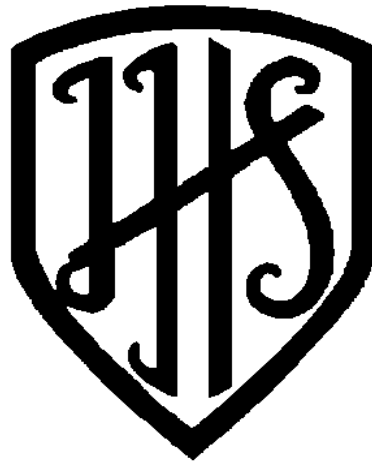


Amended November 2012  
Reviewed March 2014



Jotmans Hall Primary School

# Children with Medical Needs Policy

Approved by Curriculum & Target Setting Committee  
on 5.3.14

Accepted/Ratified by the Full Governing Body  
on 24.3.14

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## **JOTMANS HALL PRIMARY SCHOOL**

### **MEDICAL NEEDS POLICY**

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## JOTMANS HALL PRIMARY SCHOOL

### MEDICAL NEEDS POLICY

Jotmans Hall Primary School welcomes all pupils: recognising that pupils have individual needs. We will encourage and help all children to participate fully in all aspects of school life.

#### **Children with Medical Needs**

Children with medical needs have the same rights of admission as other children. Most children will at some time have short-term medical needs, perhaps entailing finishing a course of medicine such as antibiotics. Some children however have longer term medical needs and may require medicines on a long-term basis to keep them well, for example children with well-controlled epilepsy or cystic fibrosis.

Other children may require medicines in particular circumstances, such as children with severe allergies who may need an adrenaline injection. Children with severe asthma may have a need for daily inhalers and additional doses during an attack.

Staff may need to take extra care in supervising some activities to make sure that these children, and others, are not put at risk.

An individual health care plan can help staff identify the necessary safety measures to support children with medical needs and ensure that they and others are not put at risk.

#### **Access to Education and Associated Services**

Some children with medical needs are protected from discrimination under the Disability Discrimination Act (DDA) 1995. The DDA defines a person as having a disability if he has a physical or mental impairment which has a substantial and long-term adverse effect on his abilities to carry out normal day to day activities.

With reference to the Disability Discrimination Act (DDA)1995/Disability Equality Scheme: Jotmans Hall Primary School is committed to ensuring equality of education and opportunity for disabled pupils, staff and all those receiving services from the school. All pupils and staff will have an equal opportunity to meet their aspirations, realise their full potential and improve their life chances. The school embraces a culture of inclusion and diversity, in which people feel free to disclose their disability and to participate fully in school life.

With reference to the Equality Act 2010, see Jotmans Hall Primary School Equality Scheme: A Single Equality Duty.

Jotmans Hall Primary School will make reasonable adjustments for disabled children including those with medical needs at different levels of school life; and for the individual disabled child in practices and procedures and policies.

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For a disabled pupil with medical needs, staff will ensure accessibility; for access to the school premises, the curriculum and the provision of written materials in alternative formats.

### **Support for Children with Medical Needs**

Good communication is vital with parents/carers. It is the parent/carers responsibility for their child's health and they should provide information about their child's medical condition. Parents, and the child if appropriate, should obtain details from their child's General Practitioner (GP) or paediatrician, if needed. The school nurse or a health visitor and other outside agencies may also be able to provide additional background information for staff. It is important to work together to make sure that children with medical needs and school and setting staff have effective support.

It is important that responsibility for child safety is clearly defined and that each person involved with children with medical needs is aware of what is expected of them. Close co-operation between the school, parents, health professionals and other agencies will help provide a suitably supportive environment for children with medical needs.

### **Staff Involvement and Training**

All staff working with children with medical needs must have appropriate training to support children. All information about children with medical needs will be shared with staff. Complex medical assistance is likely to mean that the staff will need specialised training. This should be arranged in conjunction with local health services or other health professionals.

All staff are to be aware of the likelihood of an emergency arising and what action to take if one occurs. Back up cover will be arranged for when the member of staff responsible is absent or unavailable. At different times of the day other staff may be responsible for children, such as lunchtime supervisors. It is important that they are also provided with training and advice.

### **Prescribed Medicines**

Medicines should only be taken to 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'. Medicines will only be accepted that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber. Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions for administration and dosage.

**Medicines will not be accepted that have been taken out of the container as originally dispensed nor make changes to dosages on parental instructions.**

Where appropriate, medicines that are prescribed in dose frequencies should be taken outside school hours. Parents could be encouraged to ask the prescriber about this. It is to be noted that medicines that need to be taken three times a day could be taken in the morning, after school hours and at bedtime.

## **Controlled Drugs**

The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act. Some may be prescribed as medicine for use by children, e.g. methylphenidate.

Any 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 to look after a prescribed controlled drug, where it is agreed that it will be administered to the child for whom it has been prescribed.

All controlled drugs should be kept 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 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. See the drugs policy.

## **Non-Prescription Medicines**

Staff should **never** give a non-prescribed medicine to a child unless there is specific prior written permission from the parent/carer. The Headteacher needs to agree to administer a non-prescribed medicine. This is acceptable for short term (one week) or a one off incident ensuring the illness isn't contagious. The medicine and details of doses given must be recorded. If a child suffers regularly from frequent or acute pain the parent/carer should be encouraged to refer the matter to the child's GP.

**A child under 16 should never be given aspirin or medicines containing ibuprofen unless prescribed by a doctor.**

## **Short-Term Medical Needs**

Many children will need to take medicines during the day at some time. This will usually be for a short period only, perhaps to finish a course of antibiotics or apply a lotion. To allow children to do this will minimise the time that they need to be absent. However, such medicines should only be in school where it would be detrimental to a child's health if it were not administered during the day.

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## **Long-Term Medical Needs**

It is important to have sufficient information about the medical condition of any child with long-term medical needs. A letter from a relevant professional stating details of medication is required. If a child's medical needs are inadequately supported this may have a significant impact on a child's experiences and the way they function in school. The impact may be direct in that the condition may affect cognitive or physical abilities, behaviour or emotional state. Some medicines may also affect learning, leading to poor concentration or difficulties in remembering. The impact could also be indirect; perhaps disrupting access to education through unwanted effects of treatments or through the psychological effects that serious or chronic illness or disability may have on a child and their family.

The Special Educational Needs (SEN) Code of Practice 2001 advises that a medical diagnosis or a disability does not necessarily imply SEN. It is the child's educational needs rather than a medical diagnosis that **must** be considered.

Jotmans Hall Primary School need to know about any particular needs before a child is admitted, or when a child first develops a medical need. For children who attend hospital appointments on a regular basis, special arrangements may also be necessary. A written health care plan is necessary for such children, involving the parents and relevant health professionals.

## **Administering Medicines**

No child under 16 should be given medicines without their parent/carer's written consent. Any member of staff giving medicines to a child should check:

- the child's name
- prescribed dose
- expiry date
- written instructions provided by the prescriber on the label.

It only requires one parent/carer to agree to or request that medicines are administered. As a matter of practicality, it is likely that this will be the parent/carer with whom the school has day-to-day contact. Where parent/carers disagree over medical support, the disagreement must be resolved by the Courts. The school will continue to administer the medicine in line with the consent given and in accordance with the prescriber's instructions, unless and until a Court decides otherwise.

If a child is 'looked after' by a local authority, the child may either be on a care order or be voluntarily accommodated. A Care Order places a child in the care of a local authority and gives the Local Authority parental responsibility for the child.

If in doubt about any procedure, staff should not administer the medicines but check with the parent/carer or a health professional before taking further action. If staff have any other concerns related to administering medicine to a particular child, the issue should be discussed with the parent/carer, if appropriate, or with a health professional (school nurse).

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Written records **must** be kept each time medicines are given. Records should be completed and signed each time medicine is administered. Good records help demonstrate that staff have exercised a duty of care. In some circumstances such as the administration of rectal diazepam, it is good practice to have the dosage and administration witnessed by a second adult.

### **Storing Medicines**

Local pharmacists can give additional advice about storing medicines.

Large volumes of medicines should not be stored. Staff should only store, supervise and administer medicine that has been prescribed for an individual child. Medicines should be stored strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed. Staff should ensure that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine and the frequency of administration. Medicines are only to be accepted in the original container as dispensed by a pharmacist in accordance with the prescriber's instructions. Where a child needs two or more prescribed medicines, each should be in a separate container. Non-healthcare staff should never transfer medicines from their original containers.

Children should know where their own medicines are stored and who holds the key. All emergency medicines, such as asthma inhalers and adrenaline pens, are readily available to children and are not be locked away. Other non-emergency medicines are to be kept in a secure place not accessible to children.

A few medicines need to be refrigerated. They will be kept in a refrigerator in an airtight container and clearly labelled. Access to the refrigerator holding medicines is restricted.

### **Access to Medicines**

Children need to have immediate access to their medicines when required, ensuring that access is for those children for whom they have been prescribed.

### **Disposal of Medicines**

Staff will not dispose of medicines. Parent/carers 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 parent/carers do not collect all medicines, they should be taken to a local pharmacy for safe disposal.

'Sharps' boxes will always be used for the disposal of needles. 'Sharps' boxes can be obtained by parent/carer's on prescription from the child's GP or paediatrician as required. Collection and disposal of the boxes will be arranged with the School's waste disposal company.

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## **Hygiene and Infection Control**

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

In relation to hygiene and infectious control, all nappies, sickness and dressings used in school are to be double bagged.

## **Emergency Procedures**

As part of general risk assessment, arrangements are in place for dealing with emergency situations:

- Other children should know what to do in the event of an emergency, such as telling a member of staff.
- All staff know how to call the emergency services.
- All staff know who is responsible for carrying out emergency procedures in the event of need - Mrs Nunn and Mrs Chidgey.
- A member of staff will 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 parent/carer's are not available.
- Staff should avoid taking children to hospital in their own car; it is safer to call an ambulance.
- Individual health care plans 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.

## **Self-Management**

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

Older children with a long-term illness should, whenever possible, assume complete responsibility under the supervision of their parent/carer. There is no set age when this transition should be made. There may be circumstances where it is not appropriate for a child of any age to self-manage. Health professionals need to assess, with parent/carers and children, the appropriate time to make this transition. Children in years five and six should be encouraged to self administer in preparation for secondary school.



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If children can take their medicines themselves, staff may only need to supervise. All medicines should be stored and administered in accordance with instructions in the medical room. A parent/carer consent form is required.

Where children have been prescribed controlled drugs, staff need to be aware that these should be kept in safe custody. However children could access them for self-medication if it is agreed that it is appropriate.

### **Refusing Medicines**

If a child refuses to take medicine, staff should not force them to do so, but note this in the records and follow the agreed procedures in the child's health care plan. If there is no health care plan, the following procedures should be followed:

- Parent/carers to be informed immediately of the refusal and the time and conversation documented.
- If a refusal to take medicines results in an emergency, an ambulance will be called.

### **Record Keeping**

Parent/carers are required to tell the school about the medicines that their child needs to take and provide details of any changes to the prescription or the support required.

**Staff should make sure that this information is the same as that provided by the prescriber.**

Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions. In all cases it is necessary to check that written details include:

- name of the child
- name of the medicine
- dose
- method of administration
- time/frequency of administration
- any side effects
- expiry date

Consent must be obtained from the parent/carer and all of the above information is to be recorded on 'Parental agreement to administer medicine' form. Staff are also to sign this form to acknowledge agreed procedures.

**Staff will check that any details provided by parent/carers, or in particular cases by a paediatrician or specialist nurse, are consistent with the instructions on the container.**

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## **A Health Care Plan**

The main purpose of an individual health care plan for a child with medical needs is to identify the level of support that is needed. Not all children who have medical needs will require an individual plan. A short written agreement with parent/carers may be all that is necessary.

An individual health care plan clarifies for staff, parent/carers and the child the help that can be provided. It is important for staff to be guided by the child's GP or paediatrician. Staff and parents decide how often they will 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 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 will 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 health service, 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
- the parent or carer.
- the child (If appropriate)
- class teacher
- support staff
- staff who are trained to administer medicines
- staff who are trained in emergency situations

The Healthcare plan will include:

- details of a child's condition
- special requirements eg, dietary needs, pre-activity precautions
- any side effects of the medicines
- what constitutes an emergency
- what action to take in an emergency
- what not to do in the event of an emergency
- who to contact in an emergency
- the role the staff can play

The school nurse will help draw up individual health care plans for pupils with medical needs, and may be able to supplement information already provided by parent/carers and the child's GP. The nurse may also be able to advise on training for school staff on administering medicines, or take responsibility for other aspects of support.

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### **Educational Visits**

All children are encouraged to participate in safely managed visits. Jotmans Hall Primary School will consider what reasonable adjustments to make to enable children with medical needs to participate fully and safely on visits. Planning arrangements and risk assessment will include the necessary steps to include children with medical needs.

Arrangements for taking any necessary medicines will be taken into consideration, along with relevant emergency procedures. A copy of any health care plans will be taken on visits in the event of the information being needed in an emergency.

If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek parent/carers 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. There should be sufficient flexibility for all children to follow in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical health and well-being. Any restrictions on a child's ability to participate in PE should be recorded in their individual health care plan. All adults need to be aware of issues of privacy and dignity for children with particular needs.

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

### **Home to School Transport**

This is the responsibility of the Local Authority.

Local Authorities arrange home to school transport where legally required to do so. They **must** make sure that pupils are safe during the journey. Most pupils with medical needs do not require supervision on school transport, but Local Authorities should provide appropriate trained escorts if they consider them necessary. Guidance should be sought from the child's GP or paediatrician.

Drivers and escorts should know what to do in the case of a medical emergency. They should not generally administer medicines but where it is agreed that a driver or escort will administer medicines (i.e. in an emergency) they **must** receive training and support and fully understand what procedures and protocols to follow. They should be clear about roles, responsibilities and liabilities.

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Where pupils have life threatening conditions, specific health care plans should be carried on vehicles. Jotmans Hall Primary School will advise the Local Authority and its transport contractors of particular issues for individual children. Individual transport health care plans will need input from parents and the responsible medical practitioner for the pupil concerned. The care plans should specify the steps to be taken to support the normal care of the pupil as well as the appropriate responses to emergency situations. All drivers and escorts should have basic first aid training. Additionally trained escorts may be required to support some pupils with complex medical needs. These can be healthcare professionals or escorts trained by them.

Some pupils are at risk of severe allergic reactions. Risks can be minimised by not allowing anyone to eat on vehicles. As noted above, all escorts should have basic first aid training and should be trained in the use of an adrenaline pen for emergencies where appropriate.

This policy will be issued to all members of staff and governors. A staff meeting will be held in Autumn term 2012 for staff members to evaluate the document in the light of their current classroom practice. Review of the teaching and learning process will be continuous and ongoing: a formal review will be in line with the School Development Plan, currently Autumn Term 2012

PC - Spring term 2008

PC - Spring term 2010

## **FORM 1 - Contacting Emergency Services**

### **Request for an Ambulance**

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

1. Your telephone number
2. Give your location as follows: (insert school/setting address)
3. State that the postcode is
4. Give exact location in the school/setting (insert brief description)
5. Give your name
6. Give name of child and a brief description of child's symptoms
7. Inform Ambulance Control of the best entrance and state that the crew will be met and taken to

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

Put a completed copy of this form by the telephone

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## FORM 2

### Parental agreement for school/setting to administer medicine

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that staff can administer medicine.

Name of School/Setting \_\_\_\_\_

Date \_\_\_\_\_

Child's Name \_\_\_\_\_

Group/Class/Form \_\_\_\_\_

Name and strength of medicine \_\_\_\_\_

Expiry date \_\_\_\_\_

How much to give ( i.e. dose to be given) \_\_\_\_\_

When to be given \_\_\_\_\_

Any other instructions \_\_\_\_\_

Number of tablets/quantity to be given to school/setting \_\_\_\_\_

### **Note: Medicines must be the original container as dispensed by the pharmacy**

Daytime phone no. of parent or adult contact \_\_\_\_\_

Name and phone no. of GP \_\_\_\_\_

Agreed review date to be initiated by  
*[name of member of staff]:* \_\_\_\_\_

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

Parent's signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

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

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## **COMMON CONDITIONS – PRACTICAL ADVICE AND POLICY ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS**

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

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

From April 2004, training for first-aiders in early years settings must include recognising and responding appropriately to the emergency needs of babies and children with chronic medical conditions.

### **APPENDIX ONE – ASTHMA POLICY**

### **APPENDIX TWO – EPILEPSY POLICY**

### **APPENDIX THREE – DIABETES POLICY**

### **APPENDIX FOUR – ANAPHYLAXIS POLICY**

## APPENDIX ONE:

### ASTHMA POLICY

**PLEASE NOTE: All procedures for medicinal care and emergency situations follow the main medical needs policy.**

#### What is Asthma?

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

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

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

#### Medicine and Control

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken before exercise. Whilst **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

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

Staff should make sure that inhalers are stored in a safe but readily accessible place, and clearly marked with the child's name. Inhalers should always be available during physical education, sports activities and educational visits.

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

The signs of an asthma attack include:

- coughing



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- 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. Written information about the child's asthma should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

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

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

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

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

The school environment is asthma friendly - by removing as many potential triggers for children with asthma as possible.

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

## APPENDIX TWO:

### EPILEPSY POLICY

**PLEASE NOTE: All procedures for medicinal care and emergency situations follow the main medical needs policy.**

#### What is Epilepsy?

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

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

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

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

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

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

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

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

## **Medicine and Control**

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

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

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

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

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

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

Most seizures last for a few seconds or minutes, and stop of their own accord. Some children who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why.

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam. Instructions for use **must** come from the prescribing doctor.

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.

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## **APPENDIX THREE:**

### **DIABETES POLICY**

**PLEASE NOTE: All procedures for medicinal care and emergency situations follow the main medical needs policy.**

#### **What is Diabetes?**

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

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes 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. 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 parent/carers attention.

#### **Medicine and Control**

The diabetes of the majority of children is controlled by injections of insulin each day. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do, it may be necessary for an adult to administer the injection. Older children may be on multiple injections and others may be controlled on an insulin pump. Most children can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, 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 and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will 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 test results.

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

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

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

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

Each child may experience different symptoms and this should be discussed when drawing up a 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 sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

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

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

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## **APPENDIX FOUR:**

### **ANAPHYLAXIS POLICY**

**PLEASE NOTE: All procedures for medicinal care and emergency situations follow the main medical needs policy.**

#### **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).

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately, this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or cause severe asthma. Any symptoms affecting the breathing are serious.

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

#### **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.

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

Adrenaline injectors are simple to administer. They should be given in accordance with the manufacturer's instructions and 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 should hold, and where to store them, has to be decided on an individual basis between the headteacher, the child's parent/carers and medical staff involved.

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Adrenaline injectors should always be kept safely in a cupboard that is not locked and is accessible to all staff.

Studies have shown that the risks for allergic children are reduced where an individual health care 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 be provided each year 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 head to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risks to allergic children should be taken.

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.