

Ashleigh Primary School and Nursery, Wymondham

*"We are all stars, Ashleigh helps us shine"*



## Supporting Children with Medical Conditions in School

Formally adopted by the Governing Board of:-	Ashleigh Primary School and Nursery
On:-	27 <sup>th</sup> September 2023
Chair of Governors:-	Mr. Sam Greenhalgh
Last updated:-	July 2023
Renewal:-	September 2026

*Due consideration has been given to all children/adults/stakeholders with regard to the protected characteristics under the Equality Act 2010.*

# **SUPPORTING CHILDREN WITH MEDICAL CONDITIONS IN SCHOOL**

Every pupil in Norfolk has the right to be healthy, happy and safe. Planning, training and an inclusive ethos will ensure good practice.

The Children and Families Act 2014 includes a duty on schools to support children with medical conditions. This is inclusive of children with diabetes. Schools must make arrangements for supporting pupils at schools with medical conditions and in meeting that duty they must have regard to the statutory guidance issued by the Secretary of State.

Ashleigh Primary School and Nursery recognises that pupils at school with medical conditions should be properly supported so that they have full access to education, including school trips and physical education. Some children with medical conditions may be disabled and where this is the case the school will comply with its duties under the Equality Act 2010.

Some may also have special educational needs (SEN) and may have a statement, or Education, Health and Care (EHC) plan which brings together health and social care needs, as well as their special educational provision and the SEND Code of Practice (2014) is followed.

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

## **INTRODUCTION**

A clear policy, understood and accepted by staff, parents and children provides a basis for ensuring that children with medical needs receive proper care and support in school.

Close co-operation between school, parents, health professionals and other agencies will help provide a suitably supportive environment for children with medical needs.

This policy has been updated in line with latest guidance from the DfE 'Supporting pupils at school with medical conditions':  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/638267/supporting-pupils-at-school-with-medical-conditions.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/638267/supporting-pupils-at-school-with-medical-conditions.pdf)

## **Aims**

This policy covers:

- Roles and responsibilities for managing the administration of medicines and for administering or supervising the giving of medicines to children;
- Parental responsibilities in respect of their child's medical needs;
- Procedures for managing prescription medicines which need to be taken during the school day;
- Procedures for managing prescription medicines on trips and other school activities such as after-school clubs;
- The need for prior written agreement from parents for any medicines to be given to a child;

- Policy and procedures for assisting children with long term or complex medical needs;
- Policy on administering medicines;
- Staff training in managing medicines safely and supporting an identified individual child;
- Record keeping;
- Safe storage of medicines;
- Access to the school's emergency procedures;
- Risk assessment and management procedures.

## **Roles and Responsibilities in School**

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. Staff training will be completed as appropriate. Close cooperation between school, parents, health professionals and other agencies will help provide a suitably supportive environment for children with medical needs.

Anyone caring for children including teachers and other school staff has a common law duty of care to act like any reasonably prudent parent. Staff need to make sure that children are healthy and safe. This duty of care can extend to administering medicine and/or taking action in an emergency. This duty also extends to staff leading activities taking place off site, such as visits, outings or field trips. If staff follow documented procedures, they should be fully covered by the Council's public liability insurance if a parent subsequently makes a complaint.

- **The Headteacher.**  
The Head should make sure that all parents and staff are aware of this policy and procedures for dealing with medical needs. The Head should also make sure that appropriate systems for information sharing are followed. The policy should make clear that parents should keep children at home if they are unwell. For a child with medical needs, the Head will agree with parents exactly what support can be provided. Where parents' expectations seem unreasonable, the Head should seek advice from the school nurse, child's GP or other medical advisers and, if appropriate, the Local Authority.
- **The Secretarial Assistant.**  
Should a medical need be identified on the admission form, it is the responsibility of the secretary to inform the Head, class teacher and the SENDCO.
- **The SENDCO.**  
Once notified by the Secretarial Assistant of any medical needs on admission; it is the SENDCO's responsibility to ensure that appropriate action is taken, e.g. arranging a meeting with parents, setting up a care plan.
- **The Class Teacher.**
  - Once notified by the secretary of any medical needs on admission; it is the class teacher's responsibility to inform any other staff working with that class e.g. teaching assistants, PPA teachers, supply teachers through the supply pack, MSAs.
  - The class teacher should contribute to the establishment of a care plan.

- Should a medical need arise once a child is in school the parent is responsible for informing the class teacher or teaching assistant. They, in turn, should inform all other staff as appropriate e.g. the Head, secretary, other staff.
- **The Teaching Assistant.**  
Routine administration of medicines, within the guidelines of this policy, may be carried out by the class teaching assistant. For more complex needs a discussion will determine as to who is the best person to administer medicines.
- **Office Staff.**  
Routine administration of medicines, within the guidelines of this policy, may be carried out by Office staff.
- **Midday Supervisors.**  
MSAs do not administer medicines with the exception of inhalers during lunch periods and emergency treatment e.g. EpiPen. They administer first aid should the need arise. They have a responsibility to find out which children in their care have medical needs and should be familiar with their care plan. They are responsible for ensuring children have immediate access to inhalers should the need arise during lunchtimes.
- **Kitchen Staff.**  
Kitchen staff need to be fully informed about children who eat lunch and who also have a food allergy/intolerance or sensitivity. Parents and school staff are involved in this information sharing to ensure that food served is safe for individual children to eat.
- **Leaders of extra-curricular activities.**  
Where there are activities taking place on the school premises involving leaders who are not members of the school staff, they will need to be informed on a 'need to know' basis about the health needs of children in their care. It is the responsibility of the School Secretary to add medical needs, as appropriate, to the list of pupils supplied to the leader.

## **Parents**

It requires only one parent to agree to, or request, that medicines are administered.

Where parents disagree over medical support the school should 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.

Parents have the opportunity to provide school with sufficient medical information about their child's medical needs if treatment or special care is needed. This is through the admission form or by informing the school when a medical situation arises.

Parents should, jointly with the Head, reach agreement on the school's role in supporting their child's medical needs. Ideally the Head should seek parental agreement before passing on information about their child's health to other staff.

Information about their child's health will be passed to other staff on a 'need to know' basis. Sharing information is important if staff and parents are to ensure the best care for a child.

Parents should ensure that they keep 'emergency contact details' updated.

### **Health Service**

It is the school's responsibility to ensure that care plans/ risk assessments are in place. However, a member of the School Nursing Team or another health professional can be consulted or may support the school to draw up an individual health care plan for children with particular medical needs. Medical needs which may require a health care plan include: children who are at risk of anaphylaxis, seizures or diabetes, and may be able to supplement information already provided by parents and the child's GP. They will also advise on training for school staff on administering medicines or take responsibility for other aspects of support.

Any exchange of information between a GP and the school should normally be with the support of the parent. Usually consent will be given as it is in the best interests of children for their medical needs to be understood by school staff.

Some children with medical needs receive dedicated support from specialist nurses or community children's nurses. These nurses can provide advice on the medical needs of an individual child, particularly when a medical condition has just been diagnosed and the child is adjusting to new routines.

School works with the meals provider to ensure that food allergies/intolerances are both understood and catered for. It is the schools responsibility to inform the provider of any known food allergies/intolerances.

### **Medicines in School**

These fall into three categories:

- Prescription medicines. These are the only medicines which can be taken in school. See below.
- Non-prescription medicines. These are not to be administered in school except in certain circumstances. See below.
- Medicines for complex needs. These will be identified in the care plan and administered accordingly. See below.

### **Procedures for Managing Prescription Medicines including Asthma inhalers**

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.

We only accept medicines 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.

From 1 October 2014 UK schools will be allowed to purchase a salbutamol inhaler without a prescription for use in emergencies when a child with asthma cannot access their own inhaler.

**We must never accept medicines that have been taken out of the container as originally dispensed, nor make changes to dosages on parental instructions.**

A consent form - **Parental Agreement for School to Administer Medicine** - must be completed by the parent before prescription medicines can be administered in school. The school office keeps a supply of these.

When the medicine is administered the form - **Record of Medicine Administered to an Individual Child** - also needs to be completed. *(See Appendices 1 and 2).*

No prescription drugs should be administered without the appropriate training.

### **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 (brand name Ritalin).

Any member of staff may administer a controlled drug to the child for whom it has been prescribed. This should be done in accordance with the prescriber's instructions and this policy.

A child who has been prescribed a controlled drug may legally have it in their possession. It is permissible for schools 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 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 when no longer required to arrange for safe disposal. If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label).

### **Non-Prescription Medicines**

Apart from exceptional circumstances we do not administer non-prescribed medicines in school. Staff should never give a non-prescribed medicine to a child unless there is specific prior written permission from the parents and agreement from the Headteacher. Examples may include analgesics (pain relief), creams e.g. for eczema.

Where a non-prescribed medicine is administered to a child a consent form - **Parental Agreement for School to Administer Medicine** - must be completed by the parent before the non-prescription medicine can be administered in school.

On administration, it must be recorded on form – **Record of Medicine Administered to an Individual Child** - and the parents informed. If a child suffers regularly from acute pain the parents 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.**

No child under 16 should be given prescription or non-prescription medicines without their parent's written consent – except in exceptional circumstances where the medicine has been prescribed to the child without the knowledge of the parents. In such cases, every effort should be made to encourage the child or young person to involve their parents while respecting their right to confidentiality.

### **Procedures for Managing Prescription Medicines on Trips**

It is good practice to encourage children with medical needs to participate in safely managed visits. The visit leader should consider what reasonable adjustments might have to be made to enable children with medical needs to participate fully and safely on visits. Planning arrangements will include the necessary steps to include children with medical needs. It might also include risk assessments for such children. Copies of health care plans should be taken on visits in the event of the information being needed in an emergency.

Sometimes additional safety measures may need to be taken for outside visits e.g. the parent or another volunteer might be needed to accompany a particular child. If staff are concerned about whether they can provide for a child's safety or the safety of other children on a visit they should seek parental views and medical advice from the school health service or the child's GP.

### **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. Any restrictions on a child's ability to participate in PE should be recorded in their individual health care plan. All adults should be aware of issues of privacy and dignity for children with particular needs.

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

### **Home to School Transport**

Where pupils have life threatening conditions, specific health care plans should be carried on vehicles. 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.

If a child has a care plan and uses home school transport, a copy of the plan and any other relevant information must be sent to the Passenger Transport Unit (PTU) so that risks to pupils are minimised during home to school transport.

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 health care 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. All escorts should also be trained in the use of an adrenalin pen for emergencies where appropriate.

## **Children with Short Term, Long Term or Complex Medical Needs**

### **Short Term Needs**

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

### **Children with Long-Term or Complex Medical Needs**

It is important to have sufficient information about the medical condition of any child with long-term or complex medical needs. Schools 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 regularly special arrangements may also be necessary.

A written health care plan will be developed for such children involving the parents and relevant health care professionals. This can include:

- Details of a child's condition;
- Special requirements, e.g. dietary needs, pre-activity precautions and 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 staff can play.

It is important for staff to be guided by health professionals and parents in how often they should jointly review the health care plan. This should be done at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently.

### **Administering medicines**

**No child under 16 should be given medicines without their parent'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 or container. If a child has come into school with a prescribed medicine but no written agreement with parents has been signed (e.g. if a child arrives by taxi and has medicine with them) then the school will make every effort to contact parents to gain verbal agreement for the medicine to be administered.

If a child has Piriton or similar in school (prescribed by GP and in original bottle) to be given when they are having an allergic reaction, parents need to be aware that when it is administered, they will be telephoned and asked to come and collect the child from school (the child needs to be observed by the parent in case the reaction develops further). A member of staff needs to stay with the child and observe whilst parent is coming to collect.



If in doubt about any procedure staff should not administer the medicines but check with the parents 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, if appropriate, or with a relevant health professional.

Staff should complete and sign form – **Record of Medicine Administered to an Individual Child** each time they give medicine to a child. In some circumstances such as the administration of rectal diazepam, the dosage and administration should be witnessed by a second adult.

Teachers' conditions of employment do not include giving or supervising a pupil taking medicines. Teaching assistants are appropriately trained to manage routine medicines as part of their duties. Any member of staff who agrees to accept responsibility for administering non-routine prescribed medicines to a child should have, if appropriate, appropriate training and guidance. They should also be aware of possible side effects of the medicines and what to do if they occur. The type of training necessary will depend on the individual case.

All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures. Staff should 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.

A child under 16 should never be given medicine containing aspirin unless prescribed by a doctor. Medication, e.g. for pain relief, should never be administered without first checking maximum dosages and when the previous dose was taken. Parents should be informed.

Where clinically possible, medicines should be prescribed in dose frequencies which enable them to be taken outside school hours.

Schools should only accept prescribed medicines that are in-date, labelled, provided in the original container as dispensed by a pharmacist and include instructions for administration, dosage and storage. The exception to this is insulin which must still be in date, but will generally be available to schools inside an insulin pen or a pump, rather than in its original container.

All medicines should be stored safely. Children should know where their medicines are at all times and be able to access them immediately. Where relevant, they should know who holds the key to the storage facility. Medicines and devices such as asthma inhalers, blood glucose testing meters and adrenaline pens should be always readily available to children and not locked away. This is particularly important to consider when outside of school premises e.g. on school trips.

A child who has been prescribed a controlled drug may legally have it in their possession if they are competent to do so, but passing it to another child for use is an offence. Monitoring arrangements may be necessary. Schools should otherwise keep controlled drugs that have been prescribed for a pupil securely stored in a non-portable container and only named staff should have access. Controlled drugs should be easily accessible in an emergency. A record should be kept of any doses used and the amount of the controlled drug held in school.

School staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicines should do so in accordance with the prescriber's instructions. Schools should keep a record of all medicines administered to individual children, stating what, how and how much was administered, when and by whom. Any side effects of the medication to be administered at school should be noted.

When no longer required, medicines should be returned to the parent to arrange for safe disposal. Sharps boxes should always be used for the disposal of needles and other sharps.

### **Administration of Adrenaline Auto-injectors (AAIs)**

Should the situation arise when an adrenaline auto-injector (AAI) e.g. Epipen or Jext injectors may need to be administered, sufficient staff will be trained from each staff team to ensure that the AAI can be administered immediately.

Severe anaphylaxis is an extremely time-critical situation: delays in administering adrenaline have been associated with fatal outcomes. Schools should ensure that all AAI devices – including those belonging to a younger child, and any spare AAI in the Emergency kit – are kept in a safe and suitably central location: for example, the school office or staffroom to which all staff have access at all times, but in which the AAI is out of the reach and sight of children. They must not be locked away in a cupboard or an office where access is restricted. **Schools should ensure that AAIs are accessible and available for use at all times, and not located more than 5 minutes away from where they may be needed.** In larger schools, it may be prudent to locate a kit near the central dining area and another near the playground; more than one kit may be needed.

From 1<sup>st</sup> October 2017, schools in England are allowed to purchase adrenaline auto-injector (AAI) devices without a prescription, for emergency use on children who are at risk of anaphylaxis but whose own device is not available or not working.

See:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/645476/Adrenaline\\_auto\\_injectors\\_in\\_schools.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/645476/Adrenaline_auto_injectors_in_schools.pdf)

### **Self-Management**

We do not usually expect any of our children to manage their own medicines in school. If they need to apply a cream e.g. for eczema, they may be able to do this themselves **but** this must be under supervision. Inhalers are freely accessible to children with asthma.

### **Refusing Medicines**

If a child refuses to take medicine, staff should not force them to do so, but should note this in the records and follow agreed procedures. The procedures may either be set out in the policy or in the child's health care plan. Parents should be informed of the refusal on the same day.

### **Record Keeping**

Parents must 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 must ensure that this information is the same as that provided by the prescriber.

In all cases it is necessary to check that written details include: name of child; name of medicine; dose; method of administration; time/frequency of administration; any side effects; expiry date.

Parents should be given form - **Parental Agreement for School to Administer Medicine** - to record details of medicines in a standard format. This form confirms, with the parents, that a member of staff will administer medicine to their child.

Records must be kept of medicines given to pupils, and the staff involved. Records offer protection to staff and proof that they have followed agreed procedures. Form - **Record of Medicine Administered to an Individual Child** - must be used. In some circumstances such as the administration of rectal diazepam, it is essential to have the dosage and administration witnessed by a second adult.

### **Dealing with Medicines Safely**

#### **Safe Storage of Medicines**

Medicines will be stored in the school office or the staffroom fridge. In Nursery medicines are safely in secure containers.

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

Children should know where their own medicines are stored. Asthma inhalers Epipens and Jext injectors are kept in the school office (or in a secure container in Nursery), for immediate access for all. Staff have access to first aid cabinets in classrooms.

Non-emergency medicines for staff use are kept with their personal possessions and should be stored securely.

#### **Disposal of Medicines**

Staff should not dispose of medicines. Parents 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 the school year. If parents do not collect all medicines, they should be taken to a local pharmacy for safe disposal.

Sharps boxes should always be used for the disposal of needles. Sharps boxes can be obtained by parents on prescription from the child's GP or paediatrician. Collection and disposal of the boxes should be arranged with the district council's environmental services.

#### **Hygiene and Infection Control**

All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures. Disposable gloves must be worn when dealing with spillages of blood or other body fluids and disposing of dressings or equipment.

## **Access to the School's Emergency Procedures**

Most support staff at Ashleigh are trained in emergency first aid and are available to administer this in case of an emergency. Children should also know what to do in the event of an emergency, such as telling a member of staff. All staff should know how to call the emergency services.

A member of staff will always accompany a child taken to hospital by ambulance and will stay until the parent arrives. Health professionals are responsible for any decisions on medical treatment when parents are not available.

Staff should never normally take children to hospital in their own car; it is safer to call an ambulance.

Where a member of staff has to take a child in their own car, it should be a named driver with the appropriate business insurance.

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.

## **Drawing up a Health Care Plan**

The main purpose of a 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 parents may be all that is necessary. See form - **Parental Agreement for School to Administer Medicine**.

It is important for staff to be guided by the child's GP or paediatrician. Staff should agree with parents how often the plan should be reviewed. It should be reviewed at least annually.

Staff should judge each child's needs individually as children vary in their ability to cope with poor health or a medical condition.

The health care plan will be drawn up by the class teacher and SENDCo. Others, including health professionals may also contribute to the health care plan. This may include the child (if appropriate), teaching assistant or other support staff working with the child.

## **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 medicine or in dealing with emergencies. When staff agree to assist a child with specific medical needs appropriate training should be arranged in collaboration with local health services.

In addition staff supporting children with medical needs should attend the course "Raising Awareness of Chronic Medical Conditions: Asthma, Diabetes and Epilepsy" (course reference ENWD8).

Staff training is recorded on the school's training database.

## **School Medical Facilities**

The Education (School Premises) Regulations 1999 require every school to have a

room appropriate and readily available for use for medical or dental examination and treatment and for the caring of sick or injured pupils. It must contain a washbasin and be reasonably near a toilet. It must not be teaching accommodation.

Staff should be sensitive to the type of treatment is required. The staffroom, group rooms and Head's office are all available if privacy is required.

### **Common Conditions – Practical Advice on Diabetes, Anaphylaxis, Epilepsy and Asthma**

The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, severe allergic reaction (anaphylaxis), epilepsy and asthma. Detailed advice will be sought from the school nurse should we have a child in school suffering from one of these conditions.

**Further guidance on diabetes, anaphylaxis and epilepsy is at the back of this policy.**

### **Coordinating and Communicating Information**

Coordinating and sharing information on an individual pupil with medical needs is done on a 'need to know' basis. For routine administration of prescription medicine the responsibility lies with the class teacher. For more complex or long term medical needs the responsibility lies with the SENDCO who is the first contact for parents and staff and will liaise with external agencies.

Class teachers are responsible for sharing information about children with medical needs with other staff as appropriate and with the children.

### **Work Experience Placements**

It is the responsibility of the school, college and student themselves to notify the Deputy Head of any medical needs before starting a placement with us.

### **Safety Management**

All medicines may be harmful to anyone for whom they are not appropriate. The safe storage of medicines is reviewed annually as part of our whole school risk assessment in the summer term. It is the responsibility of individual members of staff who have personal medication in school to store it in a safe place in, well out of the reach of children.

### **Confidentiality**

Medical information is to be treated confidentially. Information is shared on a 'need to know' basis. 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.

Staff also have a responsibility to share information about their own medical needs, if appropriate, with the School Leadership Team and their classroom staff.

### **Complaints**

Any complaint relating to supporting children with medical conditions at school should in the first instance be directed in writing, to the Headteacher.

## APPENDICES

Below are:

1. The **Parental Agreement for School to Administer Medicine** consent form which must be completed before any medicine can be administered in school.
2. The **Record of Medicine Administered to an Individual Child** record keeping form which must be completed by the member of staff administering the medicine.

Not included, but available are the forms we do not routinely use. These are:

1. Staff training record. Staff training is recorded on our training database.
2. Health care plan. This is for children with long term or complex health needs. Current format is provided by the NHS and contains more detailed information.

## Parental agreement for setting to administer medicine

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

Date for review to be initiated by	
Name of school	Ashleigh Primary School and Nursery
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

### Medicine

Name/type of medicine <i>(as described on the container)</i>	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	
Procedures to take in an emergency	

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

### Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	Staff in school office

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.

Signature(s) \_\_\_\_\_

Date \_\_\_\_\_

**Record of medicine administered to an individual child**

Name of school/setting	Ashleigh Primary School and Nursery
Name of child	
Date medicine provided by parent	
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	
Quantity returned	
Dose and frequency of medicine	

Staff signature \_\_\_\_\_

Signature of parent \_\_\_\_\_

Date			
Time given			
Dose given			
Name of member of staff			
Parent Informed Y/N			

Date			
Time given			
Dose given			
Name of member of staff			
Parent Informed Y/N			



**C: Record of medicine administered to an individual child (Continued)**

Date			
Time given			
Dose given			
Name of member of staff			
Parent Informed Y/N			

Date			
Time given			
Dose given			
Name of member of staff			
Parent Informed Y/N			

Date			
Time given			
Dose given			
Name of member of staff			
Parent Informed Y/N			

Date			
Time given			
Dose given			
Name of member of staff			
Parent Informed Y/N			

## Guidance on Diabetes

**Schools requiring training in understanding diabetes should contact Norfolk and Norwich University Hospital.**

### 1. General guidelines for staff

**‘We believe that all children and young people have the right to be healthy, happy and safe; to be loved, valued and respected; and to have high aspirations for their future.’**

It is important that children and young people with diabetes are properly supported in our schools. Academic performance may be adversely affected if a child is not supported in accordance with their care plan to manage their condition.

Over 15,000 children of school age in the UK have diabetes. The majority of these children (99%) have Type 1 diabetes, which is not related to obesity or life style. This guidance gives general information, and details sources of further information.

Pupils with diabetes have rights under the Equality Act 2010 legislation. They cannot be treated less favourably than their non-disabled peers in admissions, exclusions and access to education and associated services (SENDA 2001). For example, a child with diabetes cannot be excluded from a school visit or sports activity for a reason directly related to their diabetes, refused admission to a school, or excluded because of their condition.

The Disability Equality duties (DDA 2005) require schools to promote equality of opportunity between disabled persons and other persons, promote positive attitudes towards disabled persons, and take steps to take account of disabled persons' disabilities even where that involves treating disabled people more favourably than their non-disabled peers. Your school Equality Scheme should include plans to improve equality for both pupils and staff with diabetes.

Every child with diabetes will have an individual health care plan. For further information and advice about individual children, schools should always consult with the family/carers and the diabetes support team. The child's diabetes specialist nurse will be an important contact and can advise the school on specific cases.

### 2. What is diabetes?

Diabetes is a condition in which the amount of glucose in the blood cannot be controlled due to the auto immune destruction of special cells within the pancreas.

All the food we eat is broken down into glucose. Glucose passes via the gut out into the bloodstream. If you do not have diabetes your body will release the hormone insulin in exactly the right amount at the same time as the glucose releases into the bloodstream. If you do have diabetes, both the production of insulin, and the regulation of how much glucose is available in the bloodstream, fails.

The aim of the treatment for diabetes is to keep the blood glucose levels close to the normal range so that it is neither too high (hyperglycaemia) nor too low (hypoglycaemia, also known as a hypo).

Most children with diabetes will have Type 1 diabetes. Their pancreas does not produce insulin so they will need insulin injections to regulate their blood sugar levels.

### 3. Treating diabetes

Insulin has to be injected and most children with diabetes will need several injections every day. While some injections will be given out of school hours, the majority of pupils will require one or more injections during the school day. This will be detailed in their health care plan.

#### 3.1 Blood glucose monitoring

All children with diabetes will need to test their blood sugar levels during school time. This is vital to the management of the condition and must be facilitated. Blood glucose testing involves pricking the finger, using a special device, and placing a small drop of blood onto a glucose testing strip. The level is displayed on a small electronic meter. The procedure takes as little as a minute to complete.

Most pupils will carry out this procedure discretely in the classroom. However, if they wish to do this in the medical room this should be allowed.

Staff may need to oversee the blood glucose test and help a young child to interpret the reading. If a child has low blood glucose level (hypo – see below) they may also interpret the reading incorrectly, or need assistance inserting the testing strip etc.

There are no exposed sharps that could pose a danger to other pupils in a blood glucose testing kit, though it is important to discuss the safe use and disposal of equipment in the classroom.

The Diabetes team is happy to discuss safe procedures if there are concerns.

#### 3.2 Insulin injections

In most cases the equipment will be an insulin 'pen' rather than a syringe.

Pupils usually administer the insulin injection themselves; however younger children may need the dose 'double checked' by staff prior to injection. For children under the age of 8 or who have a learning difficulty it may be necessary for a member of the school staff to administer the insulin.

Staff training, support and information will be available from the Diabetes or School Nursing Team in your area. All staff who are required to administer insulin will receive specific training.

Schools requiring training in understanding diabetes should book on to the course via the Norfolk and Norwich University Hospital.

#### 3.3 Insulin Pumps

Some children will manage their diabetes by means of a 'subcutaneous continuous **insulin infusion pump**'. The insulin pump is connected to the child via a small plastic tube called a cannula that is situated just under the

skin - in the tummy, lower back or upper leg. This is usually replaced every two or three days.

The child will still be required to 'carbohydrate count' their meal, but will then use their pump to infuse the insulin, instead of having a mealtime injection of insulin.

Staff training, support and information will be available from the Diabetes Team in your area. The Healthcare Plan will also provide specific detail about the child's needs.

### 3.4 Diet

It is important to know the times the child needs to eat and make sure that they keep to these times. It may be necessary to allow the pupil to attend first sitting of lunch, for example.

Some children will adjust their next dose of insulin according to their food intake (particularly at lunchtime). This is called carbohydrate counting and younger children and those with a learning difficulty will require support from staff to do this.

There may be occasions when a snack or dextrose will need to be taken during lesson times. Pupils should feel that they are able to ask to eat during lesson time if they need to do so, without fear of reprisal.

## 4. **Physical activity**

Diabetes should not stop children with the condition from enjoying any kind of physical activity or being selected to represent the school and other teams, providing they have made some simple preparations.

Pupils may need to check their blood glucose level before and during the activity and may need to eat a snack before and / or after an activity, otherwise their blood sugar level could fall too low and cause a hypo.

For more strenuous or prolonged activity, pre-planning, including liaison with parents/carers is advised in order to avoid hypoglycaemia. Many pupils with diabetes are having a sports drink prior to or during activities. Diabetes should not be seen as a barrier to full participation in physical activities.

While it is important to keep an eye on all children, the child with diabetes should not be singled out for special attention as this can lead to embarrassment. It will be important to ensure they are properly supervised during water activities.

## 5. **Hypoglycaemia (Hypo)**

Hypoglycaemia is the most common short-term complication in diabetes and occurs when blood sugar levels fall too low. Hypos can happen at any time.

**It is important to understand that a hypo cannot be predicted. It is a physiological response that can happen very suddenly and without warning. It is during a hypoglycaemic episode that adult support is most likely to be required and there is a need for awareness and training for all staff.**

Most children will have warning signs that will alert them, or people around them, to a hypo. However, some children will have no hypo awareness at all and can be completely unaware of their deteriorating state. It is vital to encourage pupils displaying symptoms to test their blood glucose levels.

The warning signs can include:

- Mood changes, especially angry or aggressive behaviour
- Hunger
- Sweating
- Drowsiness
- Glazed eyes
- Pallor
- Trembling or shakiness
- Headache
- Lack of concentration

The symptoms can be different for every child and it important to get information from the child and the parents/carers about each individual. Please refer to the child's health care plan for specific symptoms.

**It is vital that a hypo is treated quickly. If left untreated, the blood sugar level could fall so low that the child can become unconscious. A pupil should never be left alone during a hypo, nor sent from the classroom unaccompanied to treat it, e.g. sending a pupil to the school office alone is not appropriate. Recovery treatment must be brought to the child.**

Most children will know when they are going hypo and will be able to take appropriate action themselves. Pupils with diabetes will usually have a treatment, e.g. dextrose tablet or full sugar drink, in their school bag and an emergency kit box kept in school (often in the school office or MI room). Specific symptoms and treatments will be detailed in the child's health care plan.

**In the unlikely event of a child losing consciousness, do not give them anything by mouth. Place them in the recovery position and call an ambulance informing them that the child has diabetes.**

A hypo can occur as a result of

- Too much insulin
- Not enough food to fuel an activity
- Too little food at any stage of the day
- A missed meal, or delayed meal or snack
- A change in the weather
- The child vomiting
- Hormonal development (particularly menstruation)
- Growth
- Emotional changes – exam stress, peer pressures etc.

## **6. Other considerations**

If a child is unwell their blood glucose levels may rise. This can cause them to become very thirsty and to need to go to the toilet more frequently. If staff notice this, they should report it to the child's parents/carers.

If a child vomits at school contact the parents/carers immediately and support the child to monitor their blood glucose level. (This is of particular importance for a child using an insulin pump)

Day and residential visits out of school should not cause any additional problems as the routine should be very similar to that at school. There should be no need for parents/carers to accompany the child. The child with diabetes should take their insulin and blood glucose kit with them. It is a good idea for parents to provide extra snacks in case of delay in returning home. The emergency kits box should also be taken as back up.

Staff with responsibility for administering medicines on trips can receive training and support from Health colleagues.

Overnight assistance may be required to check blood glucose levels do not fall too low, and to assist pupils with snacks during the night should this occur.

If a school visit involves travel outside the UK, it is important to check that travel insurance covers pre-existing conditions - in case of a medical emergency. Diabetes UK produces guides for a number of countries giving information about local foods, translations of useful phrases and diabetes care. It may be useful for the pupil to carry an emergency identity card.

As with all educational visits, it is important to discuss planning with the pupil's parents/carers to ensure all health needs are met.

## **7. Staff administering medication**

Anyone caring for children, including teachers and other school staff have a common law duty of care to act like any reasonably prudent parent/carer. Staff need to make sure that children are healthy and safe. In some circumstances, (for example, a child with diabetes) the duty of care could extend to administering medication and/or taking action in an emergency. This duty extends to staff leading activities taking place away from the school site such as outings, residential visits or field trips.

Any member of staff with responsibility for administering or supervising the administration of medication should have appropriate training and guidance. Staff should be reassured that they would be covered by relevant employers insurance should the need arise.

Medical professionals will support schools in preparing health care plans for individual pupils.

The Special Educational Needs and Disability Act 2001 (SENDA) requires reasonable adjustments to be made to prevent the less favourable treatment of disabled pupils. Diabetes is a disability within the definition of the Act and pupils cannot be discriminated against. The responsible body (the Governing body in

maintained schools) would need to justify their reasons if they were to fail to make reasonable adjustments for a pupil with diabetes.

Your school Equality Scheme may address specific issues around people with diabetes. Many schools are ensuring that support staff have specific duties to provide medical assistance as part of their contract. Support staff with medical experience can be a valuable addition to any school, benefiting both disabled and non-disabled pupils.

The employer (generally the Governing Body or the Local Authority) is responsible under Health and Safety legislation, for making sure that a school has a Health and Safety Policy. This should include procedures for supporting pupils with medical needs, including managing medication. It is important that all school policies and procedures do not discriminate against disabled pupils or those with a long term medical condition.

## Guidance on Anaphylaxis

**Schools requiring training in understanding anaphylaxis should contact Norfolk and Norwich University Hospital.**

### **What is Anaphylaxis?**

This guidance document provides basic information about anaphylaxis 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.

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 children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or 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.

Staff who 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 head, the child's parents and medical staff involved. Where children are considered to be sufficiently responsible to carry their emergency treatment themselves, 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.



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 in the plan 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 should 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 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. 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 stigmatized 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.

## Guidance on Epilepsy

### Schools requiring training in understanding epilepsy should contact Norfolk and Norwich University Hospital

#### What is Epilepsy?

This guidance document provides basic information about epilepsy 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.

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. At least one in 200 children has epilepsy and around 80% 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 schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child experiences a seizure in a school or setting, details should be recorded and communicated to parents including:

- Any factors which might 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 or 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 on 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.

**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. 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. 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 parents as part of the health care plan.

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

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 health care plan.

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

Most seizures last for a few seconds or minutes and stop of their own accord. Some children who have longer seizures are likely to be prescribed buccal midazolam as an emergency treatment for prolonged seizures.

## 8. Further guidance

- [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/638267/supporting-pupils-at-school-with-medical-conditions.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/638267/supporting-pupils-at-school-with-medical-conditions.pdf)
- [https://www.walthamforest.gov.uk/documents/medical\\_needs.pdf](https://www.walthamforest.gov.uk/documents/medical_needs.pdf)
- <https://www.diabetes.org.uk/guide-to-diabetes/your-child-and-diabetes/schools>
- <https://www.anaphylaxis.org.uk/schools/schools-help/>
- <https://www.anaphylaxis.org.uk/what-to-do-in-an-emergency/>
- [http://learn.epilepsy.org.uk/training-for-schools/?gclid=Cj0KCQiAs9zSBRC5ARIsAFMtUXE0o1wwc-d9lQ\\_t1OueD\\_QZfmidFoi2hICPrMQUjZQJ38A3cHJL2C4aAkqhEALw\\_wcB](http://learn.epilepsy.org.uk/training-for-schools/?gclid=Cj0KCQiAs9zSBRC5ARIsAFMtUXE0o1wwc-d9lQ_t1OueD_QZfmidFoi2hICPrMQUjZQJ38A3cHJL2C4aAkqhEALw_wcB)
- <http://www.heron.nhs.uk/heron/organisationdetails.aspx?id=20876>
- <https://www.asthma.org.uk/advice/child/life/school>
- [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/416468/emergency\\_inhalers\\_in\\_schools.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416468/emergency_inhalers_in_schools.pdf)

### Local contacts

- School Nursing Team
- Specialist Paediatric/ Diabetes Team
- Specialist Epilepsy Nursing Team
- County Medical Needs Coordinator