Garton on the Wolds CE Primary School Medicines in School Policy

Aims
This policy is a statement of the aims, principles and strategies for supporting children unable to attend school for medical reasons.

It was developed during the autumn of 2010 through a process of consultation with teaching and non teaching staff.
It was approved by the governing body in Autumn 2010 and is reviewed annually following guidance from the NHS and East Riding of Yorkshire Council.

This school policy takes account of the statutory guidance contained in:
Medical Conditions at Schools, East Riding of Yorkshire Council & NHS 2019
The Disability Discrimination Act 2005 - pt4
Supporting pupils at school with medical conditions (DfE December 2015)
Ensuring a good education for children who cannot attend school because of health needs (Statutory guidance for local authorities DfE January 2013)
Safeguarding children in whom illness is fabricated or induced (DfE 2008)
School Attendance (DfE September 2018)
The Equality Act 2010
The Special Needs and Disability Act 2001
Special Educational needs and disability code of practice 0 to 25 years January 2015
NHS/East Riding of Yorkshire Council 'School Absence – Guidance for Parents Medical Appointments and Illness' September 2019
Guidance on First Aid for Schools (DfE February 2014)
Health & Safety: Responsibilities and Duties of School (DfE November 2018)
Guidance on the use of adrenaline auto-injectors in schools (September 2017)

The Policy
This document is a statement of the aims, principles and strategies for dealing with children with medical needs who require medication to be administered while at school or for children who require medication for short periods of time. It is not a policy to be taken in isolation and should be read in conjunction with relating school policies on Inclusion, Equal Opportunities, Drugs Policy, Child Protection Policy and the school's Accessibility Plan.

General Statement
Barmby Moor & Garton on the Wolds Primary School is committed to reducing the barriers to sharing in school life and learning for all its pupils. This policy sets out the steps the school will take to ensure full access to learning and school life for all its children that require medication.

Roles and Responsibilities
Link to: *Managing Prescribed Medicines in School – Checklist at the back of this policy*

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

The Employer

Governing bodies should ensure that the appropriate level of insurance is in place.

Local authority maintained schools opt into the liability cover arranged via the East Riding of Yorkshire Council's blanket policy, meeting the DfE requirements.

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

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

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

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

The Governing Body

The policy should be reviewed and updated on a regular basis and should contain clear systems and procedures for the safe administering of prescribed medication to pupils. Where the local authority is the employer, the school's governing body should follow the health and safety policies and procedures produced by the local authority.
If the administration of prescribed medicines requires technical or medical knowledge then the governing body should ensure training is provided to staff from a qualified health professional. Training should be specific to the individual medical needs of the child concerned.

The Headteacher

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

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

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

Parents/Carers

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

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

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

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

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

Parents and Parental Responsibility

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

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

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

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

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

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

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

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

Medication retention periods
See Medical Conditions at Schools East Riding of Yorkshire Council & NHS document 2019 2.11.

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

The school will never accept medicines that have been taken out of the container as originally dispensed/supplied or make changes to dosages on parental instructions.
Non-prescription medicines should not be administered to a child beyond 48 hours, after which a healthcare professional should be consulted. For example, if a child suffers regularly from frequent or acute pain the parents/guardians should be encouraged to seek medical advice and request prescribed medication from the Pharmacist (Minor Ailments Service) or the child's GP. A child under 16 should never be given aspirin or medicines containing ibuprofen unless prescribed by a doctor.

It is expected that parents/carers will normally administer medication to their children at home. No prescribed medication should be administered in school unless prior written permission has been given by the parent/carer (a request to administer prescribed medication form should be completed). Medicines should normally be administered during break and lunch times. If for medical reasons, the prescribed medicine has to be taken at other times of the day, arrangements should be made accordingly. Pupils should be told where their medication is kept and who will administer it. Written permission from parents/carers will be required for pupils to self-administer medication.

Any member of staff giving medicines to a child should:

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

If in doubt about any procedure staff, should not administer the medicines but check with the parents/carer or a health professional before taking further action. If staff have any concerns related to administering prescribed medicine to a particular child, the issue should be discussed with the parents/carers, if appropriate, or with a health professional attached to the school. Only designated member(s) of staff should administer medication, checking the medication log

record to avoid the risk of double dosing; however backup cover should be arranged for when the member of staff responsible is unavailable or absent.

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

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

All clinical waste must ideally be removed by a registered waste contractor or double-bagged in biodegradable bags and placed in an appropriate bin. All clinical waste bags should be less than two-thirds full and stored in a dedicated, secure area while awaiting collection.

Over the counter medicines (non-prescription)
Over the counter medicines, e.g. hay fever treatments, sun scream, should only be accepted in exceptional circumstances and be treated in the same way as prescription medication. The parent/carer must clearly label the container with the child's name, dose and time of administration and complete a consent form. Staff should check that the medicine has been administered without adverse effects in the past and that parents have certified that this is the case – a note to this effect should be recorded in the written parental agreement for the school to administer medicine. There is a potential risk of interaction between prescription and over the counter medicines so where children are already taking prescription medicine(s), prior written approval from the child's GP should be considered.

The use of non-prescribed medicines should normally be limited to a 24 hour period and in all cases no exceed 48 hours. If symptoms persist medical advice should be sought by the parent. Other remedies, including herbal preparations, should not be accepted for administration in school.

Storage and administration of Paracetamol Oral Suspension Sachets
The purpose of this guidance is:

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

Prior to supervision or administration of paracetamol oral suspension
The responsibilities of parents and schools are as follows:

Parents must:

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

Schools must:

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

Controlled Drugs
The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated documents (*Managing Medicines in Schools (DfE 2015)) and NICE guidance NG46 (2016)*. Some may be

prescribed as medicine for use by children, e.g. methylphenidate.
Any designated member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber's instructions.
It is permissible for schools and settings to look after a controlled drug, where it is agreed that it will be administered to the child for whom it has been prescribed. Schools and settings should keep controlled drugs in a locked non-portable container and only named staff should have access. A record should be kept for audit and safety purposes.
A controlled drug, as with all medicines, should be returned to the parent/carer when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label).
Misuse of a controlled drug, such as passing it to another child for use, is an offence. Schools should have a policy in place for dealing with drug misuse.

Carrying Medicines
There are regulations regarding Medicines in a School Setting. Only certain medication is allowed to be carried by pupils whilst in school. **By law parents/guardians must give written consent for their child to carry their own prescribed medication and to be given prescribed medication.**
Conditions such as allergy causing anaphylaxis, asthma and diabetes mean pupils may need to carry their own prescribed medication whilst at school; however unless it is deemed essential for their condition (e.g. the above and certain migraine medication) the pupil is not allowed to carry their own medication. It is the parent's/guardian's responsibility to ensure that prescribed medication is handed into the main office, preferably to the nurse or first aider. In these circumstances the medication should remain in school and not be returned home at the end of the day. **Medication should be in date, it is NOT the school's responsibility to notify parents/guardians if medication has gone out of date.**
Parents/guardians will also be responsible for ensuring there is an adequate supply of prescribed medication for their child whilst at school. **Any out of date medication should be collected by parents/guardians.**

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

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

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

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

Educational Visits
Schools should consider any adjustments they may need to make to enable children with medical needs to participate safely on visits. This might include reviewing and revising the visits policy and procedures, risk assessments and additional safety measures that may need to be taken for outside visits.
Staff supervising excursions should always be aware of any medical needs, including travel sickness and relevant emergency procedures. A copy of any health care plan should be taken on visit in the event of the information being needed in an emergency. If there are concerns about whether staff can provide for a child's safety or the safety of other children on a visit, they should seek parental views and medical advice from the school health service or the child's GP.

Sporting Activities
Most children with medical conditions can participate in physical activities and extra- curricular sport, in ways appropriate to their own abilities. Any restrictions on a child's ability to participate in PE should be recorded in their individual health care plan. All adults should be aware of issues of privacy and dignity for children with particular needs.
Some children may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their prescribed medicines such as asthma inhalers. Staff supervising sporting activities should

consider whether risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative prescribed medicine that may need to be taken and emergency procedures.

Storing Medicines
Schools should not store large volumes of medication. Where a pupil needs two or more prescribed medicines, each should be in a separate container. Staff should never transfer medicines from their original containers. The head is responsible for making sure that medicines are stored in a secure place. All staff should know where to obtain the medicine.

A few prescribed medicines, such as asthma inhalers, must be readily available to pupils and must not be locked away. If it is appropriate schools may allow pupils to carry their own inhalers.
Some prescribed medicines need to be refrigerated. These medicines can be kept in a refrigerator containing food but should be in an airtight container and clearly labelled, but the school should restrict access to a refrigerator holding medicines.
School staff should not dispose of medicines. Parents/carers should collect medicines held at school at the end of each term if the pupil no longer requires them and are responsible for the disposal of date-expired medicines.

Disposal of Medicines
Staff should not dispose of medicines. Parents/guardians are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal. They should also collect medicines held at the end of each term if the pupil no longer requires them. If parents/guardians do not collect medicines, arrangements should be made with the local pharmacy for safe disposal. NICE Guidance NG46 (2016).
Sharps boxes should always be used for the disposal of needles. Sharps boxes can be obtained by parents/guardians on prescription from the child's GP or paediatrician. Collection and disposal of the boxes should be arranged with the local authority's environmental services.

Emergency Procedures
The Headteacher should ensure that all staff are aware of the school's planned emergency procedure in event of medical need, and that pupils know what to do in the event of an emergency, such as telling a member of staff. A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent/carer arrives. Health professionals are responsible for any decisions on medical treatment when parents/carers are unavailable, not the member of staff.
Wherever possible staff should avoid taking children to hospital in their own car; it is safer to call an ambulance. Individual health care plans should include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency, for example if there is an incident in the playground a lunchtime supervisor would need to be very clear of their role.
Arrangements for dealing with emergency situations should be included in the schools health and safety policy.

Purpose of a Health Care Plan. The main purpose of an individual health care plan for a child with medical needs is to identify and clarify the level of support that is needed. Not all children who have medical needs will require an individual plan. An individual health care plan clarifies for staff, parents/carers and the child the help that can be provided. It is important for staff to be guided by a health professional, the child's GP or paediatrician and the register marked accordingly ensuring consistency of support when a change of staff occurs. Staff should agree with parents/guardians how often they should jointly review the health care plan. It is sensible to do this at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently. Staff should judge each child's needs individually as children and young people vary in their ability to cope with poor health or a particular medical condition.

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

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

Staff Training
A health care plan may reveal the need for some staff to have further information about a medical condition or

specific training in administering a particular type of prescribed medicine or in dealing with emergencies. Staff should not give prescribed medicines without appropriate training from health professionals. When staff voluntarily agrees to assist a child with medical needs, the employer should arrange appropriate training in collaboration with local health services and ensure that training is regularly updated. Local health services/school nurse will also be able to advise on further training needs.
There should be a clear school policy regarding medical procedures with defined roles and responsibilities. This policy should be reviewed, updated and publicised on a regular basis.

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

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

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

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

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

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

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

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

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

See flowchart titled School Guidance for Facilitation of a Medical Condition in Medical Conditions at Schools East Riding & NHS 2019 2.10.

Menstruation
In situations involving menstrual difficulties in pupils, the best remedial action would be either to send the child home after telephoning the parent/carer, or remove the child from class to rest until the discomfort disappears. There is a relevant disposal bin in the adult toilet for all pupils to use.

Evaluating the Policy
This policy statement and the school's performance in supporting pupils requiring medication at school will be monitored and evaluated regularly by the Governing Body.

It will be formally reviewed every three years to ensure that the policy enables all children to have equal access to continuity of education.

Reviewed November 2020
Next review November 2021

Managing Prescribed Medicines in School – Checklist

Checklist		Yes	No	Details
1	Does the school have a written policy for the administration of prescribed medicines in school?			Date/Location
2	Has the school nominated responsible persons to administer prescribed medicines?			List nominated staff
3	Is there a clear statement on the roles, responsibilities and supervision of staff managing and /or administering prescribed medication?			Location/Staff informed
4	Has nominated staff received appropriate information, instruction and training on the schools policy and procedures?			List staff/Date/Training Provider
5	Does the school have procedures for managing prescribed medicines on school trips and outings?			Risk assessments/Consent forms
6	Has the school received a written agreement from parents/guardians for prescribed medication to be given?			Form/Location
7	Has the school agreed to administer prescribed medication?			Form/Location
8	If health care plans are required where are they kept?			Form/Location

9	Is there guidance for children carrying and taking their own prescribed medication? *(Asthma only)*			Policy/Location
10	Does the school maintain records for the administration of prescribed medication?			Form/Location
11	Does staff have access to the schools emergency procedures?			Policy/Location
12	Does the school have appropriate and secure storage facilities?			Specify
13	Are emergency prescribed medicines, such as inhalers readily available?			Specify
14	Has the risk assessment for the storage and administration of medication been adapted and issued to all relevant staff? Have they signed to confirm receipt and understanding?			

Form 1: Contacting Emergency Services (Prompt sheet)

Request for an Ambulance

Dial 999, ask for ambulance and be ready with the following information

- Speak clearly and slowly and be ready to repeat information if asked

- Your name
- Your telephone number
- Give your location: Barmby Moor Primary School, Flat Lane, Barmby Moor YO42 4EQ Garton on the Wolds Primary School, Station Road, Garton on the Wolds YO25 3EX
- State that the postcode is YO42 4EQ (Barmby), YO25 3EX (Garton)
- Give exact location in the school (insert brief description)

- Give name and age of child

- Give a brief description of child's symptoms

- Inform Ambulance Control of the best entrance and state that the crew will be met and taken to (locality of incident)

Date: Time:

Signature:

Job Title:

Health Care Plan

This template form should be kept by a telephone

Barmby Moor CE Primary School / Garton on the Wolds CE Primary School	
Name of Child	
Class	
DOB	
Child's Address	
Medical diagnosis or condition	
Date	

Review date

Family Contact Information

Family Contact Information	
Name and relationship to child	
Telephone work	
Telephone home	
Telephone mobile	

Further Contact Information

Family Contact Information	
Name and relationship to child	
Telephone work	
Telephone home	
Telephone mobile	

Clinic/Hospital Contact/Health Care Professional

Name Phone no

G.P.

Name Phone no

Medical Needs

Describe medical needs and give details of child's symptoms

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

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

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

Follow up care

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

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

Any other information

Form copied to:

Signed (Parent/guardian): Signed (Headteacher):

Date: Date:

See Templates and Forms section of Medical Conditions in Schools East Riding of Yorkshire Council & NHS 2019 document for Parental Agreement for School to Administer Medicine forms and record of administration forms.

Table of Common Conditions

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

Common Conditions	Recommended period for child to be kept away from school
Coughs & Colds	Coughs, colds. A child with a minor cough or cold may attend school. If the cold is accompanied by a raised temperature, shivers or drowsiness, the child should stay off school and consult their GP.
Diarrhoea and/or Vomiting Illness	24 hours from last episode of diarrhoea or vomiting (when no other symptoms present). If there is no improvement, they should consult their GP.
Earache	If a child has earache they should consult their GP.
Headache	None. If the headache is more severe and accompanied by other symptoms, they should consult their GP.
Head Lice	None. However, they may be taken out of school for treatment. This takes no longer than two hours, once treated they must return to school. If the child does not return the absence will not be authorised.
Sore Throat	If a child has a sore throat with no other symptoms then they are usually well enough to attend school. It is only in severe cases that there may be good reason for them to stay at home.
Temperature	You can usually identify a raised temperature through your child looking or feeling shivery. There are lots of reasons for a raised temperature and if symptoms persist you should seek medical attention. As soon as your child is feeling better they can return to school.
Toothache	School attendance should be maintained until your child can be seen by a dentist.
Travel sickness	None. Medication should be administered in accordance with the guidance given under 'over the counter medicines (non prescription)' on p.4.

Rashes and skin infections	Recommended period for child to be kept away from school
Chicken Pox*	5 days from the onset of rash (or until the last blister has burst and crusted over which usually takes five or six days after the rash begins). Contact with pregnant women and newborn babies should be avoided.
Eczema	None. Children can attend school even when it is being treated. Pupils should only be absent from school if advised by the G.P. because it is so severe.
German Measles* (Rubella)	6 days from the onset of rash
Hives	None.

Impetigo	48 hours after consulting a GP and commencing antibiotic treatment. They will need to be kept off school until the sores have scabbed over and are healing.
Measles*	4 days from the onset of rash.
Ringworm	Absence not usually required. However, treatment should be sort.
Scabies	Child can return after first treatment.
Scarlet Fever	Child can return 24 hours after commencing appropriate antibiotic treatment.
Slapped Cheek Disease*	None (when no other symptoms present).
Shingles	Absence only if rash is weeping and cannot be covered.
Thread Worms	Absence not usually required. However, treatment should be sort.
Warts and Verrucae	None. However, treatment should be sort.

*Harmful to pregnant staff / pupils (see 'Female Staff & Pupils' advice on page 42).

For advice and procedures for reporting cases or suspected cases of infectious disease in schools and other educational establishments contact Public Health England: https://www.gov.uk/government/organisations/public-health-england Telephone: 01904 687100

Respiratory Infections	**Recommended period for child to be kept away from school**
Flu	Until recovered.
Tuberculosis	Always consult the Health Protection Unit.
Whooping Cough	2 days from commencing antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment.

Other infections	**Recommended period for child to be kept away from school**
Conjunctivitis	None. If a child has, or you suspect a child may have conjunctivitis you will need to seek medical attention. Once treated there is no need to be kept off school.
Diphtheria	Absence is essential. Always consult with your local Health Protection Unit.

Ecoli Typhoid Dysentery	48 hours from last episode of diarrhoea. Further absence may be required for some children until they are no longer excreting.
Glandular Fever	None (when no other symptoms present).
Hand, Foot and Mouth	None. School may consider absence if a large number of children are affected.
Hepatitis A	Absence until seven days after onset of jaundice (or seven days after symptom onset if no jaundice).
Hepatitis B, C, HIV/AIDS	None.
Meningococcal Meningitis/Septicaemia	Until recovered.
Meningitis due to other bacteria	Until recovered.
Meningitis Viral	None (when no other symptoms present).
Mumps	Absence for 5 days after onset of swelling.
Tonsillitis	None (when no other symptoms present).

Further information: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/

Anaphylaxis Information

Hay Fever

As with all pollen allergies, those who suffer with hay fever typically will sneeze, feel congestion and have itchy eyes and noses. It is good to note that hayfever can be a reaction to tree, grass or weed pollen. All these have differing times of pollination.
The commonly used hay fever treatment options are: antihistamine nasal sprays, antihistamine tablets, steroid nasal sprays, and eye drops, which can usually be administered before school.

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

What is Anaphylaxis?

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

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

Medicine and Control

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

Any, or all, of the following symptoms and signs may be present in an acute allergic reaction. Antihistamine should be given at the first sign of an allergic reaction and the child closely observed. Antihistamine dose may need to be repeated if the patient vomits. For a child who has asthma, if there is any sign of breathing difficulty then their reliever inhaler (usually blue) should be administered.

Minor reactions (needing oral antihistamine):

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

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

If the reaction continues to progress despite antihistamine and any of the following symptoms/signs are seen, then the EpiPen®/Anapen® should be administered into the muscle of the upper outer thigh and an AMBULANCE CALLED IMMEDIATELY.

Severe reactions (needing EpiPen/Anapen):

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

If an EpiPen®/Anapen® is administered, the child should be kept lying down, with feet raised (e.g.: on a chair) to assist circulation.

They should transfer to hospital in this "head-down" position.
Raising the patient's head or assisting them to sit or stand up can result in an acute severe deterioration of the allergic reaction.

Occasionally, a second EpiPen®/Anapen® may be required if there has been no improvement in the child's condition 5 to 10 minutes after administering the first EpiPen/Anapen.

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.

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 Principal, the child's parents and medical staff involved.

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

In other circumstances (with an appropriate Patient Group Direction[1]) a school nurse might hold a certain number of EpiPens®, not individually named, and could use these to administer emergency medication (e.g.: antihistamine/adrenaline) to a patient who has not previously had this prescribed, but who is demonstrating the clinical features of a significant allergic reaction. This would cover those rare cases

1 A patient group direction (PGD) is a written direction relating to supply and administration, or administration of a Prescription Only Medicine (POM), to persons generally, (subject to specified exclusions) and is signed by a doctor or dentist, and by a pharmacist.

where a pupil presents with a first reaction in school. Teenagers with nut allergy are a particularly vulnerable group in this respect, a recognised factor in fatal reactions is failure to carry their own medication. Therefore a backup system in schools, governed by a Patient Group Direction would be a beneficial safety net.

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

Important issues specific to anaphylaxis to be covered include:

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

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

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

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

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

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

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

More information:
Anaphylaxis Campaign www.anaphylaxis.org.uk/schools/help-for-schools Department of Health, Social Services and public safety www.dhsspsni.gov.uk

Hull and East Yorkshire Hospitals NHS Trust
The Craven Building
Hull Royal Infirmary
Anlaby Road, Hull
HU3 2JZ
01482 461403

Asthma Information

This school aims to provide a caring supportive environment where all learners can achieve their potential. We will achieve high standards in all areas, through a creative, exciting, challenging curriculum and opportunities, which meet the needs of all.
Through engagement with local, national and worldwide communities and issues, our pupils will embrace responsible 21st century citizenship. We will take pride in all that we do and celebrate both success and effort.

School Aims

- We will provide a wide range of exciting and challenging experiences for all to enable our pupils to become effective learners and reach their potential.
- We will promote responsible citizenship, built on respect for ourselves and others, through active links with the local and wider community.
- We will promote high standards of physical, emotional and mental health and well-being among our school community.

We will aim to:

- Promote equality of opportunity between disabled person and other person.
- Eliminate discrimination that is unlawful under the Act.
- Eliminate harassment of disabled pupils that is related to their disabilities.
- Promote positive attitudes towards disabled people.
- Encourage participation by disabled persons in public life.
- Take steps to account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons.

This school recognises that asthma is a widespread, serious but controllable condition affecting many pupils at the school. The school positively welcomes all pupils with asthma. We

encourage pupils with asthma to achieve their potential in all aspects of school life by having a clear policy that is understood by school staff, their employers (the Local Education Authority) and pupils. Supply Teachers and new staff are also made aware of the policy. All staff who come into contact with pupils with asthma will be provided with training on asthma from the school nurse who has had asthma training. Training will be updated once a year.

Asthma medicines

- Immediate access to reliever medicines is essential. Pupils with asthma in Years 1 – 6 keep their inhalers in the classroom in their drawer where they are easily accessible. The reliever inhalers of Foundation Stage children are kept in the classroom in a box.
- Parents / carers are asked to ensure that the school is provided with a labelled spare reliever inhaler. The class teacher will hold this separately in case the pupil's own inhaler runs out, or is lost or forgotten. All inhalers must be labelled with the child's name by the parent / carer.
- School staff are not required to administer asthma medicines to pupils (except in an emergency), however many of the school staff are happy to do this. School staff who agree to administer medicines are insured by the local education authority when acting in agreement with this policy. All school staff will let pupils take their own medicines when they need to.

Record Keeping

- At the beginning of each school year or when a child joins the school, parents / carers are asked if their child has any medical conditions including asthma on their enrolment form.
- All parents / carers of children with asthma are consequently sent an Asthma UK School Asthma Card to give to their child's doctor or asthma nurse to complete. Parents / carers are asked to return them to school. From this information the school keeps its asthma register, which is available to all school staff. School Asthma Cards are then sent to parents / carers of children with asthma on an annual basis to update. Parents / carers are also asked to update or exchange the card for a new one if their child's medicines, or how much they take, changes during the year.

Exercise and activity – PE and games

- Taking part in sports, games and activities is an essential part of school life for all pupils. All teachers know which children in their class have asthma and all teachers at the school are aware of which pupils have asthma from the school's asthma register.
- Pupils with asthma are encouraged to participate fully in all PE lessons. Teachers will remind pupils whose asthma is triggered by exercise to take their reliever inhaler before the lesson, and to thoroughly warm up and down before and after the lesson. If a pupil needs to use their inhaler during a lesson they will be encouraged to do so.
- Classroom teachers follow the same principles as described above for games and activities involving physical activity.

Out-of-hours sport

- There has been a large emphasis in recent years on increasing the number of children and young people involved in exercise and sport in and outside of school. The health benefits of exercise are well documented and this is also true for children and young people with asthma. It is therefore important that the school involve pupils with asthma as much as possible in after school clubs.
- Teachers, support staff and out-of-hours school sport coaches are aware of the potential triggers for pupils with asthma when exercising, tips to minimise these triggers and what to do in the event of an asthma attack.
- Information about asthma will be provided on the Asthma UK Out There & Active Poster, to be displayed in several locations around the school. The poster helps to encourage pupils with asthma to be active and get more involved in PE and exercise and has tips to help them do this.

School Environment

The school does all that it can to ensure the school environment is favourable to pupils with asthma. The school has a definitive no-smoking policy. As far as possible the school does not use chemicals in science and art lessons that are potential triggers for pupils with asthma. Pupils with asthma are encouraged to leave the room and go and sit in the school office if particular fumes trigger their asthma.

Making the school asthma-friendly

The school ensures that all pupils understand asthma. Asthma can be included in the National Curriculum Key Stages 1 and 2 in science, design and technology, geography, history and PE.

When a pupil is falling behind in lessons

If a pupil is missing a lot of time at school or is always tired because their asthma is disturbing their sleep at night, the class teacher will initially talk to the parents / carers to work out how to prevent their child from falling behind. If appropriate, the teacher will then talk to the school nurse and special education needs coordinator about the pupil's needs.
The school recognises that it is possible for pupils with asthma to have special education needs due to their asthma.

Asthma attacks

All staff coming into contact with pupils who have asthma should know what to do in the event of an asthma attack.

The signs of an asthma attack include:

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

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

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.
In the event of an asthma attack the school follows the procedure outlined by Asthma UK in its School Asthma Pack. This procedure should be displayed in the staffroom and every classroom.

Further support and information:

Asthma UK
www.asthma.org.uk

Hull and East Riding Hospitals NHS Trust
Paediatric Respiratory Specialist Nurse
The Craven Building
Hull Royal Infirmary

Anlaby Road, Hull
HU3 2JZ
01482 675544

Diabetes Information for Parents & Schools

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

General Information

There are two types of diabetes:

- Type 1 diabetes - due to the lack of insulin
- Type 2 diabetes - there is insufficient insulin for the child's needs or the insulin is not working properly

The majority of children with diabetes have Type 1 diabetes. They normally require daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. People with Type 2 diabetes are usually treated by diet and exercise alone.

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

- Parents' responsibility
- Early years/school responsibility
- Child's responsibility when deemed competent
- Paediatric diabetes specialist nurse
- School nurse

Medicine and Control for children

Diabetes for the majority of children is controlled by injections of insulin each day. Younger children may be on a twice daily insulin regime of a longer acting insulin which means it is unlikely these will need to be given during school hours, although for those who do require injection it may be necessary for an adult to administer it. Older children may require multiple injections and others may be controlled by an insulin pump. Most children will manage their own injections, but if doses are required school supervision may be required. A suitable, private place to carry out the injections should be made available.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means they have a daily dose of longacting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal in order to decide how much insulin to give. Diabetic specialists would only implement this type of regime once they were confident the child was competent. The child is then responsible for the injections and their regime would be detailed in the individual health care plan.
Children with diabetes need to ensure their blood glucose levels remain stable which may require checking their levels by taking a small sample of blood and using a 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. Older children should be able to do this 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 their blood glucose test results.

When staff agree to supervise blood glucose tests or administer insulin injections, they must be trained by an appropriate health professional. Administering injections is a matter for personal preference and no member of staff will be expected to carry out this task without full training and their consent.

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

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

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

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

Some children may experience **hyperglycaemia** (high glucose level) and 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 on their breath, this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

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

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

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

Contact details
Diabetes nurses:
Trudy Tapson 07801 192809
Joanne Carter 07557 322731
Nikki Hall 07557 322736
Joanne Marrow 07798 581680

Important Additional Care Information

Hyperglycaemia – high blood sugar

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

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

Hypoglycaemia – low blood sugar

Things that may cause a hypo: Exercise or prolonged activity / Heat or hot weather / Excitement / Anxiety / Stress / Hormones / Late snacks or meals / Missed snacks or meals / Too much insulin
During exercise the pupil should always have hypo treatment available and near. Staff should also consider if the pupil requires a snack before or/and after exercise, as per health care plan.
If a child has a hypo, **it is very important that the child is not left alone** and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a digestive biscuit can be given once BG levels are above 4mmols.

See Symptom/Treatment table in Medial Conditions at Schools Management Resource Pack 2018-19 (in the school office).

Epilepsy Information for schools

How common is epilepsy?

Epilepsy is the most common serious neurological condition. It affects about one in 279 children under 16. This means that there are about 42,000 children with epilepsy in UK schools. To put it another way, an average sized secondary school will have three to four children with the condition, while an average sized primary school will have one or two children with epilepsy. Over 10 per cent of calls to the Epilepsy Helpline in each year are about issues relating to epilepsy in children.

What is epilepsy?

Epilepsy is defined as having a tendency to have seizures. A seizure happens when the nerve cells in the brain stop working in harmony. When this happens the brain's messages become temporarily halted or mixed up. A child with epilepsy has recurrent seizures, unless the seizures are controlled by medicine.
Some children have epilepsy as a result of damage to the brain. This may have been due to injury before, during or after birth, and is known as symptomatic epilepsy. For other children, there is no known or identifiable cause. They have an inherited tendency to have epilepsy.
This is known as idiopathic epilepsy, and is thought to be related to a low seizure threshold.
Everyone has a seizure threshold; having a low seizure threshold means that a child is more likely to have seizures than children in general.

Seizures

A seizure can either affect part of the brain or the whole brain. There are around 40 different types of seizure, some of which are more common in children. Depending on whether a seizure affects the whole or part of the brain it is called either generalised or partial. Generalised seizures affect the whole, or a large part, of the brain and result in a loss of consciousness, which may

be very brief, or may last several minutes. Partial seizures only affect part of the brain and only partly affect consciousness.

The most common types of seizures

Tonic-clonic seizures

Children who have tonic-clonic seizures (previously known as grand-mal) 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's important that you stay with them at this point, to make sure they are alright. First aid advice for tonic-clonic seizures can be found on page 11, together with a sample of an epilepsy policy for schools.

Absence seizures

During an absence seizure (previously known as petit-mal) the child will briefly lose consciousness, but will not lose muscle tone or collapse. They will appear to be daydreaming or distracted for a few seconds. While these episodes may seem unimportant, they can happen hundreds of times a day. This can cause the child to become confused about what is happening around them.

Absence seizures are most common in children between the ages of six and 12 years old.

As the child will lose consciousness during seizures, they are at risk of missing out on vital learning.

If a child is having absence seizures during the day, the child's parents

may not be aware that their child has epilepsy. Spotting these seizures can help doctors make a diagnosis. There is no first aid needed for absence seizures, but they must not be mistaken for daydreaming or inattentiveness.

Complex partial seizures

This type of seizure can be difficult to recognise. The child's consciousness level will be affected to some extent, and they will not be fully in touch with what is happening around them. During the seizure they may do things repeatedly, such as swallowing, scratching or looking for something. Complex partial seizures can be misinterpreted as bad behaviour.

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 for complex partial seizures, it's important not to restrain the young person unless they are in immediate danger. This is because they may not recognise you and become frightened. However, if the child is walking towards a busy road, you should try to guide them to safety. When the seizure ends the child is likely to be confused, so it is vital to stay with them and reassure them.

(For more information about complex partial seizures visit www.epilepsy.org.uk or call the Epilepsy Helpline, freephone 0808 800 5050, text 07797 805 390 or email helpline@epilepsy.org.uk)

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, when usual first aid procedures are used. If the child is distressed by the seizure, they may need comforting and generally reassuring.

Atonic seizures

Atonic seizures cause a child to lose muscle tone. When this happens the child falls to the ground without warning. This can result in injuries to the face and head. Children who have regular atonic seizures may need to wear protective headgear to avoid injuries. There is no first aid needed for atonic seizures, unless the child is injured during the fall.

General seizure advice

Tonic-clonic seizures are the most widely recognised type of epileptic seizure. It's important to note that most children need a rest following this kind of seizure. Depending on how they are feeling, they may be able to return to lessons. However, if they take many hours to recover, they may need to be taken home.

In different seizures, such as absences, there are other issues. For example, symptoms may not be recognised by staff as being seizures. It is extremely important that staff understand and can recognise the lesser known seizures, so that they can provide students with the right support.

Triggers

A trigger is anything that causes a seizure to occur, in someone who already has a predisposition. There are many different triggers, but some are more relevant to school settings than others. This can include the following situations.

- When a child first starts school, or changes class, they may be excited or anxious. Both of these emotions can trigger seizures.
- When a child or young person is preparing for exams, they may become stressed or not sleep properly. Stress and lack of sleep can be triggers for seizures.
- It's often thought that all people with epilepsy have seizures triggered by flickering light (known as photosensitive epilepsy). This is not the case, as fewer than one in 20 people with epilepsy have photosensitive epilepsy.

Some children with epilepsy may be entitled to extra time or support in exams because their epilepsy affects their ability to function at the same level as their classmates. If a teacher thinks this may be the case, they should speak to the child's parents and, if possible, to a health or psychology service professional. Schools need to apply to the relevant examining body to ask for extra provision. They need to do this as soon as possible.

Guidelines on applying for special adjustments in exams are available from the Joint Council for Qualifications' website: www.jcq.org.uk

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.

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure
- the child has injured themselves badly
- they have 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

Medicines

The majority of children with epilepsy take anti-epileptic drugs (AEDs) to control their seizures. These drugs are usually taken twice a day, outside of school hours. This means there should be no issues about storing or administrating medicines in school time.

Certain types of medicines taken for epilepsy can have an effect on a child's learning or behaviour. It is important staff are aware of this. If a teacher notices a change in the child's learning or behaviour, then this should be discussed with their parents.

The only time medicine may be urgently needed by a child with epilepsy is when their seizures fail to stop after the usual time or the child goes into status epilepticus. Status epilepticus is defined as a prolonged seizure or a series of seizures without regaining consciousness in between. This is a medical emergency and is potentially life threatening. If this happens, emergency medication needs to be administered by a trained member of staff. If this isn't possible an ambulance should be called.

Emergency medicines

If a child with epilepsy is likely to need emergency medicine to stop a seizure, it is vital that the parents and school staff work together to decide how this should happen. Although it is not a legal requirement for school staff to administer medicines under the Disability Discrimination Act, the school should ensure that a sufficient number of staff are trained to administer emergency medicines. Alternatively other arrangements could be in place such as the school nurse, a paramedic or the child's parents could be contactable to administer the medicine if it is needed. Training can be arranged by the School Health Service, the local authority or through an independent training provider.

The two main forms of emergency medicines are rectal diazepam and buccal midazolam.
Rectal diazepam has been used for many years. Buccal midazolam is currently unlicensed for treating epilepsy in children. However, many consultants and some epilepsy specialist nurses prescribe this drug, as it is easier to use and less invasive than rectal diazepam. The government's own advice on the use of buccal midazolam states that if the medicine is used in schools then 'instructions for use must come from the prescribing doctor'. These instructions should be written into an individual care plan for each child who may need medication in school time.

Why schools need an epilepsy policy

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

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

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

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

School Policy Requirements

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

- This school recognises that epilepsy is a common condition affecting many children and young people, and welcomes all students with epilepsy.

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

Barmby Moor & Garton on the Wolds
Primary School Epilepsy Policy

This policy has been written in line with information provided by Epilepsy Action, the Department for Education and Skills (now the Department for Children, Families and Schools), the local authority, the school health service, the governing body, students and parents.
Our school recognises that epilepsy is a common condition affecting children and welcomes all children with epilepsy to the school.
Our school supports children with epilepsy in all aspects of school life and encourages them to achieve their full potential. This will be done by having a policy in place that is developed in conjunction with the local authority and understood by all school staff. This policy ensures all relevant staff receives training about epilepsy and administering emergency medicines. All new staff and supply staff will also receive appropriate training.

What to do when a child with epilepsy joins Barmby Moor & Garton on the Wolds Primary School
When a child with epilepsy joins our school, or a current pupil is diagnosed with the condition, the head teacher arranges a meeting with the pupil and the parents to establish how the pupil's epilepsy may affect their school life. This should include the implications for learning, playing and social development, and out of school activities. They will also discuss any special arrangements the pupil may require, for example extra time in exams. With the pupil's and parent's permission, epilepsy will be addressed as a whole-school issue through assemblies and in the teaching of PSHE or citizenship lessons. Children in the same class as the pupil will be introduced to epilepsy in a way that they will understand. This will ensure the child's classmates are not frightened if the child has a seizure in class.
The school nurse or an epilepsy specialist nurse may also attend the meeting to talk through any concerns the family or head teacher may have, such as whether the pupil requires emergency medicine. The following points in particular will be addressed.

Record keeping
During the meeting the head teacher will agree and complete a record of the pupil's epilepsy and learning and health needs. This document may include issues such as agreeing to administer medicines and any staff training needs. This record will be agreed by the parents, and the health professional, if present, and signed by the parents and head teacher. This form will be kept safe and updated when necessary. Staff will be notified of any changes in the pupil's condition through regular staff briefings. This will make staff aware of any special requirements, such as seating the pupil facing the class teacher to help monitor if the student is having absence seizures and missing part of the lesson.

Medicines
Following the meeting, an individual healthcare plan (IHP) will be drawn up. It will contain the information highlighted above and identify any medicines or first aid issues of which staff

needs to be aware. In particular it will state whether the pupil requires emergency medicine, and whether this medicine is rectal diazepam or buccal midazolam. It will also contain the names of staff trained to administer the medicine and how to contact these members of staff. If the pupil requires emergency medicine then the school's policy will also contain details of the correct storage procedures in line with the DfES guidance found in *Managing Medicines in Schools and Early Year Settings*[2].

First aid

First aid for the pupil's seizure type will be included on their IHP and all staff (including support staff) will receive basic training on administering first aid. The following procedure giving basic first aid for tonic-clonic seizures will be prominently displayed in all classrooms.

Stay calm.
If the child is convulsing then put something soft under their head. Protect the child from injury (remove harmful objects from nearby).
NEVER try and put anything in their mouth or between their teeth.
Try and time how long the seizure lasts – if it lasts longer than usual for that child or continues for more than five minutes then call medical assistance.
When the child finishes their seizure stay with them and reassure them.
Do not try and move the child unless they are in danger.
Do not try and restrain the child.
Do not give them food or drink until they have fully recovered from the seizure.
Aid breathing by gently placing the child in the recovery position once the seizure has finished.
Sometimes a child may become incontinent during their seizure. If this happens, try and put a blanket around them when their seizure is finished to avoid potential embarrassment.
First aid procedure for different seizure types can be obtained from the school nurse, the pupil's epilepsy specialist nurse or Epilepsy Action.

Learning and behaviour

Our school recognises that children with epilepsy can have special educational needs because of their condition (Special Educational Needs Code of Practice3). Following the initial meeting, staff will be asked to ensure the pupil is not falling behind in lessons. If this starts to happen the teacher will initially discuss the situation with the parents. If there is no improvement, then discussions should be held with the school's special educational needs co-ordinator (SENCO) and school nurse. If necessary, an Individual Educational Plan will be created and if the SENCO thinks it appropriate, the child may undergo an assessment by an educational or neuropsychologist to decide what further action may be necessary.

School environment

School recognises the importance of having a school environment that supports the needs of children with epilepsy. A medical room is kept available and equipped with a bed in case a pupil needs supervised rest following a seizure.
The above epilepsy policy applies equally within the school and at any outdoor activities organised by the school. This includes activities taking place on the school premises, and residential stays. Any concerns held by the pupil, parent or member of staff will be addressed at a meeting prior to the activity or stay taking place.

Legal requirements and responsibilities

The following information is taken from the Medical Conditions in Schools 2019 document. It aims to highlight the importance of having a clear school epilepsy policy and help staff understand their responsibility in ensuring the safety of a child with epilepsy in their school.

The general guidance for ensuring the health and safety of children in schools states that it is the employer's responsibility (under the Health and Safety at Work Act 1974) to make sure schools have a health and safety policy which includes procedures for supporting children with medical needs. It is also the employer's responsibility to make sure that they have taken out Employer's Liability Insurance and that this insurance provides full cover for school staff acting within full scope of their employment i.e. 'duty of care'. In community and voluntary controlled schools the employer is usually the local authority, while in foundation and voluntary-aided schools, staff are employed by the governing body.

In the day-to-day management of children's medical needs, parents should give schools information about their child's condition, including any relevant details from the child's GP, consultant or epilepsy specialist nurse. Parents are also responsible for supplying any information about the medicine their child needs and providing details of any change to the child's prescription or support required.

There is no legal duty requiring school staff to administer medicine. However, schools should consider this issue as part of their accessibility planning duties. Staff are usually happy to volunteer for training to administer emergency medicines. Some proactive schools require support staff to be trained in administering emergency medicines as part of their role (full roles and responsibilities are detailed in the government document *Managing Medicines in Schools and Early Year Settings*)." Epilepsy Action 2009

Form A: Parental questionnaire

For students with epilepsy

This questionnaire should be completed by the child's parents, Headteacher and, wherever possible, the child

Name: Date of birth:

Class/form teacher:

What type of seizure/s does your child have? (if you know what they are called)

How long do they last?

What first aid is appropriate?

How long will your child need to rest following a seizure?

Are there any factors that you have noted might trigger a seizure?

Does your child have any warning before a seizure occurs?

What is the name of your child's medicine and how much is each dosage?

How many times a day does your child take medicine?

Are there any activities that you feel may require particular precautions?

Does your child have any other medical conditions?

Is there any other relevant information you feel the school should be aware of?

Form B: Parental agreement

School or setting to administer medicine

The school will not give your child medicine unless this form is completed and the school has a policy for staff to administer medicine.

Name of school:

Child's name: Date: Class/form: Medical

condition or illness:

Name and strength of medicine:

Expiry date: When to be given:

Dosage and method of administration:

Any side effects school needs to know about: Procedure to take in an

emergency:

Number of tablets/quantity to be given to school:

NOTE: Medicines **must** be in the original container as dispensed by the pharmacy

Daytime phone number of parent or adult contact: Name and

phone number of GP:
Agreed review date to be initiated by [staff name]:

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school staff administering medicine in accordance with the school policy. I will inform the school immediately, in writing, if there is any change in dosage or frequency of the medicine or if the medicine is stopped.

Parent's signature: Print name:

Date:

Form C: Staff training record

Administration of medicines

Name of school: Name of staff:

Profession and title:

Type of training received:

Date of training completed:

Training provided by:

I confirm that [staff name] has received the training detailed above

and agrees to carry out any necessary treatment.

I recommend that the training is updated [state how often] Trainer's signature:

Date:

I can confirm I have received the training detailed above:

Staff signature: Date:

Suggested review date:

Form D: Individual Healthcare Plan

Name: Date of birth:

School: Headteacher:

Parental contact no.:

Type of seizure/s experienced: Symptoms:

Possible triggers:

Usual procedure following seizure:

Prescribed anti epileptic medication:

Where medication is stored:

Member of staff responsible for replenishment of medication:

Staff trained to give medication:

i)

ii)

iii)

Member of staff responsible for Home/School liaison:

Emergency procedure if seizure lasts for more than _____ minutes.

- Member of staff to stay with _____ to ensure safety.
- Quietly clear the classroom/area of students if you think this is necessary.
- Trained member of staff (see above) to give rectal diazepam/buccal midazolam with witness of same sex present (if possible).
- If needed, telephone 999, ask for Ambulance Service, give name of student, address and phone number of school.
- Telephone parents.
- Inform Headteacher
- Stay with _____ until ambulance arrives.
- If parents have not arrived by this time a member of staff will accompany _____ to the hospital in the ambulance.
- Fill in seizure record form for the student file and send copy to parents/GP.

Name: Date of birth:

School: Headteacher:

Parental contact no.:

Useful addresses and telephone numbers of professionals involved with:

Service	Name	Address & Tel No.
Emergency contact		
Epilepsy consultant/specialist		
Family GP		
Epilepsy/paediatric/ community support nurse		
Other		

Parental Consent Form

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

Signed: Date:

Please print name:

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

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

Paediatric Specialist Nurse
01482 674151

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

Head Lice Information for Parents

If your child has head lice it should be treated immediately and again a week later to ensure they are all gone. If lice or eggs are still found, this process will need repeating if your child has head lice you may take them out of school to treat them. This will take no longer than two hours, once treated they must return to school. If you keep your child off school due to them having head lice the absence will not be authorised. If your child has long hair you may be advised to tie their hair back to help prevent infestation.

Facts

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

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

Head lice feed by biting and sucking blood through the scalp of their host. The female louse lays eggs in sacs (nits) which are very small, dull in colour, and well camouflaged. These are securely glued to hairs where the warmth of the scalp will hatch them out in 7-10 days. Empty egg sacs are white and shiny and may be found further along the hair shaft as the hair grows out. Lice take 6-14 days to become fully grown, after which they are capable of reproduction.

Head lice are not fussy about hair length or condition. Clean hair is therefore no protection, although regular (e.g.: weekly) hair washing and combing sessions offer a good opportunity to detect head lice, and arrange treatment if discovered.

There is no need to wash or fumigate clothing or bedding that comes into contact with head lice.

Detection

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

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

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

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

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

Treatment and prevention of re-infestation

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

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

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

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

Further information
If a child has frequent and/or prolonged infestation, the School's Safeguarding Procedures should be followed.

Preventing Re-infestation

Here are some simple ways to get rid of the lice and their eggs, and help prevent a lice re-infestation:
Wash all bed linens and clothing that's been recently worn by anyone in your home who's infested in very hot water (130° F [54.4° C]), then put them in the hot cycle of the dryer for at least 20 minutes.
Have bed linens, clothing, and stuffed animals and plush toys that can't be washed dry-cleaned. Or, put them in airtight bags for 2 weeks.
Vacuum carpets and any upholstered furniture (in your home or car).
Soak hair-care items like combs, barrettes, hair ties or bands, headbands, and brushes in rubbing alcohol or medicated shampoo for 1 hour. You can also wash them in hot water or just throw them away.
Because lice are easily passed from person to person in the same house, bedmates and infested family members will also need treatment to prevent the lice from coming back

Further Information

If you are at all worried about head lice or feel you need more advice on how to cope, then you should consult your school nurse, health visitor, pharmacist or family doctor.
Read more: www.netdoctor.co.uk/diseases/facts/lice.htm

Information provided by: Department of Health

Suggested school letter and Parent Information Sheet

Dear Parent/Carer

We have had reports of live head lice infestations at school. We are therefore asking you to check your child's hair.

It is vital that every child's head is checked to determine whether or not there are lice present. The method we are advising is wet-combing (detailed below).

Procedure:

- Wash the hair in the normal way with your regular shampoo.
- Check the water for any lice.
- While the hair is still wet, comb through with conditioner and a fine toothed comb. Start at the roots of the hair and continue through to the ends of the strands. At the end of every stroke check the comb for evidence of lice.
- The conditioner ensures that it is difficult for the lice to hang onto the hair and therefore they are easy to remove with the comb.
- If any lice are found this routine should be continued every four days for a period of two weeks.
- It is advisable to use this routine on a regular basis so that any lice present can be detected early.
- If you find live lice please notify your child's class teacher and also check all members of the family using the wet comb method.
- It is helpful if you also inform anyone with whom your child has had close contact with e.g. Cub's, Brownies, friends, extended family etc.

If you require any further advice or help about the problem of head lice please do not hesitate to contact your school nurse, pharmacist or family doctor.

Head Lice

A head louse is a tiny, wingless insec t that can attach to a person's hair, where it feeds on extrem ely small amounts of blood drawn from the scalp. Lee aren't dangerous and they don't spre:ad disease. Lee eggs (nits) are seen more commonly than lice in children.

Signs and Sy1npto1ns

- Severe itching of the scalp.
- Nits (tiny oval specks of grey or yellow-white on the hair shaft).
- Lee (reddish brown tiny insects on the hair shaft).
- Small, red bumps in the scalp.
- A rash on the scalp, with crusting and oozing (if severe).
- Swollen lymph glands in the neck.

What to Do

A Pharmacist or doctor will recommend a medicated rinse or lotion to kill the lice. It's important to follow the directions for these product s exactly because applying them too much or too frequently can be harmful

Here are some simple ways to get rid of lice and their eggs around the house:

- Check everyone in the house for lice and seek treatment if necessary.
- \lash al bed linens and clothing in very hot water, then put them in the hot cycle of the dryer for at least 20 minutes.
- Dry dean any clothing, bed linens, and stuffed animals that aren't machine washable.
- Vacuum carpets and any doth-covered furniture in your home or car.

- Discard hair-care items or soak them in rubbing alcohol for one hour, then wash them in hot soapy water.

Seek Medical Care if the Child:

- Shm:vs any signs of having lice.
- Is constantly scratching or complains of itches that don't go away.
- Has scratched the scalp to the point of redness, swelling, or visiblepus.

Think Prevention!

You can help prevent head lice by telling kids:

- To try to avoid head-to-head contact with other children..
- Not to share combs, brushes, hair ties,hats, etc.
- Not to lie on bedding,pillows, and carpets recently used by someone with lice.

Impetigo Information

What is impetigo?

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

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

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

How is impetigo spread?

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

Who is most at risk of developing impetigo?

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

How long does it take until symptoms start?

The incubation period will vary depending on the particular bacteria.

It is usually 1–3 days for streptococcal and 4–10 days for staphylococcal infections.

How is impetigo treated?

- Impetigo is most often treated with antibiotics, either orally or with bactericidal ointment. It is important to follow the recommended treatment and complete the course of antibiotics.

- Treatment involves washing the sores and crusts every 12 hours or as directed with the prescribed soap or lotion. After each wash pat dry.
- Healing should begin within 3 days and the infection eliminated in 7–10 days.
- If the sores spread and get worse despite treatment or the child becomes unwell with fever, see your doctor.
- Cover the sores with an airtight dressing if the child is returning to school in order to reduce the risk of spreading the infection.
- The child's clothes, towels and bedclothes should be changed at least once a day.
- Always remember to wash your hands after touching scabs or sores or handling infected clothing.

How long does impetigo remain infectious?

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

When can children return to school or child care?

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

How can impetigo be prevented?

- Encourage children to wash their hands regularly and always use their own towel and facecloth.
- Cut your child's nails short and encourage them not to scratch scabs or pick their nose.
- Keep injured areas of skin clean and covered to minimise the chance of any bacterial infection, including impetigo.
- Always wash your hands after touching sores or scabs and use gloves if possible when treating infected children.
- Keep children with impetigo away from other children for the period of exclusion. This is until antibiotic treatment has commenced and the sores are covered with a watertight dressing.

Further Information

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

NHS Choices:
www.nhs.uk/conditions/impetigo/pages/introduction.aspx

Slapped Cheek Disease Information

What is slapped cheek disease?

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

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

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

What are the symptoms of slapped cheek disease?

Your child may have a runny nose, rash, aches and pains and a high temperature. To begin with, the rash appears on the cheeks making them look red - which is why it is called slapped cheek disease. A few days later, the rash will appear on your child's chest, arms and legs. The rash may fade a bit and then come back if your child gets hot after a bath, is in direct sunlight or runs about.
Some people can have slapped cheek disease and not have any symptoms, but they will still be able to pass the virus on to other people.
If your child has a chronic illness, particularly affecting his or her blood, you should see your GP if symptoms occur.

How is it treated?

In most children, slapped cheek disease is a mild illness, which gets better in a few days without any treatment. As a virus causes slapped cheek disease, antibiotics won't help to treat it.
If your child has aches and pains, you can give him or her paracetamol according to the instructions on the bottle. Do not give aspirin, or medications containing aspirin, to children under sixteen years old. You should encourage your child to drink plenty of fluids to reduce the chance of dehydration due to the high temperature.
The spread of slapped cheek disease can be reduced by frequent hand washing, putting your hand over your mouth when coughing and sneezing into a handkerchief or tissue.

What is the outlook for children with slapped cheek disease?

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

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

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

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

Information for Teachers: Children who wet and soil

This information is to support schools with providing care for children who wet and/or soils whilst at school. This is not a policy but suggestions for good practice as schools will need to agree individual care plans for each child.

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

Faecal soiling at school is clearly a most embarrassing and socially unacceptable problem. For the children concerned it can create isolation, low self-esteem and a situation where they are the 'butt of jokes'. With careful planning and a "circle" of support (parents, child, teacher, and

other staff) school can be a successful and happy time. The most important thing is to be prepared, establish good strategies, enlist support and work together.

What can you suggest to parents?

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

What can you do as a teacher?

- Get to know the family. Discuss with them the particular needs of the child - what equipment of appliances are needed? Such as, spare clothes, flushable wipes, plastic bags for disposal, a lidded bin, soap and a hand towel. How frequently do they soil? What are the parent's fears or apprehensions about their child starting school?
- Talk with the child as early as possible – the year before starting in your class is ideal but not always possible. It is vital to establish a good rapport with the child so that they have developed a level of trust in you before classes begin. Strategies and special arrangements can be decided so they are ready to be implemented when the year begins.

- It is also valuable if you can have time to discuss strategies etc with the current or previous teacher of the child. This is particularly helpful if the child or parents speak highly of that teacher.
- Remain in contact frequently. A notebook or communication diary is worthwhile.
- Discuss with the parents the advisability of having a nurse or specialist person talk to the class and staff about the child's disability. This should not be the only disability discussed. There will be other children in the class with asthma, diabetes, sight or hearing loss and many more. The child should not be singled out.
- Provide security and consistency in the approach to the child and the problem. The teacher needs to set up a 'no fuss' signal to let the child know that they need to go to the toilet. The child may not be able to avoid suddenly becoming smelly, but must not be allowed to remain so. It is rare for the child to be able to smell its own faeces. A child who is frequently soiled cannot tell when their pants or pad are dirty, even if there is full skin sensation, they have become unaware of the area, just as adults we become unaware of the feeling of rings, watches, earrings and other things.
- Rethink some classroom strategies such as insisting that students sit cross- legged on the floor, how to ask to leave the room, “toilet times” (some teachers are reluctant to allow students to leave the classroom soon after breaktime or lunchtime) – this may need to be re-assessed.
- Provide a toilet that is private, where other children can't look over or under the partitions to see what they are doing. Sometimes it's easiest to choose a staff toilet, a disabled toilet (provided that the wheelchair sign is removed) or simply close in one of the main toilets. Make sure that you discuss these arrangements with the child and parents before making a

decision. It is really important to understand that what you may think is a great solution may not work for the child. There is no way to determine this from an adult's perspective – give the child the final decision!

- All young children will require some supervision in the toilet. This is often just to ensure that the task is actually carried out. Children will often go to the toilet, sit there for a while, then return to the classroom and still be able to say quite honestly that they 'have been to the toilet'. Check on the child if they have been absent for a longer than "normal" time.
- Provide the 'perfect teacher': One who never shows impatience, can take the smell of faeces in closed, warm classrooms, can see through the back of his/her head to know when the child has left/returned to the classroom, has a discrete, private signal to tell the child that they have soiled, even though they think they haven't, then to remember what part of the lesson they have missed and have the time to go over it with the child later.

- ## Intimate and Invasive Care

- Staff who work with young children realise that the issue of intimate care is a difficult one and will require staff to be respectful of children's needs.

- Intimate care can be defined as care tasks of an intimate nature, associated with bodily functions, body products and personal hygiene which demand direct or indirect contact with or exposure of the genitals. Examples include care associated with continence management as well as more ordinary tasks such as help with washing.

- Staff that provide intimate care to pupils have a high awareness of child protection issues. Staff behaviour is open to scrutiny and staff at Woodlands work in partnership with parents to provide continuity of care to pupils wherever possible.

- Staff deliver a personal safety curriculum, as part of Personal, Social and Health Education, to all pupils as appropriate to their developmental level and degree of understanding. This work is shared with parents who are encouraged to reinforce the personal safety messages within the home.

- Woodlands is committed to ensuring that all staff responsible for the intimate care of pupils will undertake their duties in a professional manner at all times. Woodlands recognises that there is a need to treat all pupils with respect when intimate care is given. No pupil should be attended to in a way that causes distress or pain.

- ## Basic Components of good practice

- All pupils who require intimate care are treated respectfully at all times; the child's welfare and dignity is of paramount importance.

- As a basic principle pupils will be supported to achieve the highest level of autonomy that is possible given their age and abilities. Staff will encourage each pupil to do as much for themselves as they can.

- In most cases one pupil will be cared for by one adult unless there is a sound reason for having two adults present. If this is the case, the reasons should be clearly documented.

- ## The protection of children

- Child Protection Procedures and Multi-Agency Child Protection procedures will be accessible to staff and adhered to.

- Where appropriate, all students will be taught personal safety skills carefully matched to their level of development and understanding.

- If a member of staff has any concerns about physical changes in a student's presentation, e.g. marks, bruises, soreness etc. s/he will immediately report concerns to the appropriate

manager/ designated person for child protection. A clear record of the concern will be completed and referred to social services and/or the Police if necessary. Parents will be asked for their consent or informed that a referral is necessary prior to it being made unless doing so is likely to place the child at greater risk of harm.

- If a pupil becomes distressed or unhappy about being cared for by a particular member of staff, the matter will be looked into, outcomes recorded, and the results of any investigation shared with the child and the parent / carers.

Parents will be contacted at the earliest opportunity as part of this process in order to reach a resolution. Staffing schedules will be altered until the issue(s) are resolved so that the pupil's needs remain paramount. Further advice will be taken from outside agencies if necessary.

- If a child makes an allegation against a member of staff, all necessary procedures will be followed and the Head Teacher must be informed. If the allegation is about the Head Teacher, then the Chair of Governors should be informed instead.

Practice Guidelines

Intimate Care Policy

Children have a right to be safe and to be treated with dignity and respect. Intimate care includes washing, and toileting and changing nappies.

Intimate care of children and young people with disabilities

- Children with disabilities can be very vulnerable. They often need adult help with their personal care, including intimate care, long after non-disabled children of similar age have developed the skills to do such tasks for themselves.

- Having to depend on someone else to do these things for you may feel embarrassing or humiliating. Anyone involved with a person's intimate care needs to be sensitive to the child's needs and also aware that some care tasks could be open to possible misinterpretation.

Definition of intimate care

Intimate care may mean different things to different people but is usually used to describe any or all of the following activities:

- Washing any part of the body
- Dressing/undressing
- Changing nappy
- Assisting to use the toilet

- **Treat every child as an individual**

Don't make assumptions about how things are done with a child. Families all have their own way of doing things, their own names for body parts etc. Cultural, ethnic and religious differences may affect what is or is not appropriate. Ask the child and/or parents and respect their wishes

- **Involve the children as far as possible in their own intimate care**

Try to avoid doing things for a child that she/he can do alone and it the child is able to help, ensure that they are given the chance to do so. Support the child in doing all they can for themselves. If a child is fully dependant on you, talk with them about what you are doing and give them choices wherever possible.

- **Be responsive to a child's reactions and make sure that intimate care is as consistent as possible**

You will have had opportunities to talk with parents and learn from them how they undertake intimate care tasks. However, you should also whenever possible, check things out by asking the child, e.g.:
"Is it OK to do it this way?" "Can you wash there?"
"How does Mummy do this?" "Does that feel comfortable?"

The following are some basic guidelines to help safeguard both staff and children.

- Be familiar with any special names the child uses for body parts.

- Supply staffs are not permitted to carry out any personal care for the child, unless the supply staff member has worked sufficient hours in the building to have built up a relationship with the child.

- Supply staff should whenever possible give the pupil a choice of who they would like to help them with their intimate care.

- When changing a child's nappy or soiled clothing, the member of staff must always wear protective gloves. Parent must provide a change of clothes.

- For the safety of both staff and child it is considered totally inadvisable for a male member of staff to be involved in the intimate physical care of a girl of any age. The same limitations may not apply to female staff and boys.

Date of policy: Date of review:
Agreed by governing body:

Female Staff & Pupils – Pregnancy

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

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

- **German measles** (rubella). If a pregnant woman comes into contact with german measles she should inform her GP and antenatal carer immediately to ensure investigation. The infection may affect the developing baby if the woman is not immune and is exposed in early pregnancy.

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

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

- All female staff under the age of 25 working with young children should have evidence of two doses of MMR vaccine.

In all these cases the school must arrange cover whilst the pregnant woman is off work

In all these cases the school must arrange cover (if staff member)/education (if pupil) should the pregnant woman require to be absent at any time until it is safe for them to return.
If it is a pupil, the school must ensure their educational needs are being met either through attendance at a neighbouring school (providing transport if required) or work being sent home.

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

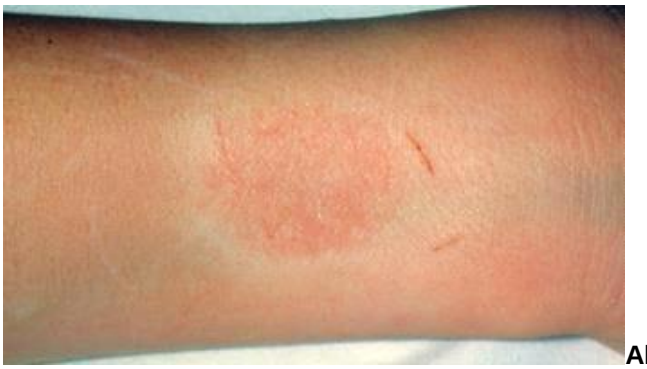
A notice should be placed on all school entrances informing visitors of the infection present at the school and the proposed risk to pregnant women.

For further information visit: http://www.dh.gov.uk/health

Information provided by: Health Protection Agency 2010

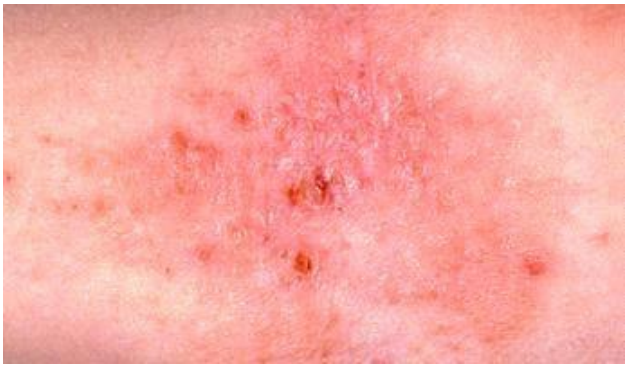
Childhood conditions

Basic guide to help recognise some of the most common childhood conditions:



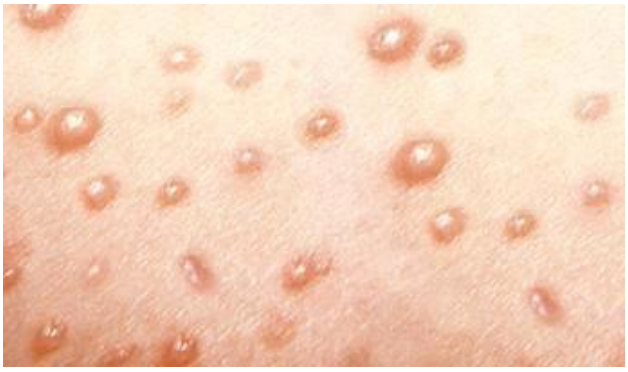
Allergic contact dermatitis

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



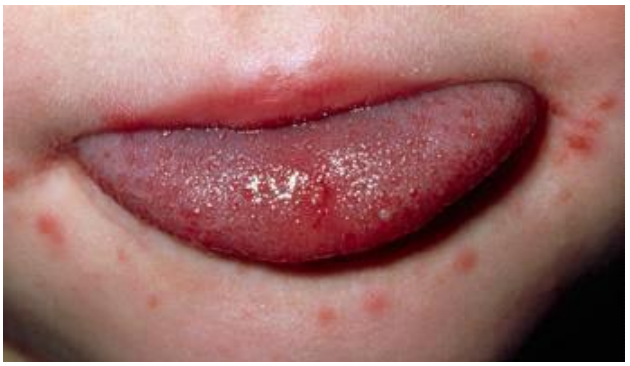
Atopic eczema

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



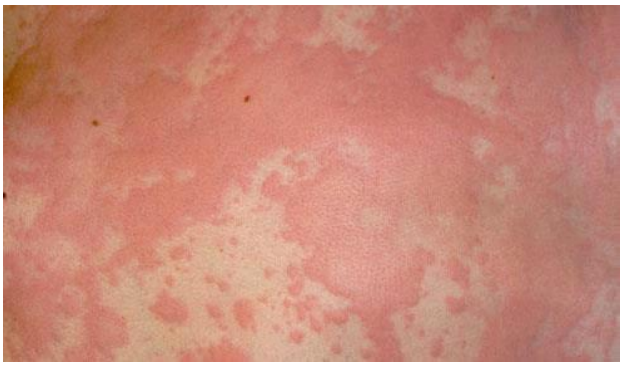
Chickenpox

Before developing a rash, there may be some mild flu-like symptoms. The rash normally appears behind the ears, on the face, scalp, under arms, on chest and stomach, and arms and legs.
The rash starts as small, itchy, red spots. After approximately 12 to 14 hours, these spots develop into fluid-filled blisters, which are intensely itchy.



Hand, foot & mouth disease

Spots and blisters may appear on the hands, feet (more commonly seen on the upper surfaces and often between the fingers and toes) and in the mouth (on the tongue and inner surface of the cheeks) that could cause blisters. They could also have a temperature which can be treated with paracetamol. However, children affected by this condition aren't usually particularly ill with it.



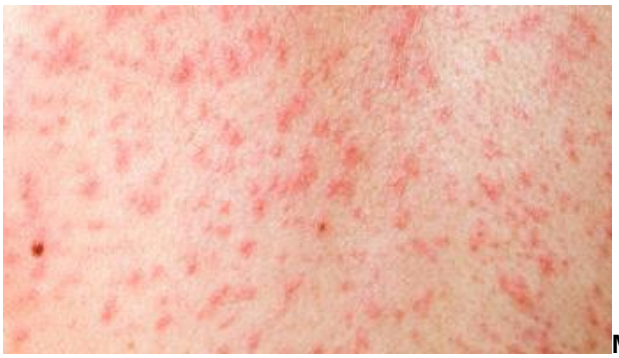
Hives

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

Head Lice

Head lice are tiny (pin-head sized) grey-brown, wingless insects that live by sucking blood from the scalp. Their eggs, which look like tiny white specks, are known as nits.

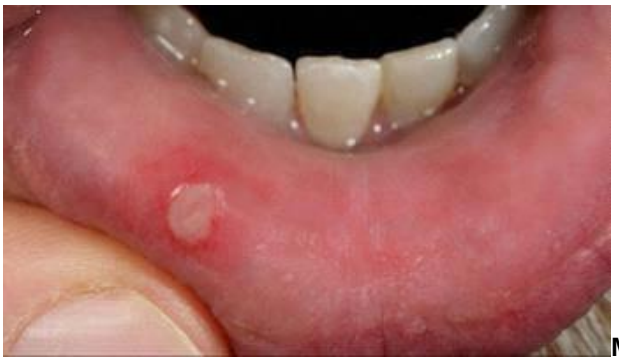
The presence of head lice is indicated by repeated itching of the scalp, or by detecting them in your hair. This can be done using a special fine-toothed comb, available from pharmacies.



Measles

Measles symptoms are cold-like, such as runny nose, red eyes, swollen eyelids, sneezing, and a mild to severe temperature.

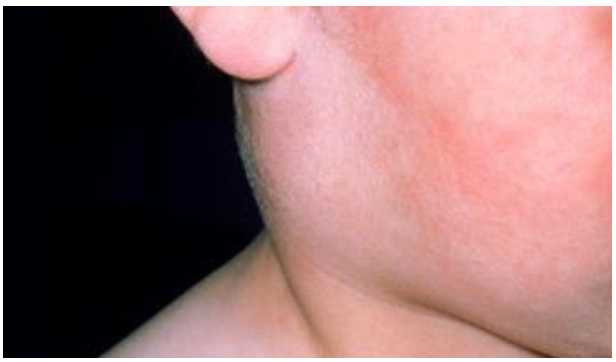
The rash is a red-brown spotty rash that appears three to four days after first symptoms, and lasts for up to eight days. It starts behind the ears, spreads around the head and neck, and after two to three days to the legs and the rest of the body.



Mouth ulcer

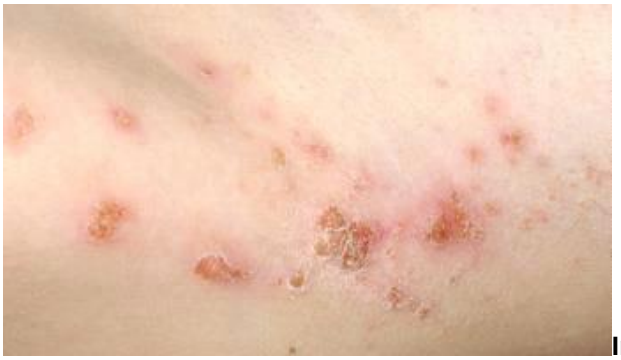
A mouth ulcer will be round or oval, and inflamed around the edge. It will be white, yellow or grey. Most mouth ulcers appear inside the lips or the cheeks, on the floor of the mouth, or the underside of the tongue.

An ulcer can cause pain and discomfort, particularly when eating, drinking or brushing your teeth. Most mouth ulcers last between 10 and 14 days.



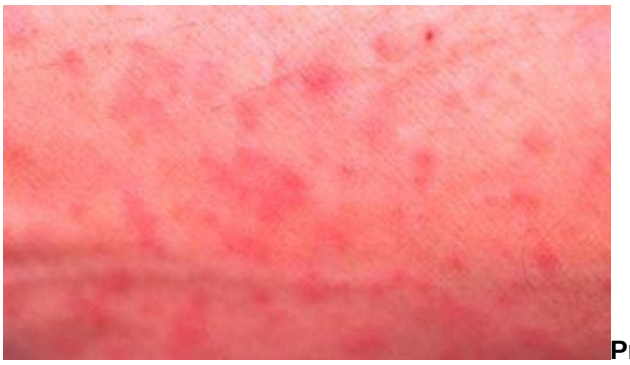
Mumps

In mumps, one or both of the salivary glands swell up and become painful. This creates the characteristic 'hamster' appearance of a swollen face, particularly just below and in front of the ear. Other symptoms include: sore throat, fever, feeling tired, loss of appetite, tummy pain, dry mouth and headache.



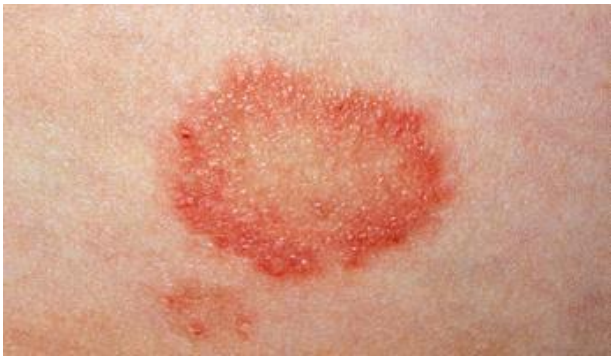
Impetigo

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



Prickly Heat

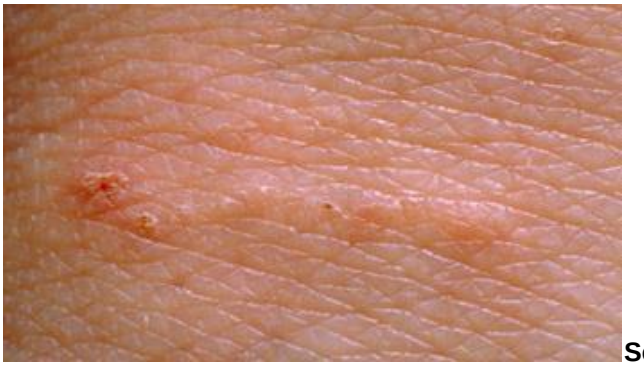
Prickly heat causes a rash made up of tiny spots, or bumps, surrounded by a patch of red skin. Sometimes, the spots look like tiny blisters. This rash may cause mild swelling, itching, stinging or a prickling sensation.
It can affect any part of your body, but most commonly appears on the back, abdomen, neck, upper chest; groin, armpits, hands or feet.



Ringworm

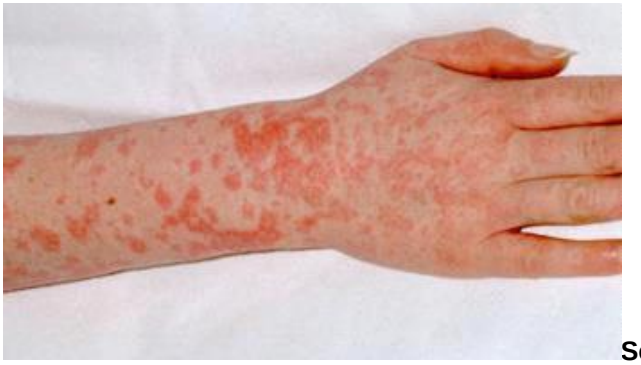
Ringworm is a fungal infection that causes ring- like, red lesions on the skin. The skin appears red and inflamed around the rim yet healthy inside the rim.

The rings may multiply and grow, and rings can also merge together. The rings will feel slightly raised to the touch, and the skin under the rash may feel itchy.



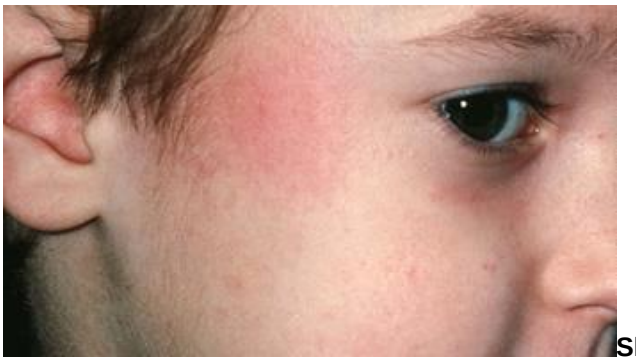
Scabies

Scabies causes the skin to feel intensely itchy. The scabies mites will also leave small red blotches and lines on the skin, which are the marks caused by them burrowing into the skin.
Burrow marks can be found anywhere including folds of skin, wrists, armpits, around the waist, inside the elbow, buttocks, soles of feet, knees, shoulder blades and trunk.



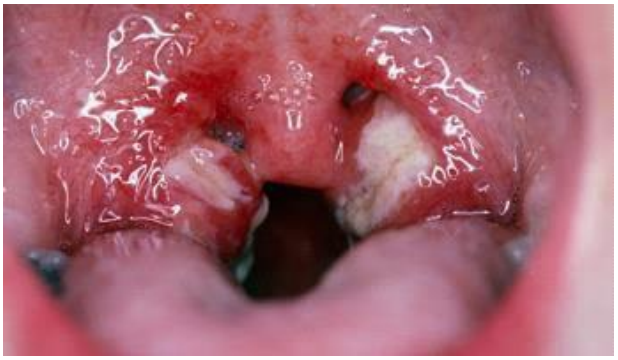
Scarlet fever

Often starts with a sore throat or skin infection and fever. The rash appears 12-48 hours after the fever. At first it is red blotches, but turns into a pinkish-red rash that feels like sandpaper.
The rash spreads to other areas, commonly ears, neck, chest, elbows, thighs and groin. The rash will turn white if you press a glass on it.



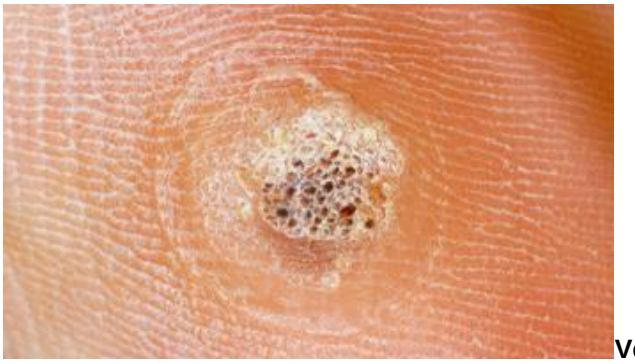
Slapped cheek syndrome

A distinctive blotchy red rash may begin to appear on the face which gives the appearance of 'slapped cheeks'.
The rash may become itchy and spread to the body and limbs and can take between one-three weeks to clear. It may also recur some time later after increased exposure to sunlight or heat.



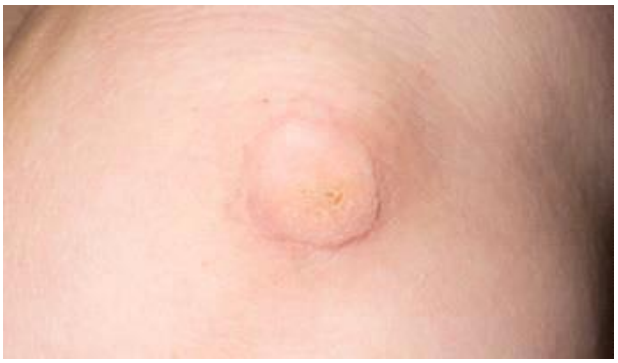
Tonsillitis

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



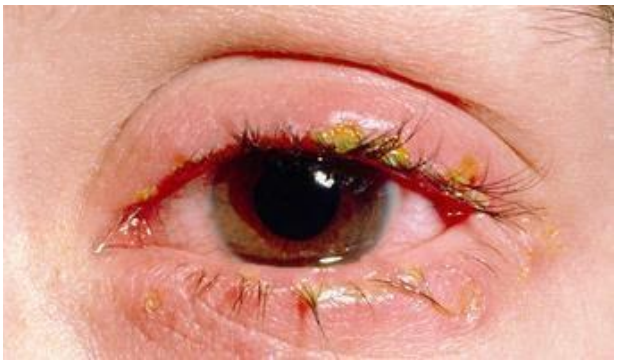
Verruca

Verrucas (plantar warts) are warts on the soles of the feet, heels and toes. Verrucas do not stick up from the surface of the skin. Verrucas often have a black dot in the centre, surrounded by a hard, white area.
The weight of the body pushing down on them makes them grow back into the skin, which can be painful.



Warts

Common warts (verruca vulgaris) are firm and raised, with a rough surface that can look a bit like a cauliflower.
They can occur anywhere, but are most common on knuckles, fingers, elbows and knees. The size of a wart can range from 1mm to more than 1cm.



Conjunctivitis

Conjunctivitis is redness and inflammation of the thin layer of tissue that covers the front of the eye (conjunctiva). It is very common.
People often refer to conjunctivitis as red eye. Other symptoms of conjunctivitis include itchiness and watering of the eyes, and sometimes a sticky coating on the eyelashes (if it's caused by an allergy).