Managing Medicines Policy

Preston Grange Primary School

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Management of Medications and Supporting Pupils with Health Conditions

Guidance

Document Change Log: Summary of document changes			
Date	Version	By	Summary of Changes
04.04.24	1.0	Billy Latham	Review and update of content including reformatting to corporate branding and creation of new guidance document
20.06.24	1.1	Billy Latham	Amendment to home transport and appendices 1 and 2 for diabetes and epilepsy guidance

Contents

Contents

Definitions

Controlled Drug (CD)	*Medication that is controlled as part of the misuse of drugs legislation (e.g. methylphenidate/Ritalin or some strong pain killers)*
Education, Health and Care (EHC) plans	*A legal document that describes a child's special educational, health and social care needs, and support required to meet those needs*
General Data Protection Regulation (GDPR)	*A data protection regulation from May 2018 intended to strengthen and unify data protection for individuals.*
Individual Healthcare Plans (IHCP)	*A document that describes a child's medical needs and support required in school to meet those needs.*
Medical condition	*For the purposes of this policy, 'medical condition' refers to any physical or mental health conditions that required ongoing health professional input (e.g. from GP, clinic, or hospital specialist).*
Adrenaline Auto-Injector (AAI)	*used for the emergency treatment of severe acute allergic reactions (anaphylaxis) to foods, medicines, or insect stings.*
Special educational needs or disabilities (SEND)	*Special educational needs and disabilities that can affect a child or young person's ability to learn.*
Confident	*If a staff member does not feel confident to administer medications following relevant training or whether a subsequent event means staff no longer feel confident then this should be raised with the Headteacher, and the competence should be removed until the confidence issue is addressed.*

Legislation

Medicines Act 1968	• No child should be given medicines without the consent of their parents/carers. • Anyone may administer a prescribed medicine, with written consent, to a third party, so long as it is in accordance with the prescriber's instructions. • A medicine may only be administered by a school or setting to the child for whom it has been prescribed, labelled and supplied. • No one but the prescriber may vary the dose or directions for administering of the medicine. In those rare cases where the dose may vary regularly, printed dose schedules should be available from the relevant health professional. • Medicines should be stored securely unless it has been agreed that the child keeps and administers the medication themselves e.g. inhaler. • Records of medicines being administered should be maintained and monitored
Misuse of Drugs Act 1971	This is of relevance to schools and settings where a child has been prescribed a controlled drug that they may legally have in their possession e.g. methylphenidate (Ritalin). It allows for staff to administer controlled drugs in such circumstances in accordance with the prescriber's instructions.
Care Standards Act 2000	The national standards for under 8's day care require that the registered person in an early years setting has: • A clear policy regarding the administration of medicines, which is understood by all staff and discussed with parents/carers. • provided staff training specific to the needs of the child concerned As some medicines may be harmful to anyone for whom they are not prescribed schools are

	required to ensure risks to the health of staff, children and others are properly controlled.
Children & Families Act 2014	Section 100 of this act places a legal duty upon schools to make arrangements for supporting pupils in schools with medical conditions and have regard to statutory guidance issued by the secretary of state. The aforementioned legislation places a duty of care upon the Local Authority, Schools, and other settings to ensure all children in their charge are healthy and safe including: • The administering of medication where necessary and/or taking action in an emergency. • The accountability for staff leading activities that take place off site e.g. visits, field trips. • Schools should ensure that they have sufficient members of support staff who are appropriately trained to manage medicines as part of their duties. Such actions will be expected for schools in meeting their responsibilities under the general equality duty referenced earlier.

Roles and Responsibilities

Role	Responsibility
Governing Body / Proprietors/Management Committees The governing body, proprietor or management committee should ensure that a school specific policy is produced	• No child with a medical condition will be denied admission or prevented from taking up a place in school because arrangements for their medical condition have not been made. • Pupils' health will not be put at unnecessary risk from, for example, infectious diseases. They therefore do not have to accept a child in school at times where it would be detrimental to the health of that child or others to do so. • The policy will be subject to regular reviews and will be made readily accessible to parents and school staff. • Suitable arrangements are in place to support individual pupils with medical conditions to enable such children the access to the same opportunities as any other child within that school.

Headteacher Headteachers should ensure that their school's policy is developed and effectively implemented with partners. This includes ensuring that:	• All staff are aware of the policy for supporting pupils with medical conditions and understand their role in its implementation. • An appropriate level insurance is in place. • The development of individual healthcare plans are appropriately planned; carried out in cooperation with appropriate personnel; and all staff who need to know are aware of the child's condition. • Sufficiently competent and trained numbers of staff are available to implement the policy and deliver against all individual healthcare plans, including in contingency and emergency situations. • If staff are trained and competent but do not feel confident to undertake this role, consideration should be given as to whether they can be removed, re-trained or whether they need to discuss this further.
Parents or Guardians Parents or Guardians are key partners and should be involved in the development and review of their child's individual healthcare plan and may be involved in its drafting. They should:	• Provide the school with sufficient and up-to-date information about their child's medical needs. They may in some cases be the first to notify the school that their child has a medical condition. • Parents or guardians should be aware of and take part in any risk assessment relating to the child. • Carry out any action they have agreed to as part of its implementation, e.g. provide medicines and equipment. • Ensure they or another nominated adult are contactable at all times.

Staff Members Any member of school staff may be asked to provide support to pupils with medical conditions, including the administering of medicines, although they cannot be required to do so. Although administering medicines is not part of teachers' professional duties, they should:	• Where necessary, make reasonable adjustments to include students with medical conditions into lessons. • Familiarise themselves with procedures detailing how to respond when they become aware that a pupil with a medical condition needs help and take into account the needs of pupils with medical conditions that they teach. • Receive sufficient and suitable ongoing training and achieve the necessary level of competency before they take on responsibility to support children with medical conditions.
0-19 Children's Public Health Service Every school can contact the 0-19 Children's Public Health Service.	If a child has complex health needs when they enter reception there would be a discussion with the 0-19 Children's Public Health Service and the school. Duty number: 0191 643 8251
Special School Nursing Service (SSN)	The SSN service is available during term time to provide specialist nursing advice for CYP with SEND attending a special school. Contact them at: NTSpecialSchoolNursing@northumbria-healthcare.nhs.uk

Other healthcare professionals including Specialist nurses.	Provide training and support. Can provide emergency care plans and advice for developing individual healthcare plans. Advice can also be obtained from the child's GP, paediatrician, or specialist doctor. The Paediatric Epilepsy specialist nurses can be contacted on: PaediatricEpilepsy@northumbria-healthcare.nhs.uk The Childrens Community Nursing Team can be contacted at: CCN-SEND@northumbria-healthcare.nhs.uk The specialist diabetes nurses can be contacted at: Di.Childrens@northumbria-healthcare.nhs.uk The children's dietetic team can be contacted at: PaediatricDietitians@northumbria-healthcare.nhs.uk The children's occupational therapy team can be contracted at: childrensotnt@northumbria-healthcare.nhs.uk

Local Authorities	• Promote co-operation between relevant partners – such as governing bodies of maintained schools, proprietors of academies, clinical commissioning groups (ICB's) and NHS England – with a view to improving the wellbeing of children with regard to their physical and mental health, and their education, ongoing training, and recreation. • Provide support, advice, and guidance, including suitable ongoing training for school staff, to ensure that the support specified within individual healthcare plans can be delivered effectively. • Work with schools to support pupils with medical conditions to attend full-time. Where pupils would not receive a suitable education in a mainstream school because of their health needs, the local authority has a duty to make other arrangements.

ICB Clinical commissioning groups commission other healthcare professionals such as specialist nurses. They should ensure that:	• Commissioning is responsive to children's needs, and that health services are able to co-operate with schools supporting children with medical conditions. • They are responsive to local authorities and schools seeking to strengthen links between health services and schools and consider how to encourage health services in providing support and advice (and can help with any potential issues or obstacles in relation to this). • Their commissioning arrangements are adequate to provide the ongoing support essential to the safety of these vulnerable children whilst in school. Children in special schools in particular may need care which falls outside the remit of local authority commissioned 0-19 Children's Public Health Service, such as gastrostomy and tracheostomy care, or postural support.
Pupils	• Pupils with medical conditions will often be best placed to provide information about how their condition affects them. They should be fully involved in discussions about their medical support needs and contribute as much as possible to the development of, and comply with, their individual healthcare plan.

Please note that the scope of this policy and guidance is agreed in support of normal school operation and what is maneagble for school in regard to timings, staff availablity and resources.

Procedure

Planning and Implementation

Individual healthcare plans help to ensure schools are effectively supporting pupils with medical conditions, they provide clarity about what needs to be done, when and by whom. They will often be essential, such as in cases where conditions fluctuate or where there is a high risk that emergency intervention will be needed and are likely to be helpful in the majority of other cases, especially where medical conditions are long-term and complex.

However, not all children will require one. The school, healthcare professional and parent/guardian should agree, based on evidence, when a healthcare plan would be inappropriate or disproportionate. If consensus cannot be reached, the headteacher is best placed to take a final view. The head teacher will not go against the advice of any medical professional but has the overall responsibility for the school. A flow chart for identifying and agreeing the support a child needs and developing an individual healthcare plan is provided in Appendix 6

Individual Healthcare Plans (IHCP)
IHCP s should be easily accessible to all who need to refer to them, while preserving confidentiality. Plans should not be a burden on a school but should capture the key information and actions that are required to support the child effectively. The level of detail within plans will depend on the complexity of the child s condition and the degree of support needed. This is important because different children with the same health condition may require very different support. Where a child has special educational needs or disabilities (SEND) but does not have a statement or EHC plan, their special educational needs should be mentioned in their individual healthcare plan. This is a live document, and any changes need to be communicated and understood by all parties.

Plans should be drawn up in partnership between the school, parents, and a relevant healthcare professional, e.g. specialist or children s community nurse or paediatrician, who can best advise on the particular needs of the child. Pupils should also be involved whenever appropriate. The aim should be to capture the steps which a school should take to help the child manage their condition and

overcome any potential barriers to getting the most from their education and how they might work with other statutory services. Partners should agree who will take the lead in writing the plan, but responsibility for ensuring it is finalised and implemented rests with the school.

Schools do not have to wait for a formal diagnosis before providing support to pupils. In cases where a pupil s medical condition is unclear, or where there is a difference of opinion, judgements will be needed about what support to provide based on the available evidence. This would normally involve some form of medical evidence and consultation with parents. Where evidence conflicts, some degree of challenge may be necessary to ensure that the right support can be put in place.

Where a child is returning to school following a period of hospital education or alternative provision (including home tuition), schools should work with the local authority and education provider to ensure that the individual healthcare plan identifies the support the child will need to reintegrate effectively.

Procedures should also be in place to cover any transitional arrangements between schools, the process to be followed upon reintegration or when pupils needs change, and arrangements for any staff training or support. For children starting at a new school, arrangements should be in place in time for the start of the relevant school term. In other cases, such as a new diagnosis or children moving to a new school mid-term, every effort should be made to ensure that arrangements are put in place within two weeks.

When deciding what information should be recorded on individual healthcare plans, the governing body should consider the following:

- The medical condition, its triggers, signs, symptoms, and treatments.
- The pupil's resulting needs, including medication (dose, side effects and storage) and other treatments, time, facilities, equipment, testing, access to food and drink where this is used to manage their condition, dietary requirements and environmental issues, e.g. crowded corridors, travel time between lessons.
- Specific support for the pupil's educational, social, and emotional needs – for example, how absences will be managed, requirements for extra time to complete exams, use of rest periods or additional support in catching up with lessons, counselling sessions.
- The level of support needed (some children will be able to take responsibility for their own health needs) including in emergencies. If a child is self-

managing their medication, this should be clearly stated with appropriate arrangements for monitoring.

- Who will provide this support, their ongoing training needs, expectations of their role and confirmation of proficiency to provide support for the child's medical condition from a healthcare professional; and cover arrangements for when they are unavailable.
- Who in the school needs to be aware of the child's condition and the support required. This may include how other pupils in the school know what to do in general terms, such as informing a teacher immediately if they think help is needed.
- Arrangements for written permission from parents and the headteacher for medication to be administered by a member of staff or self-administered by the pupil during school hours.
- Where confidentiality issues are raised by the parent/child, the designated individuals to be entrusted with information about the child's condition.
- What to do in an emergency, including whom to contact, and contingency arrangements. Some children may have an emergency healthcare plan prepared by their lead clinician that could be used to inform development of their individual healthcare plan. Where a child has an individual healthcare plan, this should clearly define what constitutes an emergency and explain what to do, including ensuring that all relevant staff are aware of emergency symptoms and procedures.
- Separate arrangements or procedures required for school trips or other school activities outside of the normal school timetable that will ensure the child can participate, e.g. risk assessments.

IHCP s should be reviewed at least annually, or earlier if evidence is presented that the child s needs have changed.

Allergies

All children with a diagnosis of an allergy and at risk of anaphylaxis should have a written Allergy Management Plan. Procedures should already be in place to ensure that schools are notified of pupils that have additional health needs, and this information will enable them to compile an allergy register. The register could include:

- Known allergens and risk factors for anaphylaxis.
- Whether a pupil has been prescribed (AAI) (and if so what type and dose).
- Where a pupil has been prescribed an AAI whether parental consent has been given for use of a spare AAI which may be different to the personal AAI prescribed for the pupil.

- A photograph of each pupil to allow a visual check to be made (this will require parental consent).

Consequently, schools should ensure that the register is easy to access and easy to read. Schools will also need to ensure they have a proportionate and flexible approach to checking the register. **Delays in administering adrenaline have been associated with fatal outcomes.**

Training
Governing bodies should ensure that the school s policy sets out clearly how staff will be supported in carrying out their role to support pupils with medical conditions, and how this will be reviewed. This should specify how training needs are assessed, and how and by whom training will be commissioned and provided.

The school s policy should be clear that any member of school staff providing support to a pupil with medical needs should have received suitable training. Suitable training should have been identified during the development or review of individual healthcare plans. Some staff may already have some knowledge of the specific support needed by a child with a medical condition and so extensive training may not be required. Staff who provide support to pupils with medical conditions should be included in meetings where this is discussed.

The relevant healthcare professional should normally lead on identifying and agreeing with the school the type and level of training required, and how this can be obtained. Schools may choose to arrange training themselves and should ensure this remains up to date.

Training should be sufficient to ensure that staff are competent and have confidence in their ability to support pupils with medical conditions, and to fulfil the requirements as set out in individual healthcare plans. They will need an understanding of the specific medical conditions they are being asked to deal with, their implications and preventative measures.

A first-aid certificate does not constitute appropriate training in supporting children with medical conditions. Healthcare professionals can provide confirmation of the proficiency of staff in a medical procedure, or in providing medication.

The school s policy should additionally set out arrangements for whole-school awareness training so that all staff are aware of the school s policy for supporting pupils with medical conditions and their role in implementing that policy - induction arrangements for new staff should also be included. The relevant

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

The family of a child will often be key in providing relevant information to school staff about how their child s needs can be met, and parents should be asked for their views. They should provide specific advice but should not be the sole trainer. Governing bodies should consider providing details of continuing professional development opportunities.

Staff must not give prescription medicines or undertake healthcare procedures without appropriate training (updated to reflect requirements within individual healthcare plans). In some cases, written instructions from the parent or on the medication container dispensed by the pharmacist may be considered sufficient, but ultimately this is for the school to decide, having taken into consideration the training requirements as specified in pupils individual health care plans.

Offsite Visits

Teachers should be aware of how a child s medical condition will impact on their participation, but there should be enough flexibility for all children to participate according to their own ability. A first-aid certificate does not constitute appropriate training in supporting children with medical conditions. Schools should make arrangements for the inclusion of pupils in such activities with any adjustments as required unless evidence from a clinician such as a GP states that this is not possible.

Schools should consider what reasonable adjustments they might make to enable children with medical needs to participate fully and safely on visits. It is advisable to carry out a risk assessment so that planning arrangements take account of any steps needed to ensure that pupils with medical conditions are included. This will require consultation with parents and pupils and advice from the relevant healthcare professional to ensure that pupils can participate safely.

Unacceptable Practice

Although school staff should use their discretion and judge each case on its merits with reference to the child s individual healthcare plan, it is not generally acceptable practice to:

- Prevent children from easily accessing their inhalers and medication and administering their medication when and where necessary.

- Assume that every child with the same condition requires the same treatment.
- Ignore the views of the child or their parents; or ignore medical evidence or opinion (although this may be challenged).
- Send children with medical conditions home frequently for reasons associated with their medical condition or prevent them from staying for normal school activities, including lunch, unless this is specified in their individual healthcare plans.
- If the child becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable.
- Penalise children for their attendance record if their absences are related to their medical condition, e.g. hospital appointments.
- Prevent pupils from drinking, eating, or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively.
- Require parents, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their child, including with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs; or
- Prevent children from participating or create unnecessary barriers to children participating in any aspect of school life, including school trips, e.g. by requiring parents to accompany the child.

Liability and Indemnity

Governing bodies of maintained schools and management committees of PRUs should ensure that the appropriate level of insurance is in place and appropriately reflects the level of risk. Proprietors of academies should ensure that either the appropriate level of insurance is in place or that the academy is a member of the Department for Education s Risk Protection Arrangement (RPA).

It is important that the school policy sets out the details of the school s insurance arrangements which cover staff providing support to pupils with medical conditions.

Insurance policies should provide liability cover relating to the administration of medication, but individual cover may need to be arranged for any healthcare procedures. The level and ambit of cover required must be ascertained directly from the relevant insurers. Any requirements of the insurance, such as the need for staff to be trained, should be made clear and complied with. In the event of a claim alleging negligence by a member of staff, civil actions are likely to be brought against the employer.

Insurance policies should be accessible to staff providing such support.

Complaints
Governing bodies should ensure that the school s policy sets out how complaints concerning the support provided to pupils with medical conditions may be made and will be handled.

Should parents or pupils be dissatisfied with the support provided they should discuss their concerns directly with the school. If for whatever reason this does not resolve the issue, they may make a formal complaint via the school s complaints procedure. Making a formal complaint to the Department for Education should only occur if it comes within scope of section 496/497 of the Education Act 1996 and after other attempts at resolution have been exhausted. In the case of academies, it will be relevant to consider whether the academy has breached the terms of its Funding Agreement or failed to comply with any other legal obligation placed on it. Ultimately, parents (and pupils) will be able to take independent legal advice and bring formal proceedings if they consider they have legitimate grounds to do so.

Home to School Transport
It may be helpful for the organisation who arranges home to school transport to be aware of a pupil s individual healthcare plan and what it contains, especially in respect of emergency situations and transportation of medications including controlled drugs. This may be helpful in developing transport healthcare plans for pupils with life-threatening conditions. There needs to be a clearly defined agreement between the school and the transport service. A policy document should be created to ensure there is no ambiguity as to responsibilities between the school and the school transport.

It is not uncommon for schools (often primary schools) to request a pupil s Adrenaline Auto Injector (AAI) is left in school to avoid the situation where a pupil or their family forgets to bring the AAI(s) to school each day. Where this occurs, the pupil must still have access to an AAI when travelling to and from school.

Management of Medication

The governing body should ensure that the school s policy is clear about the procedures to be followed for managing medicines – this should include the different types of medication, storage and disposal arrangements. It should also cover children who are competent to manage their own health needs and medicines.

Medicines should only be administered at school when it would be detrimental to a child s health or school attendance not to do so and where clinically possible, medicines should be prescribed in dose frequencies which enable them to be taken outside school hours.

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. An example of such a medication can include but not limited to birth control, abortion, mental health problems, sexually transmitted infections or alcohol and drug addiction. 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.

Schools should only accept medicines if these 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.

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 in school and the child s parents and/or carers should be informed on the same day, or as soon as reasonably practicable. Records offer protection to staff and children and provide evidence that agreed procedures have been followed. Parents should be informed if their child has been unwell at school.

If a child refuses to take medicine or carry out a necessary procedure, staff should not force them to do so, but follow the procedure agreed in the individual healthcare plan. Parents should be informed so that alternative options can be considered.

Prescription and Non-Prescription Medicines
Prescription medicines should only be taken to a setting when this is essential, and settings should only accept and administer medicines that have been prescribed by a doctor, dentist, nurse or pharmacist for that particular pupil. Staff administering medicines should do so in accordance with the prescriber s instructions.

Schools should set out the circumstances in which non-prescription medicines may be administered. **Non-prescription/over the counter (OTC) medication does not need a General Practitioner signature/authorisation in order for the provider to give it. However, medicines containing aspirin should only be given if 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.**

Where OTC medications are concerned, the school do not have to administer these. If the school decides to administer these then they should carry out an individual risk assessment for the pupil and the administering of these medications should not exceed 3 days. It is the school s decision as to whether they choose to administer OTC medications. The school can refuse to administer these medications unless they are prescribed by a GP and only if this states a specified time that it must be given to a pupil.

Self-Management
After discussion with parents, children who are competent should be encouraged to take responsibility for managing their own medicines and procedures. This should be reflected within individual healthcare plans.

Wherever possible, children should be allowed to carry their own medicines and relevant devices or should be able to access their medicines for self-medication quickly and easily. Children who can take their medicines themselves or manage procedures may require an appropriate level of supervision. If it is not appropriate for a child to self-manage, relevant staff should help to administer medicines and manage procedures for them. A risk assessed must be created before the child carries their own medication to ensure this is sae to do so. Parents, carers and the headteacher should be involved in the creation of this assessment.

Storage
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).

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 - for this reason 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. A record should be kept of any doses used and the amount of the controlled drug held.

Schools should ensure that all AAI s, inhalers, and spacers – including those belonging to a younger child, and any spares for 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 devices are 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.

Schools may wish to require parents to take their pupil s own prescribed AAIs home before school holidays (including half-term breaks) to ensure that their own AAIs remain in date and have not expired.

Inhalers and AAI devices should be stored at the appropriate temperature (in line with manufacturer s guidelines), usually below 30C, protected from direct sunlight and extremes of temperature.

Disposal
When no longer required, medicines should be returned to the parent to arrange for safe disposal. Sharps bins should always be used for the disposal of needles and other sharps – these should be kept in a safe place so it's not a risk to other people and is out of the sight and reach of children. Clinical waste collections should be used when sharp bins are full.

Adrenaline Auto Injectors
Once an AAI has been used it cannot be reused and must be disposed of according to manufacturer s guidelines. Used AAIs can be given to the ambulance paramedics on arrival or can be disposed of in a pre-ordered sharps bin for collection by the local council.
An anaphylactic reaction always requires an emergency response.

Inhalers

Manufacturers guidelines usually recommend that spent inhalers are returned to the pharmacy to be recycled, rather than being thrown away. Schools should be aware that to do this legally, they should register as a lower-tier waste carrier, as a spent inhaler counts as waste for disposal. Registration only takes a few minutes online, and is free, and does not usually need to be renewed in future years.

Controlled Drugs

For circumstances where controlled drugs are found or seized, schools are advised to:

- ensure that a second adult witness is present throughout.
- seal the sample in a plastic bag and include details of the date and time of the seizure/find and witness present.
- store it in a secure location, such as a safe or other lockable container with access limited to senior members of staff.
- notify the police without delay, who will collect it and then store or dispose of it in line with locally agreed protocols.

Further Information

The following publications are available and may offer additional support regarding the information contained within this guidance.

Department for Education
Supporting pupils at school with medical conditions
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803956/supporting-pupils-at-school-with-medical-conditions.pdf

Statutory framework for the early years foundation stage
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/596629/EYFS_STATUTORY_FRAMEWORK_2017.pdf

Templates: Supporting pupils with medical conditions
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/349437/Supporting_pupils_with_medical_conditions_-_templates.docx

Drug advice for schools
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/270169/drug_advice_for_schools.pdf

Ensuring a good education for children who cannot attend school because of health needs
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/269469/health_needs_guidance__-_revised_may_2013_final.pdf

Automated external defibrillators (AEDs): A guide for schools
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/843393/AED_guide_for_schools_Sept2019_v2_accessible.pdf

Department of Health
Guidance on the use of emergency salbutamol inhalers in schools
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/416468/emergency_inhalers_in_schools.pdf

Guidance on the use of adrenaline auto-injectors in schools

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/645476/Adrenaline_auto_injectors_in_schools.pdf

The British Medical Association
Prescribing non-prescription (over the counter) medication in nurseries and schools
https://www.bma.org.uk/advice/employment/gp-practices/quality-first/manage-inappropriate-workload/prescribing-non-prescription-medication

Appendices

Appendix 1: Diabetes Guidance

Appendix 2: Epilepsy Guidance

Appendix 3: Recognition and management of an allergic reaction/anaphylaxis
One-page guidance on signs, symptoms, and management of allergic reaction/anaphylaxis

Appendix 4: Recognition and management of an asthma attack
One-page guidance on signs, symptoms, and management of an asthma attack

Appendix 5: Policy Checklist
This checklist has been produced to assist with the development of the policy and to ensure all arrangements have been considered and implemented.

Appendix 6: Individual Health Care Plan Flow Chart
A diagram which provides an example of the process in which would support a school with the identification, development, and implementation of an IHCP.

Appendix 7: Template Documentation
Examples of supporting documentation which includes:

A. Individual Healthcare Plan
B. Parent/Guardian agreement to administer medicine
C. Record of medicine administered to an individual child
D. Record of medicine administered to all children
E. Staff training record – administration of medicines
F. Contacting emergency services
G. Model Letter Inviting Parents to Contribute to Individual Healthcare Plan Development

Appendix 1: Diabetes Guidance

What is Diabetes?

Diabetes is a condition where the amount of glucose in the blood is too high because the body cannot use it properly.

What Causes it?

Diabetes is a disorder caused when the pancreas produces an insufficient amount of the hormone insulin or when insulin production is absent. There are two main types of diabetes which are discussed briefly below:

Type 1 Diabetes

Type 1 diabetes develops when the insulin-producing cells have been destroyed and the body is unable to generate any of the substance. It is treated with insulin either by injection or pump, a healthy diet and regular physical activity. The majority of affected children have Type 1 diabetes.

Type 2 Diabetes

Type 2 diabetes develops when the body does not produce enough insulin or the insulin that is produced does not work properly.

This type of diabetes is treated with a healthy diet and regular physical activity, though medication (and/or insulin) is often required.

In both instances each child may experience different symptoms, and these should be discussed when drawing up the healthcare plan.

What is the Treatment for the Condition?

For most children diabetes is controlled by injections of insulin each day. Some children may require multiple injections, though it is unlikely that they will need to be given injections during school hours.

In some cases, the child's condition may be controlled by an insulin pump. Most children can manage their own injections, however, if doses are required at school, then supervision may be required and a suitable, private place to inject will need to be identified.

It has become increasingly common for older children to be taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime and then insulin with breakfast, lunch, and evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. The child is then responsible for administering injections and the regime to be followed would be detailed in the individual healthcare plan.

It is essential that children with diabetes make sure that their blood glucose levels remain stable. They may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs to be adjusted. The majority of older children will be able to undertake this task without assistance and will simply need a suitable place to do it. However, younger children may need adult supervision to carry out the test and/or interpret the results.

When members of staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate health professional, usually a specialist nurse with clinical responsibility for the treatment of the particular child.

What Arrangements are in Place at your School?

Healthcare Plan

A healthcare plan will be needed for pupils with diabetes; a personalised risk assessment is also likely to be required due to complexities of management of the condition and the potential for pupils to be using sharps.

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. Members of staff need to be made aware that if a child should miss a meal or snack, he/she could experience a hypoglycaemic episode (commonly known as a 'hypo') during which the blood glucose level falls too low. It is, therefore, important that staff should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand. After strenuous activity a child may experience similar symptoms, in which case the teacher in charge of physical education or other sessions involving physical activity should be aware of the need to take appropriate action.

What are the Signs of a Hypoglycaemic Episode?

Staff should be aware that the following symptoms, either individually or in combination, may be an indicator of low blood sugar:

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

Each child may experience different symptoms, and this should be discussed when drawing up individual healthcare plans.

Emergency Action

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

An ambulance should be called if:

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

Hyperglycaemia

Some children may experience hyperglycaemia, which is a high glucose level.

The underlying cause of hyperglycaemia will usually be from loss of insulin producing cells in the pancreas or if the body develops resistance to insulin.

More immediate reasons for it include:

- Missing a dose of diabetic medication, tablets, or insulin
- Eating more carbohydrates than the body and/or medication can manage.
- Being mentally or emotionally stressed
- Contracting an infection

The symptoms of hyperglycaemia include thirst and the passing of large amounts of urine. Tiredness and weight loss may indicate poor diabetic control. If these symptoms are observed members of staff should draw these signs to the attention of parents. If the child is unwell, is vomiting or has diarrhoea this can lead to dehydration. If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and he/she will require urgent medical attention.

Further information on this condition can be found on the Diabetes UK website.

Appendix 2: Epilepsy Guidance

What is Epilepsy?

Epilepsy is characterised by a tendency for someone to experience recurrent seizures or a temporary alteration in one or more brain functions.

What Causes it?

An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons and can result from a wide variety of disease or injury.

Triggers such as anxiety, stress, tiredness and illness may increase the likelihood that a child will have a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. The latter is called photosensitivity and is very rare. Most children with epilepsy can use computers and watch television without any problem.

What are the Signs of the 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.

What the child experiences depends on whether all of the brain is affected or the part of the organ that is involved in the seizure. 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 display unusual, 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.

Most seizures last for a few seconds or minutes and stop of their own accord. In some cases, 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', and sometimes there will be fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class.

What is the Treatment for the Condition?

The great majority of seizures can be controlled by anti-epileptic medication. It should not be necessary to take regular medicine during school hours.

What Arrangements are in Place at your School?

Healthcare Plan

An individual healthcare plan is needed when a pupil has epilepsy.

Parents and health care professionals should provide information to the school's Medication Coordinator so that it can be incorporated into the individual healthcare plan, detailing the particular pattern of an individual child's epilepsy. If a child experiences a seizure whilst at school, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure – for example visual/auditory stimulation, anxiety or upset.
- any unusual 'feelings' which the child reported prior to the seizure.
- the parts of the body demonstrating seizure activity, such as limbs or facial muscles
- the time when the seizure happened and its duration.
- whether the child lost consciousness
- whether the child was incontinent

The above information will help parents to give the child's specialist more accurate information about seizures and their frequency. In addition, it should form an integral part of the school's emergency procedures and relate specifically to the child's individual healthcare plan. The healthcare plan should clearly identify the type or types of seizures, including descriptions of the seizure, possible triggers and whether emergency intervention may be required.

Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or participating in science lessons. The Medication Coordinator should discuss any safety issues with the child and parents as part of the healthcare plan, and these concerns should be communicated to members of staff.

Emergency Action

The next section covers the procedures to be followed with regard to first aid for all seizures.

- Ensure that the child is out of harm's way. Move the child only if there is danger from sharp or hot objects or electrical appliances. Observe these simple rules and let the seizure run its course

- Check the time the child starts to fit.

- Cushion the head with something soft (a folded jacket would do) but do not try to restrain convulsive movements.

- Do not try to put anything at all between the teeth.

- Do not give anything to drink.

- Loosen tight clothing around the neck, remembering that this could frighten a semi-conscious child and should be done with care.

- Arrange for other children to be escorted from the area, if possible

- Call for an ambulance if:

    - a seizure shows no sign of stopping after a few minutes.
    - a series of seizures take place without the individual properly regaining consciousness.

- As soon as possible, turn the child onto his/her side in the semi-prone (recovery/unconscious) position, to aid breathing and general recovery. Wipe away saliva from around the mouth.

- Be reassuring and supportive during the confused period which often follows this type of seizure. If rest is required, arrangements should be made for this purpose.

- If there has been incontinence cover the child with a blanket to prevent embarrassment. Arrange to keep spare clothes at school if this is a regular occurrence.

If a child is known to have epilepsy:

- It is not usually necessary for the child to be sent home following a seizure, but each child is different. If the Headteacher feels that the period of disorientation is prolonged, it might be wise to contact the parents. Ideally, a decision will be taken in consultation with the parents when the child's condition is first discussed, and a Healthcare Plan drawn up.

- If the child is not known to have had a previous seizure medical attention should be sought

- If the child is known to have diabetes this seizure may be due to low blood sugar (a hypoglycaemic attack) in which case an ambulance should be summoned immediately

Finally, the next section covers procedures to be followed if the casualty is known to have epilepsy and has been prescribed rectal diazepam.

- Ensure that the child is out of harm's way. Move the child only if there is danger from sharp or hot objects or electrical appliances. Observe these simple rules and let the seizure run its course.
- Check the time the child starts to fit.
- Cushion the head with something soft (a folded jacket would do) but do not try to restrain convulsive movements.
- Do not try to put anything at all between the teeth.
- Do not give anything to drink.
- Loosen tight clothing around the neck, remembering that this could frighten a semi-conscious child and should be done with care.
- Arrange for other children to be escorted from the area, if possible
- Rectal diazepam must only be given to a child with a prescription that a Consultant Paediatrician has endorsed and updated annually.
- Rectal diazepam must only be administered in an emergency by an appropriately trained member of staff in the presence of at least one other member of staff.
- Rectal diazepam must only be administered if a trained First Aider is on site.
- If the child has been convulsing for five minutes and there is no suggestion of the convulsion abating, the first dose of rectal diazepam should be given. The medication should indicate the name of child, the date of birth, date of expiry, contents, and the dosage to be administered.
- If after a further five minutes

  (a) a seizure shows no sign of stopping or
  (b) a series of seizures takes place without the individual properly regaining consciousness, then call an ambulance

- As soon as possible, turn the child onto his/her side in the semi-prone (recovery/unconscious) position to aid breathing and general recovery. Wipe away saliva from around the mouth.
- Be reassuring and supportive during the confused period which often follows this type of seizure. Many children sleep afterwards and if rest is required, arrangements could be made for this purpose.

- If there has been incontinence cover the child with a blanket to prevent embarrassment. Arrange to keep spare clothes at school if this is a regular occurrence.
- A child should be taken home after a fit if he/she feels ill.

An ambulance should be called during a convulsive seizure if:

- it is the child's first seizure.
- the child has injured him/herself badly.
- the child has problems breathing after a seizure.
- a seizure lasts longer than the period identified in the child's healthcare plan.
- a seizure lasts for five minutes and members of staff do not know how long the seizures usually last for a particular child.
- there are repeated seizures, unless this is usual for the child, as described in the child's 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. Putting something soft under the child's head during a convulsive seizure will help to protect it from injury.

Nothing should be placed in the child's mouth. After a convulsive seizure has stopped, the pupil should be placed in the recovery position and a member of staff should stay with him/her until the child has fully recovered.

Status Epilepticus

Status epilepticus is a condition described as one continuous, unremitting seizure lasting longer than five minutes or recurrent seizures without regaining consciousness between them for greater than five minutes. It must always be considered a medical emergency.

A five-minute seizure does not in itself constitute an episode of status and it may subsequently stop naturally without treatment. However, applying emergency precautions after the five-minute mark has passed will ensure that prompt attention will be available if a seizure does continue. Such precautions are especially important if the child's medical history shows a previous episode of status epilepticus.

Any child not known to have had a previous seizure should receive medical assessment as soon as possible. Both medical staff and parents need to be informed of any events of this nature.

Emergency Medication

Two types of emergency medication are prescribed to counteract status, namely:

- Buccal (oromucosal) midazolam. This is the most common treatment for prolonged acute convulsive seizures, which is placed via syringe into the buccal cavity (the side of the mouth between the cheek and the gum).

- Rectal diazepam, which is given rectally (into the bottom). This is an effective emergency treatment for prolonged seizures.

These drugs are sedatives which have a calming effect on the brain and are able to stop a seizure. In very rare cases, these emergency drugs can cause breathing difficulties so the person must be closely watched until they have fully recovered.

Training in the administration of buccal midazolam and rectal diazepam is essential and is provided by the specialist nurse with clinical responsibility for the treatment of the particular child. Special training should be updated annually.

Administration of Buccal Midazolam and Rectal Diazepam

Any child requiring rectal buccal midazolam or diazepam should have his/her medication reviewed every year. As an additional safeguard, each child requiring buccal midazolam or rectal diazepam should have his/her own specific healthcare plan that will focus exclusively on this issue. All interested parties should be signatories to this document. An example is reproduced in Appendix 12.

Buccal midazolam and rectal diazepam can only be administered in an emergency if an accredited first aider, trained in mouth to nose/mouth resuscitation, is easily accessible (that is only one or two minutes away). At least one other member of staff must be present as well.

Arrangements should be made for two adults to be present for such treatment, at least one of whom is the same sex as the child; this minimises the potential for accusations of abuse. The presence of two adults can also make it much easier to administer treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.

Staying with the child afterwards is important as buccal midazolam and diazepam may cause drowsiness. Moreover, those who administer buccal midazolam and rectal diazepam should be aware that there could be a respiratory arrest. If breathing does stop a shake and a sharp voice should usually start the child breathing again; if this does not work, it will be necessary to give mouth to mouth resuscitation.

Appendix 3: Recognition & management of an allergic reaction/anaphylaxis

Signs and symptoms include:	Action to take:
• Swollen lips, face or eyes • Itchy/tingling mouth • Hives or itchy skin rash • Abdominal pain or vomiting • Sudden change in behaviour	• Stay with the child, call for help if necessary • Locate adrenaline autoinjector(s) • Give antihistamine according to the child's allergy treatment plan • Phone parent/emergency contact

• Watch for signs of ANAPHYLAXIS (life-threatening allergic reaction):

Airway:	**B**reathing:	**C**onsciousness:
•Persistent cough •Hoarse voice •Difficulty swallowing, swollen tongue	•Difficult or noisy breathing •Wheeze or persistent cough	•Persistent dizziness •Becoming pale or floppy •Suddenly sleepy, collapse, unconscious.

- Lie child flat with legs raised:(if breathing is difficult, allow child to sit)
- **Use Adrenaline autoinjector* without delay**
- **Dial 999** to request ambulance and say ANAPHYLAXIS

***** IF IN DOUBT, GIVE ADRENALINE *****

- After giving Adrenaline:
  - Stay with child until ambulance arrives, do NOT stand child up
  - Commence CPR if there are no signs of life
  - Phone parent/emergency contact
  - If no improvement **after 5 minutes, give a further dose** of adrenaline using another autoinjector device, if available.

Anaphylaxis may occur without initial mild signs: **ALWAYS use adrenaline autoinjector FIRST in someone with known food allergy who has SUDDEN BREATHING DIFFICULTY** (persistent cough, hoarse voice, wheeze) – even if no skin symptoms are present.

Appendix 4: Recognition & management of an asthma attack

Signs of an Asthma attack:
• Persistent cough (when at rest) • A wheezing sound coming from the chest (when at rest) • Difficulty breathing (the child could be breathing fast and with effort, using all accessory muscles in the upper body) • Nasal flaring • Unable to talk or complete sentences. Some children will go very quiet. • May try to tell you that their chest 'feels tight' (younger children may express this as tummy ache)

CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD:
• Appears exhausted • Has a blue/white tinge around lips • Is going blue • Has collapsed

• Keep calm and **reassure the child** • Encourage the child to **sit up and slightly forward** • **Use the child's own inhaler – if not available, use the emergency inhaler** • **Remain with the child** while the inhaler and spacer are brought to them • Immediately help the child to **take two separate puffs of salbutamol** via the spacer • **If there is no immediate improvement, continue to give two puffs at a time every two minutes, up to a maximum of 10 puffs** • Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better • **If the child does not feel better or you are worried at ANYTIME before you have reached 10 puffs, CALL 999 FOR AN AMBULANCE** • **If an ambulance does not arrive in 10 minutes give another 10 puffs in the same way**

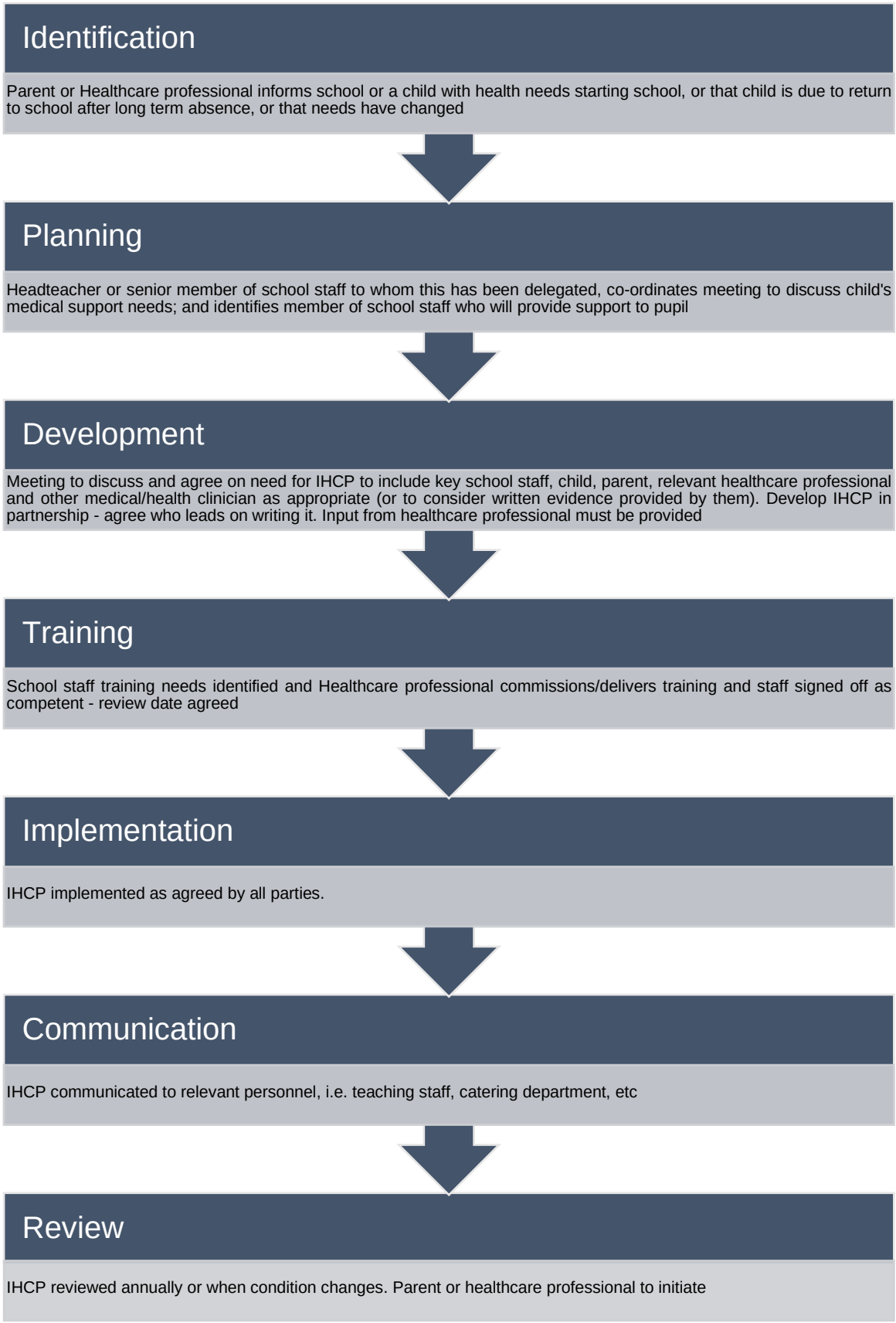
Appendix 5: Policy Checklist for developing a school policy

Agreed policy includes arrangements that are clear and unambiguous about: • No child with a medical condition will be denied admission or prevented from taking up a place in school because arrangements for their medical condition have not been made. • Pupils' health will not be put at unnecessary risk from, for example, infectious diseases. They therefore do not have to accept a child in school at times where it would be detrimental to the health of that child or others to do so. • The need to support pupils with medical conditions to participate in school trips and visits, or in sporting activities, and not prevent them from doing so;	
A clear identification of roles and responsibilities of all those involved in the arrangements they make to support pupils at school with medical conditions which includes: • Monitoring implementation of policy • Individual with responsibility for ensuring that sufficient staff are suitably trained Cover arrangements should also be considered in case of staff absence or staff turnover to ensure someone is always available	
Insurance cover current and adequate to needs	
Process in place for notifying the school of pupils with medical conditions with procedures which must be followed after confirmation	
A clear procedure to be followed for managing medicines which includes written records of all medicines administered to children and the circumstances in which non-prescription medicines may be administered	
Arrangements for children who are competent to manage their own health needs and medicines	
A register of pupils with medical conditions in a secure location, with individual healthcare plans, medication consent forms, medication records, and individual risk assessment forms	
Risk assessment arrangements for school visits, holidays, and other school activities outside the normal timetable	
Relevant practices which are unacceptable for supporting pupils with medical conditions	
How complaints concerning the support provided to pupils with medical conditions may be made and will be handled	

Process in place for monitoring individual healthcare plans and ensuring they are suitably reviewed every year with cover arrangements in case of staff absence or staff turnover to ensure someone is always available	
Protocol for use of emergency inhalers and adrenaline autoinjectors *(if applicable)*	
Medication securely stored but accessible	
Process for ensuring all medication and equipment are in date	
Suitable communication relating to this policy (training days, staff handbook, etc.) Policy is part of all staff induction, including temporary, supply staff and volunteers	
Suitable communication relating to staff knowing the pupils they work with who have an individual healthcare plan/medical condition All staff are aware of the emergency procedures	
Policy available on the school website	
Policy regularly reviewed in consultation with governors and staff	

Optional additions to the policy	✔
Home-to-school transport arrangements	
AAI protocol which includes the following: • Arrangements for the supply, storage, care, and disposal of spare AAI(s) in line with the school's policy on supporting pupils with medical conditions • A register of pupils who have been prescribed an AAI(s) (or where a doctor has provided a written plan recommending AAI(s) to be used in the event of anaphylaxis). • Written consent from the pupil's parent/legal guardian for use of the spare AAI(s), as part of a pupil's individual healthcare plan. • Ensuring that any spare AAI is used only in pupils where both medical authorisation and written parental consent have been provided. • Appropriate support and ongoing training for staff in the use of the AAI in line with the school's wider policy on supporting pupils with medical conditions. • Keeping a record of use of any AAI(s), as required by this guidance and informing parents or carers that their pupil has been administered an AAI and whether this was the school's spare AAI or the pupil's own device. • Staff responsibilities for maintaining the spare anaphylaxis kit (where in place)	
Asthma protocol which includes the following: • Arrangements for the supply, storage, care, and disposal of the inhaler and spacers in line with the school's policy on supporting pupils with medical conditions • A register of children in the school that have been diagnosed with asthma or prescribed a reliever inhaler, a copy of which should kept with the emergency inhaler. • Written parental consent for use of the emergency inhaler included as part of a child's individual healthcare plan. • Ensuring that the emergency inhaler is only used by children with asthma with written parental consent for its use. • Appropriate support and ongoing training for staff in the use of inhalers in line with the school's wider policy on supporting pupils with medical conditions. • Keeping a record of use of inhaler as required by this guidance and informing parents or carers that their child has used the emergency inhaler. • Staff responsibilities for maintaining the spare emergency asthma kit (where in place)	

Appendix 6: IHCP Flow Chart



Appendix 7: School owned AAI s and Inhalers for Emergencies Guidance

Schools can purchase emergency use AAI s and inhalers (including the spacer) from a pharmaceutical supplier, such as a local pharmacy, without a prescription, provided the general advice relating to these transactions are observed: i.e. small quantities on an occasional basis and the school does not intend to profit from it. Further guidance on how to obtain these can be found in the guidance documents: The use of adrenaline auto-injectors in schools and The use of emergency salbutamol inhalers in schools

In line with this guidance, the use of such devices should be recorded. This should include where and when the reaction or attack took place (e.g. PE lesson, playground, classroom), how much medication was given, and by whom. The pupil s parent/guardians should be contacted at the earliest opportunity following summoning of emergency services.

Adrenaline Autoinjector(s)

Schools may administer their spare" adrenaline auto-injector, without prescription, for use in emergencies, if available, but only to a pupil at risk of anaphylaxis, where both medical authorisation and written parental consent for use of the spare AAI has been provided. This includes children at risk of anaphylaxis who have been provided with a medical plan confirming this, but who have not been prescribed AAI. In such cases, specific consent for use of the spare AAI from both a healthcare professional and parent/guardian must be obtained.

The school s spare AAI can be administered to a pupil whose own prescribed AAI cannot be administered correctly without delay. **This information should be recorded in a pupil s individual healthcare plan.**

Emergency use medication held in the emergency kit should be kept separate from any pupil s own prescribed AAI which might be stored nearby; the spare medication should be clearly labelled to avoid confusion with that prescribed to a named pupil. The emergency kit could contain:

- 1 or more AAI(s).
- Instructions on how to use the device(s).
- Instructions on storage of the AAI device(s).
- Manufacturer's information.
- A checklist of injectors identified by their batch number and expiry date with monthly checks recorded.
- A note of the arrangements for replacing the injectors.

- A list of pupils to whom the AAI can be administered.
- An administration record.

Ongoing Maintenance/Checks

- A monthly check that the AAIs are present and in date.
- Replacement AAIs are obtained when expiry dates approach (this can be facilitated by signing up to the AAI expiry alerts through the relevant AAI manufacturer).

Inhalers

The emergency salbutamol inhaler should only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication. The inhaler can be used if the pupil s prescribed inhaler is not available (for example, because it is broken, or empty). The emergency salbutamol inhaler should only be used by children who have been diagnosed with asthma and prescribed a reliever inhaler; or who have been prescribed a reliever inhaler and for whom written parental consent for use of the emergency inhaler has been given. **This information should be recorded in a child s individual healthcare plan.**

Emergency use medication held in the emergency kit should be kept separate from any pupil s own prescribed inhaler which might be stored nearby; the spare medication should be clearly labelled to avoid confusion with that prescribed to a named pupil. The emergency kit could contain:

- a salbutamol metered dose inhaler.
- at least two plastic spacers compatible with the inhaler.
- instructions on using the inhaler and spacer.
- instructions on cleaning and storing the inhaler.
- manufacturer's information.
- a checklist of inhalers, identified by their batch number and expiry date, with monthly.
- checks recorded.
- a note of the arrangements for replacing the inhaler and spacers (see below);
- a list of children permitted to use the emergency inhaler (see section 4) as detailed in their individual healthcare plans.
- a record of administration (i.e. when the inhaler has been used)

To avoid possible risk of cross-infection, the plastic spacer should not be reused. It can be given to the child to take home for future personal use.

Ongoing Maintenance/checks

- A monthly check that the inhaler and spacers are present, in working order with sufficient time before expiry and has sufficient number of doses available.
- Replacement spacers are available following use.

Plastic inhaler housing (which holds the canister) has been cleaned, dried and returned to storage following use, or that replacements are available if necessary.

The inhaler itself however can usually be reused, provided it is cleaned after use. The inhaler canister should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place The canister should be returned to the housing when it is dry, and the cap replaced, and the inhaler returned to the designated storage place.

However, if there is any risk of contamination with blood (for example if the inhaler has been used without a spacer), it should also not be re-used but disposed of.

Appendix 8: Template Documentation

Individual Healthcare Plan

Name of school/setting	
Child's name	
Group/class/form	
Date of birth	
Child s address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information	
Name	
Phone no. (work)	
(home)	
(mobile)	
Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	
Clinic/Hospital Contact	
Name	
Phone no.	

G.P.	

Name	
Phone no.	

Who is responsible for providing support in school	

Describe medical needs and give details of child s symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the pupil s educational, social and emotional needs

Arrangements for school visits/trips etc

Other information

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

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

Plan developed with

Staff training needed/undertaken – who, what, when

Form copied to

Parental Agreement for Setting to Administer Medicine

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

Date for review to be initiated by	
Name of school/setting	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine	
Name/type of medicine. *(as described on the container)*	
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	[agreed member of staff]

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

Signature(s) Date

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	
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			
Staff member witnessing			
Staff initials			

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

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

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

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

Record of Medicine Administered to an Individual Child

Name of school/setting	

Date	Child's name	Time	Name of Medicine	Dose given	Any reactions	Signature of staff

Staff Training Record – Administration of Medicines

Name of school/setting	
Name	
Type of training received	
Date of training completed	
Training provided by	
Profession and title	

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 [name of member of staff].

Trainer's signature		Date	

I confirm that I have received the training detailed above.

Staff signature		Date		Suggested review	

Contacting Emergency Services

Request an ambulance - dial 999, ask for an ambulance and be ready with the information below.

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

1. your telephone number.
2. your name
3. your location as follows [insert school/setting address]
4. state what the postcode is – please note that postcodes for satellite navigation systems may differ from the postal code
5. provide the exact location of the patient within the school setting
6. provide the name of the child and a brief description of their symptoms
7. inform Ambulance Control of the best entrance to use and state that the crew will be met and taken to the patient
8. put a completed copy of this form by the phone

Model Letter Inviting Parents to Contribute to Individual Healthcare Plan Development

Dear Parent
DEVELOPING AN INDIVIDUAL HEALTHCARE PLAN FOR YOUR CHILD

Thank you for informing us of your child s medical condition. I enclose a copy of the school s policy for supporting pupils at school with medical conditions for your information.

A central requirement of the policy is for an individual healthcare plan to be prepared, setting out what support each pupil needs and how this will be provided. Individual healthcare plans are developed in partnership between the school, parents, pupils, and the relevant healthcare professional who can advise on your child s case. The aim is to ensure that we know how to support your child effectively and to provide clarity about what needs to be done, when and by whom. Although individual healthcare plans are likely to be helpful in the majority of cases, it is possible that not all children will require one. We will need to make judgements about how your child s medical condition impacts on their ability to participate fully in school life, and the level of detail within plans will depend on the complexity of their condition and the degree of support needed.

A meeting to start the process of developing your child s individual health care plan has been scheduled for xx/xx/xx. I hope that this is convenient for you and would be grateful if you could confirm whether you are able to attend. The meeting will involve [the following people]. Please let us know if you would like us to invite another medical practitioner, healthcare professional or specialist and provide any other evidence you would like us to consider at the meeting as soon as possible.

If you are unable to attend, it would be helpful if you could complete the attached individual healthcare plan template and return it, together with any relevant evidence, for consideration at the meeting. I [or another member of staff involved in plan development or pupil support] would be happy for you contact me [them] by email or to speak by phone if this would be helpful.

Yours sincerely