

Section 5

Medication in Schools

Introduction

Children will sometimes have a medical condition which will require the administration of medication whilst at school. These children have the same right to admission to school as other children. They cannot be refused admission, denied access to curricular entitlements, prevented from participation in extra curriculum activities or excluded from educational visits and off-site activities because of their medical condition.

The SEN and Disability Act 2001 guarantees the rights of access to school for children with disabilities, including those with medical needs. This Act places a duty on the school to consider what arrangements can reasonably be made to help support a pupil (or prospective pupil) who has a disability, and makes governing bodies subject to any claim made by a parent to the SEN and Disability Tribunal if the school fails to do so. The 'reasonable adjustments' which a school makes will ensure that children with disabilities, including long-term medical needs, do not receive less favourable treatment than other children. Further guidance is contained in the Disability Rights Commission Code of Practice for Schools (2002).

National standards to minimise the disruption to education of pupils with medical needs were introduced in statutory guidance for the first time in November 2001 and were revised in October 2004 as part of the National Service Framework for Children, Medicines Standard (see later section on 'Responsibilities' for more information). This guidance reflects the expectations set out in these standards.

Advice and training from local healthcare professionals will help schools when looking at what arrangements they may reasonably make to support and include a pupil with a disability. Local health professionals, local authorities and schools work closely through the Continuing Care Panel to ensure that children with complex medical regimes, whether through chronic ill health or disability, receive the specific support they need so that they can attend school on a regular basis. In the most complex cases health professionals will provide the support. Where support is provided by school staff, they will be fully trained by health professionals (see 'Staffing Issues').

School arrangements for medicines

All schools need systems in place to support children with long-term medical needs who require access to medicines in school. National guidance for schools 'Managing Medicines in Schools and Early Years Settings', DfES (2005), provides advice and guidance on the effective management systems needed to support individual pupils with medical needs.

School arrangements need to consider carefully how individual pupil's medicines will be managed:

- With the exception of self-administered inhalers, anaphylaxis treatments (e.g. Epipens and Anapens) and insulin, all medicines should be securely stored.

- The parent should arrange delivery of all medicines to be taken or administered in school.
- Medicines should be clearly labelled with the child's name and in the containers in which they were originally dispensed. Where the medication is specified in a Health Care Plan (see Appendix 5.1) General Practitioners will prescribe in a way which allows medication to be held both in school and in the home.
- The medication should always be accompanied by written instructions from the parent or prescribing doctor specifying the preparations, storage arrangements, dosage and circumstances under which it should be given (see Appendix 5.2 for suggested template).
- More unusual preparations and conditions will require a protocol specific to the condition to be completed by the prescribing doctor, and will usually be accompanied by training from a healthcare professional.

Storage of medicines

Medicines should be given to schools by the parent in the original container on which the following information will be described in BLOCK CAPITALS:

Name of the child
 Name of the medication and dosage
 Date of issue to the parent
 Expiry date and batch number.

With the exception of asthma inhalers and Epipens / Anapens which should be readily accessible, medicines should be kept in a secure cupboard at ambient temperature, near to the child's medication record. Occasionally a drug will need to be stored in a fridge. In these circumstances schools should take advice from their School Nurse.

Local procedures should be in place to ensure that the expiry date has been checked periodically. Appropriate amounts of the drug should be kept for these procedures and should be acknowledged in writing upon receipt from the parents, and upon return to the parent at the end of term or just prior to expiry.

Schools should store controlled drugs (e.g. ritalin, fentanyl, oramorph) in a locked, non-portable container and only named staff should have access.

On receipt of drugs from parents, school staff should count contents and record details (see Appendix 5.4). Staff should not assume the label will necessarily match the contents.

Written permission must be obtained from parents if they want their child to keep his/her own medicines on him/her for use as necessary (see Appendix 5.5). If staff have any concerns, they should discuss this request with healthcare professionals.

Self-administration of medication

Self-administration of such prescribed medication is actively encouraged even in younger children and would cover such medicines as inhalers for asthma, glucose and/or insulin for diabetes or anti-convulsants. Staff should supervise the administration of medication and complete the necessary record (see Appendix 5.3). Occasionally children may have to rely on trained adults for acute attack treatments, such as rectal diazepam, adrenaline.

Refusing medicines

If a child refuses to take a medicine, staff should not force them to do so. The refusal should be noted (see Appendices 5.3 or 5.4 in the case of controlled drugs) and parents informed. If a refusal results in an emergency, the school's emergency procedures should be followed.

Staffing issues

Schools should ensure that they have sufficient members of staff who are employed and appropriately trained to administer medication as part of their duties. When appointing to support staff posts, the expectation that the postholder will, after appropriate training and guidance, administer medication, should be made clear and be included in the job description / contract of employment.

Unless specifically included in a job description / contract of employment, the requirement to administer medication cannot be imposed on an existing member of staff. However, it is possible to ask for volunteers from existing staff to provide this, following appropriate training and guidance. Please note that teaching staff have no legal nor contractual duty to provide such support.

Even if a school does not have a child with such needs currently, disability legislation requires schools to anticipate future needs. Contracts of employment for new staff could, therefore, include a clause that specifies that the new postholder takes on this responsibility with a commitment that training and guidance will be provided by Health and/or support service staff as necessary.

It is important that all staff involved in supporting children with medical needs have received appropriate training from Health and/or support service staff (see Appendix 5.6). Professional development activities on personal care will depend very much on the circumstances of that school or setting. It is, however, important to anticipate on a whole setting basis the full range of needs that children present with, as well as considering specific training for those staff who provide care to individual children.

Staff may be anxious about taking responsibility for managing medicines because they fear something 'going wrong'. In the event of a claim for alleged negligence it is the Employer (the Local Authority or Governing Body), not the employee, who is held responsible and, providing that the member of staff has followed their Employer's policy and has acted within the scope of their training, the Council's insurance will defend any such action and meet any costs if the claim is successful. Schools which subscribe to the Local Authority's insurance cover are automatically protected against these risks. Those schools that do not subscribe to the WCC arrangements will need to ensure they are adequately covered.

Routine conditions and illness

Children who are clearly unwell with, for example, vomiting, diarrhoea or high temperature, should not be in school and headteachers may ask parents to keep them at home.

In general, treatments can be managed so that it is not necessary for medicines to come into school. Most medication can be managed by doses timed to be outside the school day.

The exceptions to this would be those pupils who have conditions such as asthma or diabetes, where such an approach would prevent their schooling long term. In these cases, and in circumstances where the administration of medicines during the school day cannot be avoided, schools should secure the signed consent of parents (see Appendix 5.2).

Children with longer-term medical needs

The procedures needed to support children with more complex or long-standing health needs will be formally set out in an individual Health Care Plan (see Appendix 5.1) drawn up by the School Nurse in conjunction with parents, the young person, the school and other health professionals. The Health Care Plan is likely to involve a risk assessment and once drawn up will be monitored by the School Nurse.

The school is responsible for making sure that all relevant school staff know about children with longer-term health needs and that, wherever necessary, sufficient school staff receive training to provide the additional support and care that pupils need. During induction training all new staff should be made aware of any requirement for prescribed medication or medical procedure which affects pupils with whom they have contact; consideration also needs to be given to briefing any supply staff covering absences in school.

Children with health needs will not necessarily have a Statement of Special Educational Need, unless their condition impacts significantly upon their learning and their access to the curriculum. Schools have a responsibility under the Disability Discrimination Act to make 'reasonable adjustments' to ensure a child's access to school. Where there are concerns about access and the

facilities available in a child's local mainstream school, the Local Authority will use funding available through the Access Initiative Fund to facilitate adjustments to suit individual pupil needs.

The steps which a school takes to include pupils with medical needs should be included in the school's Disability Equality Scheme and Access Plan.

Education of children out of school (ECOS)

Where children cannot physically access school-based education the Local Authority makes alternative provision via the Education of Children Out of School Service. ECOS employs a variety of strategies to meet the needs of children out of school including home visits and supported distance learning through a virtual classroom.

To refer a pupil unable to attend school through ill-health or pregnancy, schools should download the appropriate referral form or information pack from: www.warwickshire-ecos.org.uk/referral.html

Any questions should be directed to ECOS on (01788) 578343.

Respective responsibilities of PCTs and schools

The National Service Framework for Children, Medicines Standard summarises the respective responsibilities of the Primary Care Trusts and schools as follows:

Primary Care Trusts should ensure that –

- appropriately trained, named nurses are available to all mainstream and special schools (see Standard 1)
- schools have access to appropriate advice, training and support from local health professionals so that they can make decisions on supporting pupils with their medicines
- a range of options are explored to enable children and young people to receive their medicines during the school day, including:
 - prescribers consider the use of medicines which need to be administered only once or twice a day (where appropriate) for children and young people so that they can be taken outside school hours
 - prescribers consider providing two prescriptions, where appropriate and practicable, for a pupil's medicine: one for home use and one for use at school, avoiding the need for repackaging or relabelling of medicines by parents
- appropriate risk assessments are available.

Schools should ensure that –

- they have sufficient members of support staff who are employed and appropriately trained to manage medicines as part of their duties
- any member of staff undertaking the management of medicines, either voluntarily or as part of their terms and conditions of service, is appropriately trained, acting within the scope of their employment, and is indemnified by their employer's insurance arrangements
- escorts on school transport are advised, and trained where appropriate, on what to do in an emergency
- school staff do not administer **non-prescription** medication. Parents should be discouraged from sending children to school with non-prescribed medication. This policy should be clearly communicated to parents. Where parents insist, they should take responsibility for administering the medication
- appropriate risk assessment has taken place
- arrangements for medicines are compliant with relevant legislation, for example the DDA, and do not discriminate against disabled pupils (or prospective pupils) in relation to education and associated services
- there are clear procedures for staff on managing medicines, including a robust system for record-keeping and an audit trail in accordance with 'Managing Medicines in Schools and Early Years Settings', DfES (2005)
- staff managing medicines follow the prescriber's instructions as noted on the label on the container of the dispensed medicine. It is not safe practice to follow relabelled / rewritten instructions or to receive and use repackaged medicines other than as originally dispensed.

Educational visits and off-site activities

The following guidelines should be followed in the case of the pupil leaving the school premises; for the purpose of this policy this is defined as anywhere beyond the boundary perimeter of the school grounds.

For educational visits and off-site activities, emergency procedures following an individual risk assessment, should be drawn up with the parents well in advance of the activity occurring. Ideally as a minimum, one trained member of staff and a chaperone should accompany the trip. Parents should give written consent of their approval of the arrangements for each activity or school trip. This includes regular arrangements such as walking / travelling to a swimming pool for example, although if the journey is to be repeated and the circumstances have not altered, approval need only be sought termly.

Standard procedures for running an educational visit such as checking the location, checking mobile phone network coverage and setting up emergency twenty-four hour telephone procedures, will have been established for all pupils, but for pupils with medical needs it is essential that schools follow the guidelines precisely.

Further advice and guidance is available in Section 5 of the Local Authority's "Off-Site Activities" pages 15-22 and pages 124-129:
www.warwickshire.gov.uk/offsiteactivities

Types of medicines in schools (examples)

Non-prescribed preparations

It is not recommended that children are sent to school with medicines, such as cough mixtures. School staff should not administer these medicines. Where parents insist, parents must take responsibility for administering these.

Prescribed medicines

National guidance encourages GPs and other prescribers to use medicines which need to be taken outside school hours.

Antibiotics

It is essential that a child completes the prescribed course even if they are well enough to return to school.

Inhalers

A child with asthma may have inhalers for regular use or when he/she becomes wheezy. See section on "Policy and Procedure for a Child with Asthma".

Enzyme Additives

Children with cystic fibrosis can be prescribed an enzyme supplement. This is to help digest their food.

Anti-Convulsant

A child on this type of maintenance drug for seizures may need to take this during school hours.

Glucose / Insulin

Diabetic children may need extra glucose or extra insulin during school hours dependent upon the level of sugar in their blood stream. Further guidance is given if the sudden onset of hypoglycaemia (low blood sugar) occurs.

Methylphenidate (e.g. ritalin, equasym)

This medication is a stimulant drug and is used for the treatment of Attention Deficit Hyperactivity Disorder. The drug must be given at set times to be effective, however, there are time release versions, which may mean that doses can be avoided during the school day. Parents should discuss options with their GP or prescribing consultant.

Policy and procedure for the care of a child in school with asthma

Introduction

Prevalence of asthma is increasing although the reasons for this increase are not completely understood.

It is a significant disease of childhood. A severe asthma attack can be fatal.

Asthma causes considerable distress to children as well as disruption to their school life. Recent studies have shown that a child's quality of life and life opportunities are impaired as a result of poorly controlled asthma. Therefore, everyone has a role to play in the care of an asthmatic child.

Causes

Asthma is a condition involving narrowing of the airways caused by inflammation and constriction of airway muscle. These changes may require treatment to reduce inflammation and relax airway muscles. There are many possible factors which may trigger asthma including:

- infections, e.g. the common cold
- allergies, e.g. house dust mites, cats/dogs, feathers, pollen
- irritants such as smoke, pollution, chemicals, cool air.
- exercise.

Symptoms

These include:

- a cough, especially at night, first thing in the morning and during exercise
- wheezing
- tightness
- shortness of breath.

Management of asthma

All school staff should be aware of those children in the school who have asthma and have a basic awareness of asthma and correct inhalation techniques. Some children with asthma may require a Health Care Plan. The School Nurse will advise as necessary.

Treatment

There is a range of treatments available, the most common being inhalers which are prescribed medications. There are two main types of inhalers:

- Bronchodilators, relievers (blue in colour): these provide relief and help the airways to relax and open up again. They work within ten minutes and can relieve wheeziness and coughing.
- Preventors (brown, orange, red, maroon): these reduce inflammation and protect against trigger factors. They work slowly and take up to fourteen days to become effective. To remain effective they must be taken twice daily as prescribed. They will help prevent an attack, but will not stop an attack that has started.
- Many children with asthma may have a combination product containing a preventor and a long-acting reliever. These are usually taken twice a day, morning and evening.

Please note some children may require a dose at lunchtime.

The relieving inhalers must be readily available at all times and not locked away like other medicines, i.e. on the child's person where the child is considered mature enough for self-medication.

If the child is not mature enough, the headteacher should ensure that appropriate arrangements are made so that the inhaler is **always available**.

Summary of the procedure for the care of an asthmatic child

Exercise induced asthma

These children must take their relieving inhaler 15 minutes before exercise, i.e. PE and lunchtime break (if running about outside). Many children need gentle reminders.

Seasonal asthma

Some children have seasonal asthma, e.g. in spring/summer related to hay fever, or in winter related to cold weather and damp atmospheres.

Acute asthma attacks

1. Use relieving inhalers at the normal dose
 - for children aged 3-10 years preferably use through a spacer, as this device improves effectiveness
 - children aged 10+ use dry powder inhaler or usual inhaler reliever.
2. Do not leave the child alone.

If relief is achieved child may return to class.

If not, repeat dose of relieving inhaler.

If after 1-2 minutes there is no relief then:

- stay calm – do not panic
- sit with the child in a quiet room.

Observe the child. If any of these symptoms are present:

- cannot speak in sentences
- exhausted with effort of breathing,
- loss of colour (pale or grey) or
- appears in distress

and the child does not improve after two doses then:

- dial 999 – Ambulance – specify Asthma Attack
- call the parent(s)
- repeat Blue Inhaler. Provided the child is over two years of age, you can give two puffs of the relieving inhaler every two minutes up to 10 puffs in total whilst waiting for medical help. You should record number of uses to inform the ambulance.

Policy

No child should be refused admission to mainstream schools because of having asthma or their need for medication. To do so could potentially lead to a claim of disability discrimination.

School staff should, however, be aware of the basic care needed for asthma. Training will be provided by the PCT.

Staff who do not have a medical qualification are expected to respond to a level of skill of a caring parent and are not expected to be medically competent.

Staff to be trained

All school staff should receive basic awareness training in the recognition of asthma attacks and inhaler techniques. The need for widespread training reflects the prevalence of the condition. School Nurses will advise on the training required.

Selected staff should receive further training in the management of asthma, this may include PE staff, Year Heads and nominated Teaching Assistants working with named children. This training will cover the condition itself, including causes and symptoms; types of inhalers and inhaler techniques; the management of an asthma attack; and record keeping and documentation.

Communication and record keeping

See general principles in earlier section on managing medicines in school.

In the event of a child being admitted to hospital from school, any medical records held by school will aid the admitting doctor in his/her treatment plan.

Where children appear to be having increasing attacks, parents should be informed as this will indicate to the prescribing doctor the effectiveness of prescribed medication, and allow changes to be made as required.

School Nurses will advise which children with asthma will require a Healthcare Plan.

All children with asthma medication should be identified and have their medication regime completed in writing, using the forms in Appendix 5.3.

All class and subject teacher(s) must be made aware where one of their pupils has asthma, and the location of the relieving (Blue) inhaler. Procedures must be in place to inform supply staff as necessary.

The relieving inhaler must be readily available at all times and not locked away.

Children considered mature enough to self-administer without supervision should carry inhalers with them.

Policy and procedure for the care of a child in school with epilepsy

Introduction

Epilepsy is an established tendency to recurrent epileptic seizures.

A seizure (commonly called a fit) is due to the occasional sudden abnormal electrical discharge from brain cells.

There are many different types of seizure depending on which brain cells are behaving abnormally and whether the condition is happening all over the body or focally in one area.

- Discharges from motor cells will produce abnormal movements over the whole body (generalised) or over a small part of the body (local).
- Discharge from sensory cells may produce abnormal unpleasant smells, tastes or visual sensations.
- Some seizures render the person unconscious for a variable length of time or may cause them to lose their posture.
- Other seizures produce an unaware state for a few seconds to a few minutes without a change in body position (absence seizures).
- Rarely seizures may follow one upon the other rapidly or continue without cessation. This condition is called status epilepticus and it requires urgent medical supervision.
- A seizure may also be a febrile convulsion due to raised body temperature associated with illness.

Between five and eight children per thousand have epilepsy.

The majority of these will have their condition controlled with medication and will never have a seizure in school. Usually medication is taken twice a day and will not be needed during school hours. The majority will attend mainstream schools and will make normal academic progress.

For a very few children, seizures will still occur at intervals in school.

Some children who have evidence of present or past brain damage, e.g. some children with learning difficulties or some children with cerebral palsy, may have more severe epilepsy which requires medication in school time. For a small minority of this group, with very severe epilepsy, rectal diazepam (stesolid) or buccal (via the cheek) midazolam may be prescribed for use in school – see section on Treatment of Severe Epilepsy.

Dangers of epilepsy

Most of the dangers of epilepsy are due to the loss of voluntary control of the body during a seizure and are not due to the effects of the seizure itself; the exceptions are prolonged seizures of more than 10 minutes and closely recurrent seizures which may cause brain damage).

Children are particularly at risk in a generalised seizure with unconsciousness and much abnormal movement.

Dangers are from falls, drowning, fire, machinery, traffic.

Precautions for children with known epilepsy

All children with epilepsy are entitled to as broad balanced, interesting and exciting a curriculum as their peers without the condition. These children should have full access to all aspects of the curriculum, extra curricular activities, educational visits, etc. Thorough risk assessment of these activities is the key to maximising inclusion and minimising risks to safety. A Healthcare Plan, underpinned by thorough risk assessment, will be drawn up by the School Nurse in consultation with parents, the pupil and school staff.

Photosensitive epilepsy is unlikely to be caused by normal computer use.

Any extra supervision that is necessary should be considered, assessed and funded as any other additional educational need.

School Health Teams will be pleased to discuss individual children's needs with parents and teaching staff.

Swimming

Swimming is a National Curriculum entitlement for all children.

Planning for swimming activities should be undertaken following the advice and guidance in "Swimming Guidelines":

[www.warwickshire.gov.uk/Web/corporate/pages.nsf/Links/E826394510CF2977802570C000332D94/\\$file/LA+Swimming+Guidelines.pdf](http://www.warwickshire.gov.uk/Web/corporate/pages.nsf/Links/E826394510CF2977802570C000332D94/$file/LA+Swimming+Guidelines.pdf)

The needs of a pupil with epilepsy should be carefully assessed prior to any swimming activities, then staffed and resourced accordingly. Requirements will vary according to individual need, therefore, it is vital that a specific individual risk assessment is undertaken. This may result in the need for one-to-one supervision, use of the 'buddy' system, etc.

Further advice on swimming is available from Epilepsy Action, including how to deal with seizures in water:

www.epilepsy.org.uk/info/sportsandleisure/swimming.html

What to do if a child has a generalised epileptic seizure

Throughout the child's right to dignity and privacy should be paramount.

- Place the child on the floor
- remove nearby furniture and obstructions to minimise the risk of injury
- summon adult assistance
- loosen tight clothing
- check that the child is breathing
- **do not try to put anything in mouth to prevent tongue biting**
 - tongues heal quickly if bitten
 - broken teeth may be irreparably damaged
- when convulsive movements have stopped, place the child in the recovery position (see Appendix 5.9)
- when consciousness is regained, take the child to a safe, supervised place to recover
- reassure the child and explain what has happened.

While the above is being followed, a second responsible adult could assist by:

- reassuring other children and, if appropriate, guiding other children away from the child having the seizure
- if no-one knows that the child has epilepsy dial 999, requesting an ambulance and stating that the child seems to have had a seizure
- contacting the parents.

What to do if the child has a partial seizure

If a child has a partial seizure:

- talk calmly and reassure the child
- if possible, guide the child away from any dangers.

Initial recognition of seizures

If a child has a generalised convulsive seizure, teachers may readily recognise the condition and seek medical attention. However, many local, partial or absence seizures may be quite difficult to identify.

A child presenting in class with repeated uncontrollable and apparently unprovoked episodes of:

- abnormal movement
- changes to attention span
- changes to posture
- loss of consciousness

should be discussed with the parents and referral to a health professional recommended. There may be other causes of such episodes but they need medical investigation. Most types of epilepsy are diagnosed following accurate

history and observation by lay and professional observers with medical tests then providing additional information.

Children with epilepsy who develop learning difficulties need further educational and medical assessment to ensure their educational potential is maximised through targeted support and intervention and to ensure that their medication is optimal for controlling seizures without interfering with normal brain function.

Each child with epilepsy has a different pattern and frequency of seizures. Teachers should seek discussion between the parents, the child, specialist teachers and the health professionals involved (School Health Team, General Practitioner, Paediatrician) about the sort of support that the child may need in order to safely access the curriculum. It may also be necessary to seek specific advice from the Local Authority's Health and Safety Officer.

Epilepsy includes repeated sudden uncontrollable loss of autonomy for each child and can easily damage self-esteem and make the child more vulnerable to bullying.

Epilepsy Action produces DVDs, educational packs, posters and literature which are invaluable for children, families, peers and teachers. Their website has specific pages for children, as well as teenagers. There is also advice on helping children and young people who are being bullied. The website has useful tips for teachers, including a downloadable factsheet on exams.

Epilepsy Action runs a telephone helpline on 08 08 800 5050 or you can email helpline@epilepsy.org.uk

Policy and procedure for the administration of rectal diazepam or buccal midazolam to a child in school

Introduction

Children rarely will have prolonged fits, but some do and will require rectal diazepam or buccal midazolam ('buccal' means in the cheek of the mouth).

School staff will be trained in the administration of either drug. When the child is admitted to the school under normal admission arrangements, procedures will also be drawn up to ensure all staff know how to deal with the seizure whilst waiting for an ambulance following a 999 call, in case for any reason trained staff are not available at the time of the seizure.

Staff will also assist in such procedures as clearing other children from the area or placing the child in the recovery position until the Emergency Service can attend.

In consultation with the parents/carers, a protocol of treatment / healthcare plan will be written and agreed. The protocol for the management of seizures will be completed by prescribing doctor ,e.g. consultant paediatrician.

The following factors are important considerations:

1. The age and sex of the child

At all times consideration should be given to preserving the dignity of the pupil in the classroom and school environment. This may mean removing other children from the classroom whilst a seizure takes place. Consideration may need to be given for appropriate screening facilities within the school especially during the administration of Rectal diazepam.

Ideally, the members of staff administering Rectal diazepam should be the same sex as the pupil and on all occasions there should be **two members of staff present**, one of whom at least should be trained in its administration. This will protect the interest of staff when they are placed in the position of performing such an intimate function. The second member of staff may be, but need not be, the same sex as the pupil unless it is judged that the age of puberty has been reached and this would no longer be appropriate.

The headteacher will be responsible for deciding on the appropriateness of the arrangements for individual pupils subject to consultation with parents and other professionals.

2. The size of the pupil

Protocols should be kept under review and, as pupils grow, it may be inappropriate to continue the management of seizures as per the child's original protocol. When upon review by the prescribing doctor, a change to the protocol is made, parents and teachers should be part of the review process. If the school feels a review of the protocol is necessary the headteacher should inform the school nurse. The headteacher should also write to the parents to inform them that the School Nurse has been contacted.

Liability

In the event of a claim for alleged negligence it is the Employer (the Local Authority or Governing Body), not the employee, who is held responsible and, providing that the member of staff has followed their Employer's policy and has acted within the scope of their training, the Council's insurance will defend any such action and meet any costs if the claim is successful. Schools which subscribe to the Local Authority's insurance cover are automatically protected against these risks. Those schools that do not subscribe to the WCC arrangements will need to ensure they are adequately covered.

Training of staff

Sufficient members of staff per school should be trained in the administration of rectal diazepam / buccal midazolam to ensure coverage in the event of staff absence.

Staff will be trained in the administration of rectal diazepam / buccal midazolam by trainers nominated by the PCT. This training is child specific and is updated annually.

The training will consist of:

- the condition itself including types and presenting features
- the treatment of epilepsy
- the management of specific children during seizures
- the administration of rectal diazepam
- record keeping and other responsibilities.

Schools need to keep details of who has been trained and when; this will need to be updated periodically.

Newly appointed staff and those on supply should be made aware of the needs of children with epilepsy during their induction and should know which members of staff are trained in the administration of rectal diazepam / buccal midazolam.

Record keeping

See general principles in earlier section on managing medicines in school.

As well as written consent from parents/carers to administer rectal diazepam / buccal midazolam, there should be a written protocol / healthcare plan for the administration of the drugs during school hours (see Appendix 5.7). This specifies how much rectal diazepam / buccal midazolam should be administered during a seizure, how often and what to do if the seizure continues. It also specifies who are the named staff who may administer the drug.

Schools should keep a written record of all seizures occurring in schools, including the date, time, duration of seizure, any treatment administered and whether emergency services called (see Appendix 5.8).

Parents should be requested to keep the school informed of any seizures which have occurred outside school hours so that in the event of transfer to hospital during school time, this information can be communicated to hospital staff.

On transfer to another school or setting it is essential that details of the child's protocol, medication, seizure logs and other relevant information are transferred to the receiving school/ setting with the parent's written permission.

Educational visits and off-site activities (see earlier section on page 81)

Protocols for each named child should be reviewed at least annually. This may take place at the time of the statutory review of the child's statement of special educational needs or IEP.

The headteacher may wish to specify more frequent reviews of each child's protocol in the light of any changes of the aforementioned factors.

Where for any reason rectal diazepam / buccal midazolam cannot be administered and the Emergency Services should be called immediately and parents/carers and the prescribing doctor informed.

The recovery position (see also Appendix 5.9)

Where rectal diazepam or buccal midazolam has been administered, if possible, pupils should be placed in the recovery position to ensure a clear air-way and prevent self-damage. Awareness raising and in-service training will have been offered in school to all staff on basic positioning for the child. For those pupils with a manual handling plan, what to do in an emergency will be covered in this plan.

No member of staff will be expected to undertake basic first aid procedures for which they have not been trained, but when they do place the child in the recovery position this will be interpreted as acting in the child's best interests, and not as someone who is medically competent.

Members of staff who have received further training will take every subsequent action.

Pupils must not be carried from the place of seizure, however, where the place is considered unsafe, e.g. near furniture where injury may occur, the area should be rendered safe.

All staff should be aware of the procedures for ensuring the well-being of the other children in the class group or surrounding areas.

Administration of rectal diazepam or buccal midazolam

For many of the seizures the length of time of the seizure will mean that it will not be necessary to administer rectal diazepam or buccal midazolam. The length of time before administration is necessary will be recorded in the child's protocol / healthcare plan.

If the duration of the seizure does not require the administration of the drug, the seizure details should still be recorded on the child's record of seizures and the parents informed as soon as possible.

Each child protocol / healthcare plan will be different. It may be, for example, that the administration does not take place until the second seizure, or there may be detailed instruction with regard to the administration of more than one dose per seizure. It is important that the individual protocol for the child is very clear on such matters.

Each member of staff receiving training in the administration of rectal diazepam or buccal midazolam, will be signed off as competent in the administration of the relevant drug.

Staff awareness of emergency procedures

The headteacher should ensure that all members of staff, including non-teaching and temporary staff, should be aware of the emergency procedures, and in particular, noting the time of the onset of the seizure.

If there is any doubt of the length of time since the beginning of the seizure, then a 999 call should be activated immediately.

Storage of medicines

See earlier (page 77).

Policy and procedure for the administration of methylpheniate (ritalin, equasym) to a child in school

Introduction

The aim of this document is to provide guidance for schools that are being asked to support the administration of methylphenidate (ritalin, equasym). Such drugs are prescribed as part of the treatment of Attention Deficiency Disorder (ADHD).

This medication is a stimulant drug, paradoxically allowing the young person to focus and concentrate on his/her own behaviour and surrounding environment. If doses are missed at school, this opportunity is lost. Consequently, the young person's attention and concentration will diminish and behaviour may become less well controlled and more impulsive in the classroom.

The Chief Pharmacist has confirmed that this is a 'controlled' drug, but once it is dispensed to a patient it is exempt from the legislation that 'controls' it. Schools therefore are not required to make exceptional arrangements for the administration of methylpheniate, but need to follow their agreed policies for the giving of medication in schools.

An individual protocol / health care plan is essential and will help schools to identify the necessary safety measures to support pupils with medical needs, and ensure that they and others are not put at risk (see Appendix 5.1).

Some schools may need to review their policies and storage arrangements in line with the recommendations below.

Principles

This protocol applies during term time only and for off-site educational visits.

Training for staff

Unless specifically included in a job description or contract of employment, the requirement to administer medication cannot be imposed on an existing member of staff. However, it is possible to ask for volunteers from existing staff to provide this, following appropriate training and guidance. Please see earlier section on Staffing Issues on page 78.

All employees administering Methylphenidate will be trained by the PCT. Training will include an understanding of possible side effects, the development of suitable action plans and procedures to be followed. (**Note:** There are no particularly worrying concerns regarding this medication.) Schools need to keep details of who has been trained and when; this will need to be updated periodically.

Management of medication

Written permission must be obtained from the parent /carer regarding the administration of medication (see Appendix 5.2).

The parent/carer is responsible for ensuring that medication is provided for the pupil whilst he/she is at school. The medication should be in the form of a daily supply if possible, but certainly no more than five days supply.

The methylphenidate must be sent and kept in the dispensing container. This may mean a parent/guardian asking their pharmacist for two containers, one for home and one for school. Containers must be clearly labelled with the pharmacist's instructions. The drugs must be handed to a responsible member of school staff on arrival, and then transferred to a suitable secure storage area. See earlier section on the Storage of Medication (page 77).

The school cannot accept any responsibility if the pupil does not take the medication for any reason. Under these circumstances the school must inform the parent/carer.

The prescribing doctor must confirm any changes of dosage in writing to the school.

All unused or out-of-date methylphenidate must be returned to the parent/carer or disposed of via the local pharmacist.

Home to school transport

If transport or an escort is provided for the pupil, the parent/carer should hand the medication to the driver/escort for safe keeping on the journey. The driver/escort should then hand it to a responsible member of school staff on arrival. It should then be transferred immediately to suitable secure storage.

General information

If a pupil is on an educational visit, no special authorisation is needed for methylphenidate. The drug should be stored in a locked container where possible.

If an employee recovers a controlled drug from a pupil they are in lawful possession until handing it over to the police for lawful destruction. This should be undertaken as soon as possible.

Temporary exclusion of an individual may only be considered on health and safety grounds following appropriate risk assessment, and in exceptional circumstances to safeguard the individual and others. In all these cases advice must be sought from the Local Authority as there may be implications under the Disability Discrimination Act.

Monitoring and reviewing

Protocols must be reviewed annually. Where there are changes to a pupil's medical requirements, a review of the protocol should occur concurrently.

Policy and procedure for care of a child in school with severe allergies

Anaphylaxis is an acute, severe allergic reaction needing immediate medical attention. It occurs when substances, e.g. histamines, are released by the body as a response to hypersensitivity to external substances (allergens). In its most severe form, the condition is life threatening.

Common allergens

- Insect stings
- Foodstuffs, e.g. peanuts, eggs, shellfish, cow's milk
- Medicines, drugs, e.g. penicillin
- Blood products
- Vaccines (although rarer).

Symptoms

These may include:

- flushing (redness of skin)
- itching (can include a blotchy rash)
- difficulty in breathing caused by swelling which results in blocking of main airways
- swelling, e.g. on face, eyes, tongue, throat
- fainting/collapse, caused by a drop in blood pressure
- abdominal discomfort.

Symptoms usually occur within minutes of exposure to the allergen; not all the above symptoms need to be present at the same time.

Treatment

Locate epipen / anapen and give to child. Ask another responsible person to dial 999 stating 'anaphylaxis'.

Policy and procedure for administration of adrenaline

Before the child's admission to the school and in consultation with the parents/guardian, a Health Care Plan / Protocol will be written by a member of the School Health Team following a comprehensive risk assessment. This form specifies how much adrenaline is to be given if anaphylaxis occurs. It also

specifies the named personnel who have been trained and who may administer the drug. The Plan / Protocol will identify any further staff training needs and how these will be met.

In the case of any adverse event, a member of staff will have been deemed to have acted in good faith if the written procedures and individual child protocols have been followed. Staff who do not have a medical qualification are expected to respond to a level of skill of a caring parent and are not expected to be medically competent.

Numbers of staff to be trained

Ideally all staff in school where there is an affected child should be trained in the administration of adrenaline and should receive instruction recognising symptoms. The needs of the child should be part of the induction of the new members of staff groups and supply teachers.

Training

Staff will be trained by the Primary Care Trust and will be updated annually. Training will consist of: a description of the condition, including the causes and presenting features; how to administer adrenaline; the management of specific children; record keeping and documentation.

Communication

Each child's file should contain:

- Health Care Plan / Protocol for the management and treatment of anaphylaxis (see Appendix 5.1).
- A record sheet of events (Appendix 5.8). This form should be completed as soon as possible after the child has been treated for anaphylaxis. In the event of hospitalisation it aids the admitting and prescribing doctor to provide safe and ongoing treatment.

It is essential that all staff, teaching and non-teaching, know who the child is and what the problem could be. With parents' permission, it is helpful to have a photograph of the child attached to a note on noticeboards in the staffroom and kitchen.

Transfer of records

When pupils transfer to another school or educational setting it is essential that details of the health care plan, medication, etc., are transferred to the receiving school or service with the parent's written permission.

Educational visits and off-site activities

See Section 5, page 81.

Administration of adrenaline

The administration of adrenaline is a critical part of the treatment of anaphylaxis. Both epipen and anapen automatically administer the appropriate dose of adrenaline. Many children are able to self-administer the injection. The epipen or anapen must be given into the outer thigh muscle; there is no need to remove outer clothing.

Emergency 999 calls

All children who are having an anaphylactic reaction should be sent to hospital for observation. The child may well have recovered in response to the epipen / anapen, however, may deteriorate again, so every child must be hospitalised. Staff should call the emergency 999 service and specify 'anaphylaxis' and that adrenaline is being administered.

If parents are not immediately available, one of the trained members of staff should accompany the child in the ambulance and take with them the child's records including the child's name, address and home contact telephone number. Also the time of the attack, the time and type of medication given should also be recorded and taken to hospital.

Anaphylactic shock – checklist

- If you think a child is in anaphylactic shock, act immediately, even if not all the typical symptoms are present.
- If child is getting worse, give epipen or anapen.
- Dial 999.
- Lie the child down, preferably in a quiet room.
- Retain epipen / anapen, as trained, to hand over to the ambulance.
- The school office should contact the child's emergency telephone number and ask the parent to come to school.
- Stay with the child to reassure them.
- Even if the child appears to have recovered fully, he/she must still go to hospital in an ambulance for a check. If a parent has not been able to get to school, a teacher must go with the child and remain there until the parent can attend.
- Complete and return the Anaphylaxis – Record of Events (see Appendix 5.8) and retain in appropriate school records. Ask the parent to arrange for a replacement epipen.

Storage of adrenaline

- A child with a known anaphylactic reaction will have their own epipen or anapen.
- Adrenaline must be kept as close to the child as possible, and where the child is considered old enough it can be kept by the child.
- Parents should also supply the school with additional adrenaline for use in the event of loss or breakage of the child-held supply. Adrenaline has a short shelf life, commonly not longer than a year. Parents are responsible for renewing both the child-held and school-held supply, and checking the expiry dates.

Policy and procedure for the care of a child in school with diabetes

Introduction

One in 400 children of school age has diabetes. It is therefore likely that you will teach or supervise a child with the condition at some time.

What is diabetes?

Diabetes is a condition in which the amount of glucose in the blood is too high because the body is unable to use it properly. This is because the body's method of converting glucose into energy is not working as it should.

Normally the amount of glucose in the blood is carefully controlled by the hormone insulin which is made by the gland called the pancreas. Insulin helps the glucose to enter the cells where it is used as fuel by the body.

We obtain glucose from the food that we eat, either from sweet foods or from the digestion of starchy foods such as bread, potatoes, cereals or pasta. Glucose is also made by the liver.

After a meal including these starchy foods the blood glucose level rises and insulin is released into the blood. When the blood glucose level falls, the level of insulin falls. Insulin therefore plays a vital role in regulating the level of blood glucose and in particular stopping the blood glucose from rising too high.

Children with diabetes have lost the ability to produce insulin because the cells in the pancreas that produce it have been destroyed. Without insulin the child's body cannot use glucose and therefore the blood glucose levels will rise.

Symptoms

- Passing lots of urine
- Increased thirst
- Tiredness
- Weight loss.

Management of diabetes

Diabetes cannot be cured but it can be treated effectively. Children with diabetes will have treatment consisting of insulin injections and appropriate diet and exercise.

The aim of this treatment is to keep the blood glucose level close to the normal range so that the blood glucose is neither too high (hyperglycaemia) or too low (hypoglycaemia).

Insulin injections

All children with diabetes will need injections of insulin. In most cases children will be on two injections of insulin. The injections will be taken at home before breakfast and again before the evening meal.

Some children will be taking more than two injections of insulin per day in which case one of the injections may be taken at lunchtime. If a child needs to inject whilst at school, he/she will need a suitable place to:

- perform injections
- keep insulin if required.

Most children, even at primary school, can physically manage 'the injection' but will need an adult to check that they have 'dialled up' the correct dose on the injection device, be that an 'insulin pen' or a 'pump'.

They will also need to test their own blood sugars. Again most children can manage this, but an adult should check the result and help select the appropriate correction (dose of insulin usually, but if levels are running low (see section on Hypoglycaemia below) the correct action).

Children with diabetes need to balance their insulin with the food they eat and the level of physical activity.

Hyperglycaemia

If blood glucose level is high (hyper), the child may need to pass urine frequently. It is important that water is available to drink and requests to visit the toilet are allowed. If this happens the parents should be informed at the end of the day so that appropriate adjustments to treatment can be made.

Diet

Diet is an essential part of the treatment of diabetes. The diet recommended for people with diabetes is based on a healthy and varied diet recommended for the whole population. Meals should be based on starchy foods. Food choices should be generally low in sugar and fat and high in fibre. Children with diabetes do not need different meals and may choose main course items and fruit from the main menu. It is useful for the child to have an early pass if more than one sitting occurs. This ensures there is full availability of choices.

Snacks

Most children will also need snacks between meals which may occasionally need to be eaten during class time. It is important to allow the child to eat

snacks without hindrance or fuss, and it may be worthwhile to explain to the class why this needs to be done to prevent problems occurring with other children.

It is essential that the child with diabetes eats food at regular times during the day to help maintain a reasonable blood glucose level. He/she therefore may need to be near the front of the queue (and the same sitting each day) for the mid-day meal. If meals or snacks are delayed too long the blood glucose level will fall.

General advice

Physical activity

Diabetes should not stop children with the condition from enjoying any kind of physical activity, or being selected to represent school and other teams, providing they have made some simple preparations – look at five-time Olympic gold medallist, Steve Redgrave.

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

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

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

During an activity, there should be glucose tablets or a sugary drink nearby (e.g. on the side of the pool or at the side of the pitch) in case the child's blood glucose level drops too low, which could lead to a hypo.

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

Children with diabetes should not use their condition as an excuse for not participating in any physical activity. If this does happen regularly, speak to their parents/carers to find out more about the individual situation. Diabetes should not be an excuse for opting out of school activities.

Other considerations

Sickness

If the child is unwell, his/her blood glucose levels may rise. This can happen even if the child just has a cold. High blood glucose levels may cause the child to be thirsty and need to go to the toilet more frequently. If teaching staff notice this during the day, they should report it to the child's parents/carers so the necessary adjustments can be made to the insulin dose.

If the child vomits at school, start him/her sipping on a sugary drink, e.g. Lucozade, and call his/her parents/carers. Should the child continue to vomit, take him/her to the nearest accident and emergency department.

Blood glucose testing

Most children with diabetes will need to test their blood glucose levels on a regular basis. They may need to do this at school, especially before or after physical activity, or if they feel that their blood glucose level is falling too low or climbing too high.

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

If these tests are needed in school, the child's parents/carers can advise on how often and where they should be done.

Educational visits and off-site activities (see earlier section on page 81)

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

Children with diabetes should take their insulin and injection kit, in case of any delays over their usual injection time. They will have to eat some starchy food following the injection, so should also have some extra starchy food with them. They should also take with them their usual hypo treatment.

Overnight stays

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

If the children are not doing their own injections, most parents/carers would not consider letting them go away at this stage.

If any medical equipment has been lost or forgotten, contact the paediatric department or accident and emergency department at the nearest hospital who will be able to help.

Remember when going on any kind of trip, take a copy of the diabetes record card for each child.

Hypoglycaemia

Hypoglycaemia (Hypo) means low blood glucose. The possibility of a child having a hypoglycaemic episode is a worry to many people supervising children with diabetes. People have visions of children fainting or becoming unconscious. This is rarely the case, and most hypos can be identified and treated without calling for professional medical help.

It is important to know what causes hypoglycaemia, how to recognise it and what action to take.

Common causes of hypoglycaemia are:

- a missed or delayed meal or snack
- too much insulin
- unplanned exercise.

It has been noted that hypoglycaemia may occur more frequently when the weather is very hot or very cold.

Symptoms may include:

- hunger
- glazed eyes
- sweating
- shaking
- drowsiness
- lack of concentration.

Each child's signs and symptoms will differ and the parents will be able to tell you how hypoglycaemia affects their child. If the child displays any of these signs and you are unsure, always treat as hypoglycaemia, you will not cause the child further problems.

How to treat hypoglycaemia

Fast acting sugar should be given immediately. This will raise the blood sugar level. It is important that children who are hypo stay where they are and are supervised taking their fast acting sugars. If they do not have these with them, they should be brought to the child.

Examples of fast acting sugars are:

First choice

- glucose tablets x 3
- Lucozade 50mls.

Other choices

- fresh fruit juice 100 mls
- honey, jam
- 'Glucogel' (a glucose gel which is available from the medical team).

You can help by having fast acting sugar in your desk and, when out of the classroom, some readily available at all times, e.g. PE and lunchtime supervision.

If the child is unco-operative or unable to swallow, squeeze 'Glucogel' (or if you are absolutely stuck, some honey) into the cheek where it can be absorbed. When the child is co-operative, give fast acting sugar until recovered.

In the unlikely event of the child losing consciousness, do not give anything to swallow. Place him/her in the recovery position and call an ambulance.

Except with 'massive' overdoses of insulin, even where a child does lose consciousness from a hypo, he/she will come round eventually and should not come to any immediate harm.

Recovery from hypoglycaemia

When the child recovers, he/she will need to eat some slower acting starch (such as biscuits, milk or fruit) in order to maintain the blood glucose level until the next meal or snacks. Recovery from hypos should take about 10-15 minutes. The child may feel nauseous, tired or have a headache. If the child is having hypos at school you should inform the family.

The above is courtesy of Diabetes UK's Booklet – Children with Diabetes

Policy

No child should be refused admission to, or excluded from, schools because of having diabetes. However, staff at schools where children have diabetes should be aware of the basic care needed for diabetes. Training will be provided by health professionals.

School staff can assist in such procedures as clearing other children away from the affected child and/or seeking paramedic attendance via the emergency services (999 Ambulance).

Staff who do not have a medical qualification are expected to respond to a level of skill of a caring parent and are not expected to be medically competent.

Staff to be trained

All school staff should receive a basic awareness training in diabetes and the recognition of hypoglycaemia and treatment.

Basic training will consist of:

- the condition itself including causes and symptoms
- treatment of hypoglycaemia.

Selected voluntary staff should receive further training in the management of diabetes. These staff could include Year Heads and PE staff.

This training will include:

- the condition itself including causes and symptoms
- treatment of hypoglycaemia and hyperglycaemia
- the management of a hypoglycaemic attack
- record keeping and documentation.

Details of training will be kept by the trainers and updated periodically.

Communication

Each child who is diagnosed as having diabetes should be known to the school. Keep medical information:

- in a register
- in the staff room.

Record keeping

In the event of a child being admitted to hospital from school, a record of treatment already given should be sent with the child to hospital.

Procedures

In the event of hypoglycaemia where the child is subsequently admitted to hospital, it is recommended that the time of onset and treatment given is logged. This assists the admitting doctor's subsequent treatments. Where children appear to be having increasing hypoglycaemic episodes, parents should be informed to allow changes in insulin regimes.

All children having diabetes should be identified to all members of staff and children should be encouraged to wear/carry some form of identification. The class teacher must be aware that the child has diabetes and the location of fast acting sugars.

Fast acting sugars must be readily available at all times.

Children considered mature enough to self-administer without supervision should carry fast acting sugar about their person. However they should be encouraged to inform the teacher or adult available that they are needing treatment.

Children participating in sporting activities should have a snack prior to that exercise. This is an essential treatment and must not be withheld.

Many children may need gentle reminders.

Summary of the procedure for the care of an hypoglycaemic child

1. Give fast acting sugar from the child's emergency pack.
2. Do not leave the child alone.
3. When recovery is achieved, give slow acting starchy foods such as fruit, biscuits or milk.
4. Child may return to class.

If not achieved:

1. If there is no improvement with a fast acting sugar such as 3 x glucose tablets or Lucozade within 2 to 3 minutes:
repeat the fast acting sugar
sit the child in a quiet room
stay with the child.
2. When recovery is achieved, give the child slow acting starchy foods such as fruit, biscuits or milk. The child may then return to class.
3. If improvement is not achieved after 2 fast acting sugars, repeat the fast acting sugar every 3 to 4 minutes or use 'Glucogel' but seek emergency medical assistance (999).

If the child is unco-operative or unable to swallow:

1. Administer 'Glucogel' as per instructions.
2. When co-operative, give fast acting sugar until recovered.
3. Give slow acting starchy foods such as biscuits, fruit or milk.
4. Seek medical advice (999) and inform parents.

If the child is unconscious:

1. Do not try to get the child to swallow.
2. Place in the recovery position.
3. Dial 999. Specify the need for an ambulance, stating reason as severe hypoglycaemia.
4. Log time of onset and any treatment given.
5. Ensure parents are contacted.
6. Accompany the child to hospital taking the log with you (in the absence of the parent).

At no time should the child be sent home from school or to hospital unaccompanied.

Healthcare plan for a pupil with medical needs

Name	PHOTO
Date of Birth	
Condition	
Class/Form	
	Date
	Review Date
Name of School	

CONTACT INFORMATION

Family Contact 1	Family Contact 2
Name	Name
Phone No (work)	Phone No (work)
Phone No (home)	Phone No (home)
Relationship	Relationship

Clinic/Hospital Contact	G.P.
Name	Name
Phone No	Phone No

Describe condition and give details of pupil's individual symptoms:

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

Which staff trained in Healthcare Procedures:

Describe what constitutes an emergency for the pupil and the action to take if this occurs:

Follow up care:

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

Form copied to (must include parents):

Appendix 5.2

Agreement for school/setting to administer medicine

Name of school/setting	
Name of child	
Date of birth (dd/mm/yyyy)	
Group/class/form	
Medical condition or illness	
Medicine	
Name/type of medicine (as described on the container)	
Date dispensed	
Expiry date	
Agreed review date to be initiated by [name of member of staff]	
Dosage and method	
Timing	
Special precautions	
Are there any side effects that the school needs to know about?	
Self administration	Yes/No (delete as appropriate)
Procedures to take in an emergency	
Contact Details	
Name	
Daytime telephone no.	
Relationship to child	
Address	

- I understand that I must deliver the medicine personally to [agreed member of staff] and that Medicines should be in the same container as dispensed by the pharmacy.
- The above information is to the best of my knowledge accurate at the time of writing and I understand that I must notify the school/setting of any changes in writing.

Date	Parent's Signature(s)
_____	_____

I consent to staff administering the above to me.

Child's signature (wherever possible) _____

Record of medicines administered

Name of Child

Normal Medicine

Strength/Dose

Special Instructions

Date	Time	Name of medicine or N (Normal/as above)	Dose given or S (Standard/as above)	Any reactions	Signature of staff	Print Name

For controlled drugs only (e.g. ritalin, morphine)

Record of medicine administered to an individual child

Name of school/setting	
Name of child	
Date medicine provided by parent	
Group/class/form	
Quantity received (NB Always check, do not assume quantity will tally with quantity on container)	
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			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Request for child to carry his/her own medicine

This form must be completed by parents/guardian

If staff have any concerns, discuss this request with healthcare professionals

Name of school/setting

Child's name

Group/class/form

Address

Name of medicine

Procedures to be taken in an emergency

Contact Information

Name

Daytime phone no.

Relationship to child

I would like my son/daughter to keep his/her medicine on him/her for use as necessary.

Signed _____

Date _____

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

**Staff training record – administration of medicines
+ healthcare procedures**

Name of school/setting	<input type="text"/>
Name	<input type="text"/>
Type of training received	<input type="text"/>
Date training was completed	<input type="text"/>
Training provided by	<input type="text"/>
Profession and title	<input type="text"/>

I confirm that [name of member of staff] _____ has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [please state how often] _____

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

**Authorisation for the administration of rectal diazepam
or buccal midazolam**

Name of school/setting	<input type="text"/>
Child's name	<input type="text"/>
Date of birth	<input type="text"/>
Home address	<input type="text"/>
G.P.	<input type="text"/>
Hospital consultant	<input type="text"/>

_____ should be given rectal diazepam or buccal midazolam _____ mg. (delete as appropriate) If he/she has a *prolonged epileptic seizure lasting over _____ minutes

OR

*serial seizures lasting over _____ minutes

Am Ambulance should be called to *at the beginning of the seizure

OR

If the seizure has not resolved *after _____ minutes.

(*please delete as appropriate)

Doctor's signature _____

Parent's signature _____

Date _____

Record of seizures occurring in school

Name: _____

Address: _____

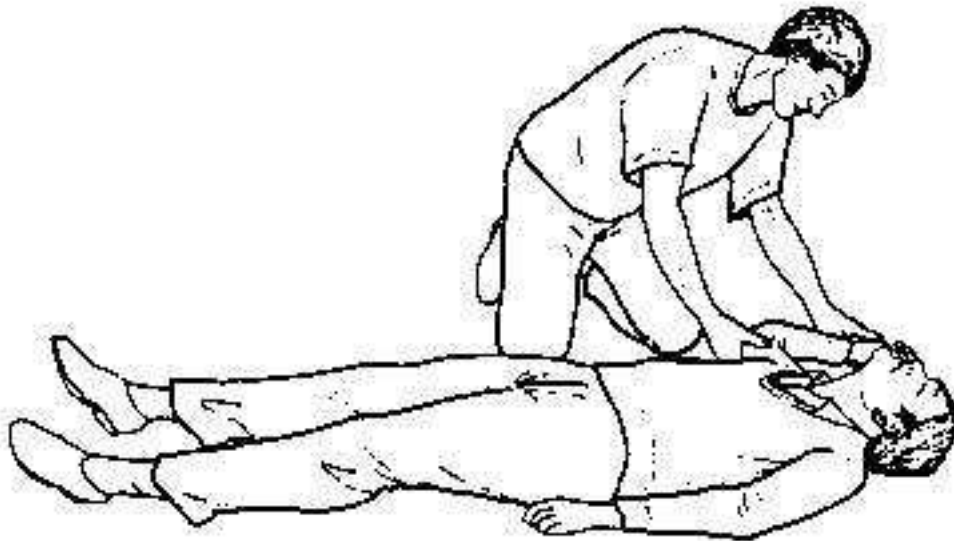
Date of birth: _____

Date	Time	Seizure observed by	Rectal Diazepam required?	Administered by	In presence of	Parents informed

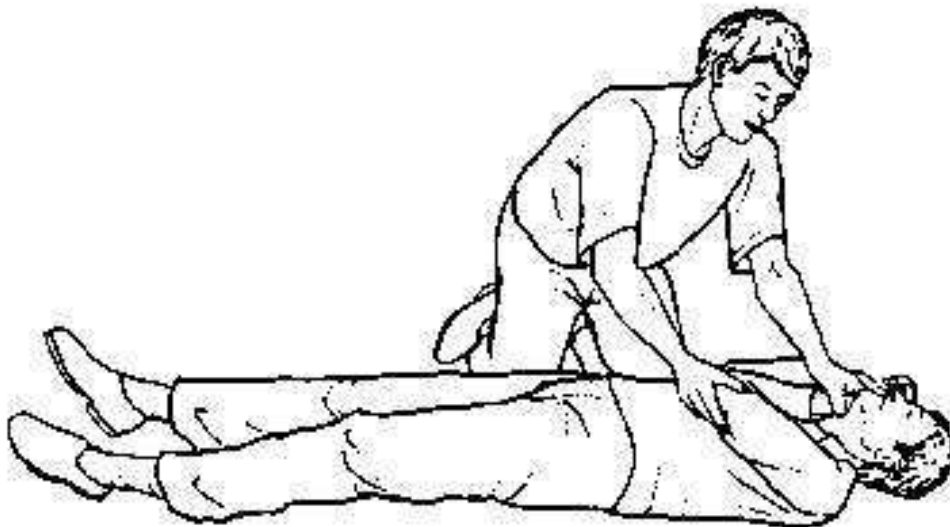
Recovery position

The unconscious casualty who is breathing should be placed in the recovery position. This allows the tongue to fall forward keeping the airway clear. It also reduces the risk of stomach contents entering the air passages.

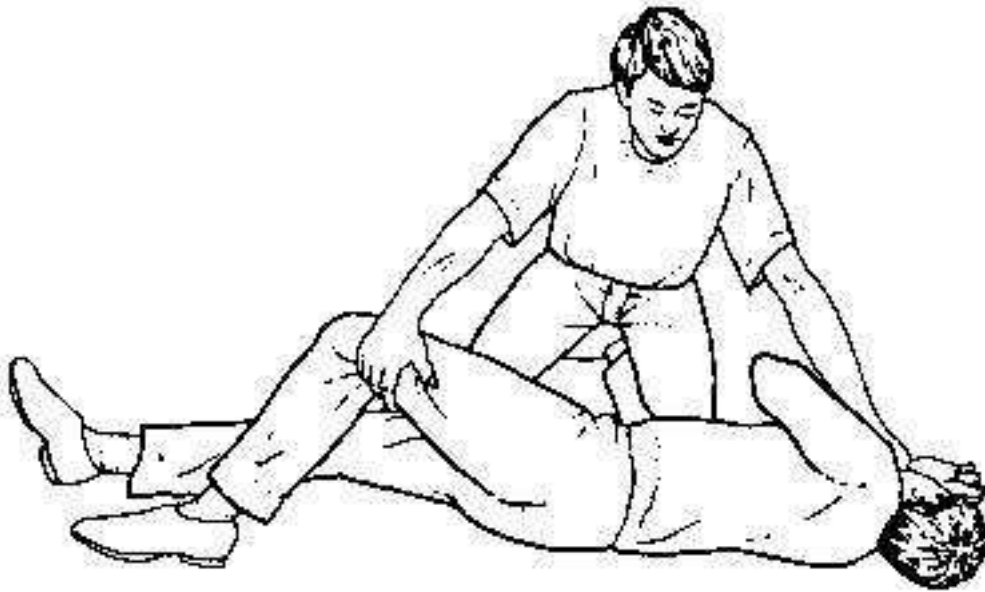
Kneel beside the casualty and open the airway by tilting the head and lifting the chin. Place the arm nearest to you at right angles to the body, elbow bent and with hand palm uppermost.



Bring the arm furthest from you across the chest. Hold the back of the casualty's hand against his nearer cheek.



With your other hand grasp the thigh furthest from you and pull up the knee, keeping the foot flat on the ground. Keeping the hand pressed to the cheek, pull at the thigh to roll the casualty on to his side, towards you.



Tilt the head back to ensure that the airway stays open, adjusting the hand under the cheek, if necessary. Make sure that the knee and hip of the casualty's upper leg are bent at right angles. This prevents him rolling on to his face. Re-check frequently to ensure that the airway is open and clear and that breathing and pulse remain present.

