicines or undertake health care procedures without appropriate training (updated to reflect individual healthcare plans at all times) from a healthcare professional. A first-aid certificate does not constitute appropriate training in supporting children with medical conditions.

31. The school nurse or other suitably qualified healthcare professional should confirm that staff are proficient before providing support to a specific child.

32. The school nurse should be able to advise on training that will help ensure that all health conditions affecting pupils in the school are understood fully. This includes preventative and emergency measures so that staff can recognise and act quickly when a problem occurs.

33. Parents should be asked for their views and may be able to support school staff by explaining how their child's needs can be met. They should provide specific advice, but should not be the sole trainer.

34. Medicines should only be administered at school when it would be detrimental to a child's health or school attendance not to do so.

Policy Checklist

35. Schools and settings are encouraged to develop policies and procedures that draw on the overall policy contained in this document and are amended for their particular circumstances regarding administrative procedures, staff responsibilities and layout of buildings.

36. The DfES/DH guidance states that an administration of medicines policy should cover:

- procedures for managing prescription medicines which need to be taken during the school or setting day
- procedures for managing prescription medicines on trips and outings
- a clear statement on the roles and responsibility of staff managing administration of medicines, and for administering or supervising the administration of medicines
- a clear statement on parental responsibilities in respect of their child's medical needs
- the need for prior written agreement from parents for any medicines to be given to a child
- the circumstances in which children may take any non-prescription medicines
- the school or setting policy on assisting children with long-term or complex medical needs
- policy on children carrying and taking their medicines themselves – i.e. older children being able to carry their own medicines
- staff training in managing medicines safely and supporting an identified individual child
- record keeping
- safe storage of medicines
- access to the school's emergency procedures
- risk assessment and management procedures
- safe disposal of sharps

37. The purpose of this document is to help to clarify responsibilities, forms and procedures: it is understood that many of the above policies will already be in place in schools and settings. It is also recognised that schools have always enjoyed excellent support from health professionals.

Health and Safety Responsibilities

38. This document is in line with the Local Authority's Health and Safety Policy and Guidelines. The Health and Safety Executive takes the view that providing management and staff act in accordance with the Health and Safety Policy and Guidelines, asking for advice if in doubt, there should be no difficulty in meeting health and safety obligations, within the protection of the Local Authority's insurance policies.

Appendix A: USEFUL CONTACTS

Allergy UK
Allergy Help Line: (01322) 619864
Website: www.allergyfoundation.com

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

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

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

Council for Disabled Children
Tel: (020) 7843 1900
Website: www.ncb.org.uk/cdc/

Contact a Family
Helpline: 0808 808 3555
Website: www.cafamily.org.uk

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

Diabetes UK
Careline: 0345 123 2399 (Weekdays 9am to 5pm)
Website: www.diabetes.org.uk

Department for Education and Skills
Tel: 0870 000 2288
Website: www.dfes.gov.uk

Department of Health
Tel: (020) 7210 4850
Website: www.dh.gov.uk

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

Epilepsy Action
Freephone Helpline: 0808 800 5050 (Monday – Thursday 9am to 4.30pm, Friday 9am to 4pm)
Website: www.epilepsy.org.uk

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

Health Education Trust
Tel: (01789) 773915
Website: www.healthedtrust.com

Hyperactive Children's Support Group
Tel: (01243) 551313
Website: www.hacsg.org.uk

MENCAP
Telephone: (020) 7454 0454
Website: www.mencap.org.uk

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

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

Psoriasis Association
Tel: 0845 676 0076 (Mon-Thurs 9.15am to 4.45pm Fri 9.15am to 16.15pm)
Website: www.psoriasis-association.org.uk/

Sure Start
Tel: 0870 000 2288
Website: www.surestart.gov.uk

Appendix B: FORMS

Healthcare Plan

Parental agreement for school/setting to administer medicines

Record of medicines administered to children

Authorisation for administration of rectal diazepam

Healthcare Plan

Part A – For completion by parent

Name of School/Setting ______________________________

Child's name ______________________________

Group/Class/Form ______________________________

Date of Birth ______________________________

Child's Address ______________________________

Medical Diagnosis or Condition ______________________________

Date ______________________________

Review date ______________________________

CONTACT INFORMATION

Family contact 1			**Family contact 2**		
Name			Name		
Phone No. (work)			Phone No. (work)		
(home)			(home)		
(mobile)			(mobile)		

Clinic/Hospital contact

Name ______________________________

Phone No. ______________________________

GP

Name ______________________________

Phone No. ______________________________

Part B – For Completion by the appropriate health professional

Describe medical needs and give details of child's symptoms:

____

____

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

____

____

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)

____

____

____

Form copied to:

____

____

DEPARTMENT FOR LIFELONG LEARNING

ADMINISTRATION OF MEDICINES IN SCHOOLS

Name of Pupil: ....

Address: ....

....

Medical Condition: ....

Medicine: ....

Dose: .... Frequency: ....

Parental Consent

1. I give my permission for the Headteacher / Principal (or their nominee) to administer the medicine to my child during the time they are at school.

Signed: .... Name: .... Date: ....

(Parent / guardian / Person with parental responsibility)

2. I give my permission for my child to carry their asthma inhaler with them whilst at school and to manage its use.

Signed: .... Name: .... Date: ....

(Person with parental responsibility)

3. I give my permission for my child to manage the use of its own pen injector for diabetes.

Signed: .... Name: .... Date: .... *(Person with parental responsibility)*

Hele's School Policy No:		Person/Group responsible:	**Deputy Principal (Support)**
Review Period:	**Annual**	Last review date:	**January 2022**

NOTES OF GUIDANCE

- The Headteacher / Principal (or their nominee) will only administer medicines prescribed by a doctor.
- This form should be completed by the parent, guardian or person with parental responsibility for the pupil / student and be delivered personally, together with the medicine, to the Headteacher / Principal.
- The medicine should be in date and clearly labelled with:

  ○ Its contents; ○ The owners name; ○ Dosage and frequency;
  ○ Name of prescribing doctor.

- The information overleaf is requested, in confidence, to ensure that Hele's School is fully aware of the medical needs of your child.

While no staff member can be compelled to give medical treatment to a pupil / student, it is hoped that the support given through parental consent, the support of Hele's School through these guidelines and the help of the School Medical Services will encourage them to see this as part of the pastoral role.

Where such arrangements fail it is the parents' responsibility to make appropriate alternative arrangements.

Record of medicines administered in school/setting to all children

Name of School/Setting ________________________________

Date	Name of pupil	Medicine	Dosage	Any reactions/ additional notes	Time of day	Signature	Print name

Date	**Name of pupil**	**Medicine**	**Dosage**	**Any reactions/ additional notes**	**Time of day**	**Signature**	**Print name**

Hele's School

Authorisation for the administration of Rectal Diazepam

Name of School/Setting	
Child's name	
Date of birth	
Home address	
GP	
Hospital consultant	

_________________ *[name of child]* should be given Rectal Diazepam____ mg. If he/she has a *prolonged epileptic seizure lasting over ____ minutes

OR

*serial seizures lasting over __________________ minutes.

An Ambulance should be called for *at the beginning of the seizure

OR

If the seizure has not resolved *after ______________ minutes.
(* please delete as appropriate)

Doctor's signature:	
Parent's signature:	
Print Name:	
Date:	

NB: Authorisation for the Administration of Rectal Diazepam

As the indications of when to administer the diazepam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state:

- when the Diazepam is to be given e.g. after 5 minutes; and
- how much medicine should be given.

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

Records of administration should be maintained using Form 4 or similar.

Appendix C: COMMON CONDITIONS

CHAPTER 5: COMMON CONDITIONS – PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS

INTRODUCTION

1. The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This chapter provides some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children are assessed on an individual basis.

2. Further information, including advice specifically for schools and settings, is available from leading charities.

3. Training for first-aiders in early years settings must include recognising and responding appropriately to the emergency needs of babies and children with chronic medical conditions.

ASTHMA

What is Asthma?

4. Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children has asthma in the UK.

5. The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get all these symptoms, and some children may only get symptoms from time to time.

6. However in early years settings staff may not be able to rely on younger children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is therefore imperative that early years and primary school staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for children with asthma when this happens. This should be supported by written asthma plans, asthma school cards provided by parents, and regular training and support for staff. Children with significant asthma should have an individual health care plan.

Medicine and Control

7. There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes

taken before exercise. **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

8. **Children with asthma need to have immediate access to their reliever inhalers when they need them.** Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers, and the child may need some help to do this. It is good practice to support children with asthma to take charge of and use their inhaler from an early age, and many do.

9. Children who have been taught the correct inhaler technique (usually by the parents) and are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

10. For a child with severe asthma, the health care professional may prescribe a spare inhaler to be kept in the school or setting.

11. The signs of an asthma attack include:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

12. When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. An ambulance should be called if:

- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to speak
- the child is becoming exhausted
- the child looks blue

13. It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

14. A child should have a regular asthma review with their GP or other relevant healthcare professional. Parents should arrange the review and make sure that a copy of their child's management plan is available to the school or setting. Children should have a reliever inhaler with them when they are in school or in a setting.

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

16. Reluctance to participate in physical activities should be discussed with parents, staff and the child. However children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate.

17. Children with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate.

18. All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and medical needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK). The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

19. All staff, particularly PE teachers, should have training or be provided with information about asthma once a year. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

EPILEPSY

What is Epilepsy?

20. Children with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children has epilepsy and around 80 per cent of those children attend mainstream school. Most children with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

21. Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)
- any unusual "feelings" reported by the child prior to the seizure
- parts of the body demonstrating seizure activity e.g. limbs or facial muscles
- the timing of the seizure – when it happened and how long it lasted
- whether the child lost consciousness
- whether the child was incontinent

This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

22. What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only a part of the brain is affected, a child will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected, a child may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

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

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

25. Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

Medicine and Control

26. Most children with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school hours.

27. Triggers such as anxiety, stress, tiredness or being unwell may increase a child's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity. It is very rare. Most children with epilepsy can use computers and watch television without any problem.

28. Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan.

During a seizure it is important to make sure the child is in a safe position, not to restrict a child's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

29. An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured him/herself badly
- the child has problems breathing after a seizure
- a seizure lasts longer than the period set out in the child's health care plan
- a seizure lasts for five minutes, if you do not know how long they usually last for that child
- there are repeated seizures, unless this is usual for the child as set out in the child's health care plan

30. Such information should be an integral part of the school or setting's emergency procedures and also relate specifically to the child's individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

31. Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures or seizures that repeat themselves with very little break will be prescribed either Midazolam or Stesolid. Children who are prone to longer seizures may be prescribed Midazolam or Stesolid which are effective emergency treatments. The paediatrician or other appropriate health professional should provide guidance as to when to administer medicines and why.

32. Training in the administration of Midazolam or Stesolid is essential and staff must be updated annually. Currently school nurses train in schools and children's community nurses train in early years establishments. Children prescribed Midazolam **must** have a protocol provided by the paediatrician which has been agreed with the parents. This will explain the seizure types and provide instruction on when to administer the medicine. Midazolam is a liquid solution given into the mouth or nasal passages which is absorbed by the mucous membrane. Diazepam is given rectally as a suppository, again it is absorbed into the mucous membrane. Both medications cause drowsiness so it is important to stay with the child after administration.

33. Children and young people requiring rectal Diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse (although this risk should be kept in perspective).

Two adults can also ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under-8s day care require the registered person to ensure the privacy of children when intimate care is being provided.

DIABETES

What is Diabetes?

34. Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child's needs or the insulin is not working properly (Type 2 diabetes). Type 2 is rare locally.

35. About one in 550 school-age children has diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes may be treated by diet and exercise alone but it is usually medicated.

36. Each child may experience different symptoms and this should be discussed when drawing up the health care plan. After diagnosis, all children enter school with a health plan detailing the symptoms of a hypoglycaemic episode ("hypo") and how the family have chosen to treat it. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

Medicine and Control

37. The diabetes of the majority of children is controlled by injections of insulin each day. Younger children may be on twice daily injections which are given outside school hours; however many

are changing to multiple daily injections which include one at lunch time: this reduces the risks of **hyperglycaemic** incidents or "hypers". It is increasingly likely that staff may be asked to give or assist with insulin injections for younger children. Older children may be able to manage their own injections or may only need supervision; they should be offered a suitable private place to do this. Occasionally an older child may have their insulin delivered by an insulin pump.

38. Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime, and then insulin with breakfast, lunch and the evening meal, as well as before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

39. Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Generally, older children will be able to do this for themselves and will simply need a suitable place to do so. However, younger children may need adult supervision to carry out the test and/or interpret test results.

40. When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional.

41. Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

42. Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycaemic reaction** ("hypo") in a child with diabetes:

- hunger
- sweating
- drowsiness
- pallor
- glazed eyes
- shaking or trembling

- lack of concentration
- irritability
- headache
- mood changes, especially angry or aggressive behaviour

43. Each child may experience different symptoms and this should be discussed when drawing up a health care plan. The health plan should be checked annually with parents.

44. If a child has a "hypo", it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

45. An ambulance should be called if:

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

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

47. Such information should be an integral part of the school or setting's emergency procedures and also relate specifically to the child's individual health care plan.

ANAPHYLAXIS

What is anaphylaxis?

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

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

50. The most severe result of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically, the airways narrow, causing breathing difficulties, and the patient loses consciousness.

51. Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully; the symptoms may be heralding the start of a more serious reaction.

Medicine and Control

52. All children should be prescribed an oral antihistamine as a first line of treatment; training indicates which symptoms may be treated in this way and which symptoms require treating with adrenaline (also known as epinephrine). The treatment for a severe allergic reaction is an injection of adrenaline. Pre-loaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths – adult and junior.

53. Should a severe allergic reaction occur the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

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

55. The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the head, the child's parents and medical staff involved.

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

57. Studies have shown that the risks for allergic children are reduced where an individual health care plan is in place. The plan will need to be agreed by the child's parents, the school and the treating doctor. The doctor will usually prescribe and leave plan details to other medical staff.

58. Important issues specific to anaphylaxis to be covered include:

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine

- food management
- precautionary measures

59. Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practise with trainer injection devices.

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

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

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

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

Appendix D: FAITH CONSIDERATIONS

INTRODUCTION

1. The treatment of medical conditions in children that most commonly cause concern in schools and settings may also be affected by the religious traditions and practices of the different faith groups to which children and their families may belong.

2. Further information, including advice specifically for schools and settings, is available from the local or national leaders of the religious organisation or faith group concerned.

THE MEDICAL NEEDS OF MUSLIM CHILDREN

Fasting

3. No **oral** medication can be taken by a person who is fasting. However, anyone needing regular medication during fasting hours is normally **exempt** from fasting in any case.

4. Medical **injections** can be taken by a person who is fasting, although not those injections that influence body nutrition.

5. Should a child be unable to take part in routine vaccinations due to a period of fasting, it is the parental responsibility to arrange with the GP to have the vaccinations administered at an alternative time.

6. During emergencies, when a child's wellbeing is at risk, medicine should be administered.

7. Guidance should be sought from local Muslim organisations on specific issues if necessary.