MANAGING MEDICINES POLICY

Date
Ratified by Governors
Review Date

NOVEMBER 2008
NOVEMBER 2017
Byron Wood Academy is committed to reducing the barriers to sharing in school life and learning for all its pupils. This policy sets out the steps which the school will take to ensure full access to learning for all its children who have medical needs and are able to attend school.

N.B. Paragraph numbers refer to the DfES publication 'Managing Medicines in Schools and Early Years Settings':

1. Managing prescription medicines which need to be taken during the school day.
   1.1 Parents should provide full information about their child’s medical needs.
   
   1.2 Short-term prescription requirements should only be brought to school if it is detrimental to the child’s health not to have the medicine during the school day.  
   
   1.2 The school will not accept medicines that have been taken out of the container as originally dispensed, nor make changes to prescribed dosages.  
   
   1.3 The school will not administer medicines that have not been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber.
   
   1.4 Some medicines prescribed for children (e.g. methylphenidate, known as Ritalin) are controlled by the Misuse of Drugs Act. Members of staff may administer a controlled drug, in accordance with the prescriber’s instructions. Children may not legally have a prescribed controlled drug in their possession. The school will keep controlled drugs in a container in the school office, to which only named staff will have access. A record of access to the container will be kept. Misuse of a controlled drug is an offence, and will be dealt with under the school’s behaviour code.
   
   1.5 Medicines should always be provided in the original container as dispensed by a pharmacist and should include the prescriber’s instructions for administration. In all cases this should include:
   
   - Name of child
   - Name of medicine
   - Dose
   - Method of administration
   - Time/frequency of administration
   - Any side effects
   - Expiry date
   
   1.6 The school will refer to the DfES guidance document when dealing with any other particular issues relating to managing medicines.
2. Procedures for managing prescription medicines on trips and outings and during sporting activities

2.1 The school will consider what reasonable adjustments might be made to enable children with medical needs to participate fully and safely on visits. This may extend to reviewing and revising the visits policy and procedures so that planning arrangements incorporate the necessary steps to include children with medical needs. It might also incorporate risk assessments for such children.  

Paragraph 56

2.2 If staff are concerned about how they can best provide for a child’s safety or the safety of other children on a visit, they should seek parental views and medical advice from the school health service or the child’s GP. Please refer to the DfES guidance on planning educational visits.  

Paragraph 58

2.3.1 The school will support children wherever possible in participating in physical activities and extra-curricular sport. Any restriction on a child’s ability to participate in PE should be recorded on their Health Care Plan.  

Paragraph 60

2.4 Some children may need to take precautionary measures before or during exercise, and may need access, for example, to asthma inhalers. Staff supervising sporting activities will be made aware of relevant medical conditions, and will consider the need for a risk assessment to be made.  

Paragraph 61

2.5 The school will cooperate with the Local Authority in fulfilling its responsibilities regarding home to school transport. (See above). This may include giving advice regarding a child’s medical needs.  

Paragraph 64

3. The roles and responsibilities of staff managing administration of medicines, and for administering or supervising the administration of medicines

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

Annex A

3.2 It is important that responsibility for child safety is clearly defined and that each person responsible for a child with medical needs is aware of what is expected of them.  

3.3 The school will always take full account of temporary, supply and peripatetic staff when informing staff of arrangements for the administration of medicines.  

3.4 The school will always designate a minimum of two people to be responsible for the administering of medicine to a child.  

3.5 Medicines given to children in school are normally prescribed medication.
3.5.1. **PAIN RELIEF** Sometimes pupils may ask for pain relief (analgesics) at school e.g. paracetamol. Generally, school staff should not give non-prescribed medication to pupils. This is because they may not know whether the pupil has taken a previous dose or whether the medication may interact with other medication being taken. If the principal decides to allow the administration of pain relievers, parents must be notified and the following information given to parents:

- name of the analgesic and if this has been given to the child before
- the dose to be given
- the circumstances in which it is being given
- includes checking when previous doses have been taken / given
- includes obtaining parental permission (Written permission and then on the day via telephone to check whether any drugs were given that day and the dosage)
- adheres to the manufacturer’s instructions and warnings which accompany the product to be used
- Parents must be notified that paracetamol has been given to the child that day, the time and dosage by completing form 5 (see Annex)

In these rare cases, a child may be given the correct dosage of liquid paracetamol in the event of earache, headache or a slight temperature. Non-prescribed medication will normally be given under the supervision/direction of the Principal or Vice Principal.

Consideration should be given to the choice of analgesia. A child under 16 should never be given aspirin unless prescribed.

A parental consent form, renewed annually, must always be completed, and this form should confirm that the child has been given the stated medication without any adverse effect in the past.

The parent/carer should always be informed on the same day, when such medication has been given.

As with any medication, records must be kept of when pain relief has been administered and of the checks made.

If a child suffers from pain regularly the parents/carers should be encouraged to seek medical advice.

3.6 Any controlled drugs which have been prescribed for a child must be kept in safe custody.

3.7 If a child refuses to take medicine, staff will not force them to do so. Staff should record the incident and follow agreed procedures (which should be set out in the policy or the child’s Health Care Plan). Parents will be informed of the refusal on the same day. If refusal results in an emergency, the school’s normal emergency procedures will be followed. *(Paragraph 49)*

N.B. *The DfES guidance document gives a full description of roles and responsibilities Paragraphs 66 to 102.*
4. **Parental responsibilities in respect of their child’s medical needs**

4.1 It is the parents’ responsibility to provide the class teacher and the teaching team with sufficient information about their child’s medical needs if treatment or special care is needed.

4.2 Parents are expected to work with the Headteacher/Inclusion Manager to reach an agreement on the school’s role in supporting their child’s medical needs, in accordance with the school’s policy.

4.3 The school should have parental agreement before passing on information about their child’s health to other staff. Sharing information is important if staff and parents are to ensure the best care for a child.

4.4 If parents have difficulty understanding or supporting their child’s medical condition themselves, they should be encouraged to contact either the school nurse or the health visitor, as appropriate.

4.5 It is the parents’ responsibility to keep their children at home when they are acutely unwell.  

4.6 It requires only one parent/carer to agree to or request that medicines are administered to a child. It is likely that this will be the parent with whom the school has day-to-day contact.

4.7 Prior written agreement should be obtained from parents/carers for any medicines to be given to a child. (See specimen forms in Appendix A.)

5. **Assisting children with long-term or complex medical needs**

Where there are long-term medical needs for a child, a Health Care Plan should be completed, using Form 2, involving both parents and relevant health professionals.

5.1 A Health Care Plan clarifies for staff, parents and the child the help that can be provided. It is important for staff to be guided by the child’s GP or paediatrician or specialist nurse.

5.2 The school will agree with parents how often they should jointly review the health care plan. It is sensible to do this at least once a year, but much depends on the nature of the child’s particular needs; some would need reviewing more frequently.

5.3 The school will judge each child’s needs individually as children and young people vary in their ability to cope with poor health or a particular medical condition. Plans will also take into account a pupil’s age and need to take personal responsibility.
5.4 Developing a Health Care Plan should not be onerous, although each plan will contain different levels of detail according to the needs of the individual child.  

Paragraph 121

5.5 In addition to input from the school health service, the child’s GP or other health care professionals depending on the level of support the child needs, those who may need to contribute to a health care pro forma include the:

- Headteacher/Inclusion Manager
- Parent or carer
- Child (if appropriate)
- Early Years Practitioner/Class Teacher
- Support staff
- Staff who are trained to administer medicines
- Staff who are trained in emergency procedures

Paragraph 122

5.6 The school will consult the DfES publication 'Managing Medicines in Schools and Early Years Settings' when dealing with the needs of children with the following common conditions:

- Asthma
- Epilepsy
- Diabetes
- Anaphylaxis

Paragraphs 131–193

6.0 Policy on children carrying and taking their prescribed medicines themselves

An example of this would be a child with **asthma** using an inhaler.

6.1 It is good practice to support and encourage pupils, who are able, to take responsibility to manage their own medicines.  

Paragraph 45

6.2 There is no set age when a child or young person can take responsibility for their own medication. This needs to be a joint decision between school, parents/carers and the pupil. Please refer to Form 7.  

Paragraph 46

6.3 Where pupils have been prescribed controlled drugs, these must be kept in safe custody. Pupils could access them for self-medication if it was agreed that this was appropriate.  

Paragraph 48

7 Staff support and training in dealing with medical needs

7.1 The school will ensure that staff receives proper support and training where necessary; in line with the contractual duty on Headteachers to ensure that their staff receive the training. The Headteacher/Inclusion Manager will agree when and how such training takes place, in their capacity as a line manager. The head of the school or setting will make sure that all staff and parents are
aware of the policy and procedures for dealing with medical needs.  
(Paragraph 83)

7.2 Staff who have a child with medical needs in their class or group will be informed about the nature of the condition, and when and where the child may need extra attention.

7.3 The child’s parents and health professionals should provide the information specified above.

7.4 All staff should be aware of the likelihood of an emergency arising and what action to take if one occurs.

7.5 Back up cover should be arranged for when the member of staff responsible is absent or unavailable.

7.6 At different times of the day other staff, such as lunchtime supervisors, may be responsible for children. They will also be provided with training and advice.

7.7 The school will ensure that there are sufficient members of support staff who manage medicines as part of their duties. This includes the specification of such duties in their job description and participation in appropriate training.

7.9 Any member of staff who agrees to accept responsibility for administering prescribed medicines to a child will have appropriate training and guidance. They will also be made aware of possible side effects of the medicines, and what to do if they occur. The type of training necessary will depend on the individual case.

7.10 Teachers’ conditions of employment do not include giving or supervising a pupil taking medicines. Agreement to do so must be voluntary.

8 Record keeping

8.1 Parents should tell the school or setting about the medicines that their child needs to take and provide details of any changes to the prescription or the support required. However the school will make sure that this information is the same as that provided by the prescriber. Any change in prescription should be supported by either new directions on the packaging of medication or by a supporting letter from a medical professional.  
(Paragraph 50)

8.2 The school will use Form 3A to record short-term administration of medication. Consent forms should be delivered personally by the consenting parent/carer.

8.3 The school will use Form 3B to record long-term administration of medication. Consent forms should be delivered personally by the consenting parent/carer.
8.4 It is the parent/carer’s responsibility to monitor when further supplies of medication are needed in the school. It is not the school’s responsibility.

8.5 Form 4 should be used to confirm, with the parents, that a member of staff will administer medicine to their child.  

8.6 All early years settings must keep written records of all medicines administered to children, and make sure that parents sign the record book to acknowledge the entry. This setting will do so.

8.7 Although there is no similar legal requirement for schools to keep records of medicines given to pupils, and the staff involved, it is good practice to do so. Records offer protection to staff and proof that they have followed agreed procedures. Some schools keep a logbook for this. Forms 5 and 6 provide example record sheets. This school will/will not keep a logbook of medicines given.

9. Safe storage of medicines

9.1 The school will only store, supervise and administer medicine that has been prescribed for an individual child.

9.2 Medicines will be stored strictly in accordance with product instructions - paying particular note to temperature and in the original container in which dispensed.

9.3 Staff will ensure that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine and the frequency of administration.

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

9.5 Non-healthcare staff will never transfer medicines from their original containers.

9.6 Children will be informed where their own medicines are stored.

9.7 All emergency medicines, such as asthma inhalers and adrenaline pens, will be readily available to children and will not be locked away.

9.8 Schools may allow children to carry their own inhalers. This school will do so for pupils who it is felt are responsible enough in Key Stage 2.

9.9 Other non-emergency medicines will be kept in a secure place not accessible to children.

9.10 A few medicines need to be refrigerated. They will be kept in a refrigerator containing food but will be in an airtight container and clearly labelled. There will be restricted access to a refrigerator holding medicines.
9.11 **Access to Medicines** - Children need to have immediate access to their medicines when required. The school will make special access arrangements for emergency medicines that it keeps. However, it is also important to make sure that medicines are kept securely and only accessible to those for whom they are prescribed. This will be considered as part of the policy about children carrying their own medicines.  

*Paragraph 111*

10. **Disposal of Medicines**

10.1 The school will not dispose of medicines. Parents are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal.

10.2 Parents should also collect medicines held at the end of each term. If parents do not collect all medicines, they will be taken to a local pharmacy for safe disposal.  

*Paragraph 112*

10.3 Sharps boxes will always be used for the disposal of needles. Collection and disposal of the boxes will be arranged with the Local Authority.  

*Paragraph 113*

11. **Hygiene and Infection Control**

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

11.2 Staff will have access to protective disposable gloves and will take care when dealing with spillages of blood or other body fluids, and disposing of dressings or equipment.

11.3 OfSTED guidance provides an extensive list of issues that early years providers should consider in making sure settings are hygienic.  

*Paragraph 114*

12. **Access to the school's emergency procedures**

12.1 As part of general risk management processes the school will have arrangements in place for dealing with emergency situations. [This could be part of the school's first aid policy and provision. See DfES Guidance on First Aid for Schools: a good practice guide, 1998]

12.2 Other children should know what to do in the event of an emergency, such as telling a member of staff.

12.3 All staff should know how to call the emergency services. Guidance on calling an ambulance is provided in Form 1.

12.4 All staff should also know who is responsible for carrying out emergency procedures in the event of need.
12.5 A member of staff will always accompany a child taken to hospital by ambulance, and will stay until the parent arrives.

12.6 Health professionals are responsible for any decisions on medical treatment when parents are not available. \( \text{Paragraph 115} \)

12.7 Staff should never take children to hospital in their own car; it is safer to call an ambulance. \( \text{Paragraph 116} \)

12.8 The national standards require early years settings to ensure that contingency arrangements are in place to cover such emergencies. \( \text{Paragraph 116} \)

12.9 Individual Health Care Plans will include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency. Those with responsibility at different times of day (e.g. lunchtime supervisor) will need to be very clear of their role. \( \text{Paragraph 117} \)

13. **Risk assessment and management procedures**

This policy will operate within the context of the school’s Health and Safety Policy.

13.1 The school will ensure that risks to the health of others are properly controlled.

13.2 The school will provide, where necessary, individual risk assessments for pupils or groups with medical needs.

13.3 The school will be aware of the health and safety issues relating to dangerous substances and infection.
ANNEX:

FORMS

Form 1: Contacting Emergency Services
Form 2: Health Care Plan
Form 3A: Parental agreement for school/setting to administer medicine
Form 3B: Parental agreement for school/setting to administer medicine
Form 4: Headteacher/Head of setting agreement to administer medicine
Form 5: Record of medicine administered to an individual child
Form 6: Record of medicines administered to all children
Form 7: Request for child to carry his/her own medicine
Form 8: Staff training record – administration of medicines
Form 9: Authorisation for the administration of rectal diazepam
FORM 1

Contacting Emergency Services

Request for an Ambulance

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

1. Your telephone number
   0114 272 3624

2. Give your location as follows
   Byron Wood Academy, Earldom Road

3. State that the postcode is
   S4 7EJ

4. Give exact location in the school
   [insert brief description]

5. Give your name

6. Give name of child and a brief description of child’s symptoms

7. Inform Ambulance Control of the best entrance and state that the crew will be met and taken to

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

Put a completed copy of this form by the telephone
**FORM 2**

**Health Care Plan**

<table>
<thead>
<tr>
<th>Name of school/setting</th>
<th>Byron Wood Academy</th>
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<tbody>
<tr>
<td>Child’s name</td>
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<tr>
<td>Group/class/form</td>
<td></td>
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<tr>
<td>Date of birth</td>
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<tr>
<td>Child’s address</td>
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<td>Medical diagnosis or condition</td>
<td></td>
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<tr>
<td>Date</td>
<td>/ /</td>
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<tr>
<td>Review date</td>
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</table>

**Family Contact Information**

| Name                        |                    |
|                            |                    |
| Phone no. (work)            |                    |
| (home)                     |                    |
| (mobile)                   |                    |

| Name                        |                    |
|                            |                    |
| Phone no. (work)            |                    |
| (home)                     |                    |
| (mobile)                   |                    |

**Clinic/Hospital Contact**

| Name                        |                    |
|                            |                    |
| Phone no.                   |                    |

**G.P.**

| Name                        |                    |
|                            |                    |
| Phone no.                   |                    |
Describe medical needs and give details of child's symptoms

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

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

Follow up care

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

Form copied to
**FORM 3A**

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

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

<table>
<thead>
<tr>
<th>Name of school</th>
<th>Byron Wood Academy</th>
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<tbody>
<tr>
<td>Name of child</td>
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<td>Date of birth</td>
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<td>Group/class/form</td>
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<tr>
<td>Medical condition or illness</td>
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**Medicine**

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<tr>
<th>Name/type of medicine (as described on the container)</th>
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<td>Date dispensed</td>
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<tr>
<td>Expiry date</td>
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<tr>
<td>Agreed review date to be initiated by:</td>
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<tr>
<td>Dosage and method</td>
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<tr>
<td>Timing</td>
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<td>Special precautions</td>
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<thead>
<tr>
<th>Are there any side effects that the school/setting needs to know about?</th>
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<tr>
<td>Self administration</td>
<td></td>
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<tr>
<td>Procedures to take in an emergency</td>
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**Contact Details**

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<tr>
<th>Name</th>
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<tr>
<td>Daytime telephone no.</td>
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<tr>
<td>Relationship to child</td>
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<tr>
<td>Address</td>
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I understand that I must deliver the medicine personally to:

I accept that this is a service that the school/setting is not obliged to undertake.
I understand that I must notify the school/setting of any changes in writing.

Date Signature(s)
FORM 3B

Parental agreement for Byron Wood Academy to administer medicine

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

Name of school
Byron Wood Academy

Date
/
/

Child’s name

Group/class/form

Name and strength of medicine

Expire date
/
/

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

When to be given

Any other instructions

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

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

Daytime phone no. of parent or adult contact

Name and phone no. of GP

Agreed review date to be initiated by:

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

Parent’s signature ________________________________

Print name ________________________________

Date ________________________________

If more than one medicine is to be given a separate form should be completed for each one.
FORM 4

Head teacher

Name of school

Byron Wood Academy

It is agreed that ______________________ will receive __________________ every day at ____________

______________________________ will be supervised whilst he/she takes their medication by

________________________________________

This arrangement will continue until otherwise instructed by parents/ medical staff

Date __________________________

Signed ____________________________

(Head teacher)
# Record of medicine administered to an individual child

| Name of school/ | Byron Wood Academy |
| 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 | |

<p>| Date | / / |
| Time given | |
| Dose given | |
| Name of member of staff | |
| Staff initials | |</p>
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<td>Staff initials</td>
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# Form 6

## Record of medicines administered to all children

**Name of school**: Byron Wood Academy

<table>
<thead>
<tr>
<th>Date</th>
<th>Child’s name</th>
<th>Time</th>
<th>Name of medicine</th>
<th>Dose given</th>
<th>Any reactions</th>
<th>Signature of staff</th>
<th>Print name</th>
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FORM 7

Request for child to carry his/her own medicine  e.g. Inhalers

This form must be completed by parents/guardian

If staff have any concerns discuss this request with healthcare professionals

<table>
<thead>
<tr>
<th>Name of school</th>
<th>Byron Wood Academy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child's name</td>
<td></td>
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<tr>
<td>Group/class/form</td>
<td></td>
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<tr>
<td>Address</td>
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<tr>
<td>Name of medicine</td>
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<tr>
<td>Procedures to be taken in an emergency</td>
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</table>

**Contact Information**

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
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<tbody>
<tr>
<td>Daytime phone no.</td>
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<tr>
<td>Relationship to child</td>
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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
**FORM 8**

**Staff training record – administration of medicines**

<table>
<thead>
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<th>Name of school</th>
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<tbody>
<tr>
<td>Name</td>
<td></td>
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<tr>
<td>Type of training received</td>
<td></td>
</tr>
<tr>
<td>Date of training completed</td>
<td>/ /</td>
</tr>
<tr>
<td>Training provided by</td>
<td></td>
</tr>
<tr>
<td>Profession and title</td>
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</tbody>
</table>

I confirm that ____________________ has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated __________________________

Trainer's signature __________________________

Date __________________________

I confirm that I have received the training detailed above.

Staff signature __________________________

Date __________________________

Suggested review date __________________________
**FORM 9**

**Authorisation for the administration of rectal diazepam**

<table>
<thead>
<tr>
<th>Name of school</th>
<th>Byron Wood Academy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s name</td>
<td></td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
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<tr>
<td>Home address</td>
<td></td>
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<tr>
<td>G.P.</td>
<td></td>
</tr>
<tr>
<td>Hospital consultant</td>
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</tbody>
</table>

should be given Rectal Diazepam \( \text{mg.} \)

If s/he has a *prolonged epileptic seizure lasting over \( \text{minutes} \)

**OR**

*serial seizures lasting over \( \text{minutes} \). An Ambulance should be called for *

OR

If the seizure has not resolved *after \( \text{minutes} \). 

(*please enter as appropriate)

Doctor’s signature

Parent’s signature

Date
NB: Authorisation for the administration of rectal diazepam

As the indications of when to administer the diazepam vary, an individual authorisation is required for each child. This should be completed by the child’s GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state:

- when the diazepam is to be given e.g. after 5 minutes; and
- how much medicine should be given.

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

Records of administration should be maintained using Form 5 or similar
Common Conditions – Practical Advice on Asthma, Epilepsy, Diabetes and Anaphylaxis

Introduction

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

132. Further information, including advice specifically for schools and settings, is available from leading charities listed in Annex D.

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

ASTHMA

What is Asthma?

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

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

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

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

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

139. Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child’s name. Inhalers should always be available during physical education, sports activities and educational visits.

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

141. The signs of an asthma attack include:

142. When a child has an attack they should be treated according to their individual health care plan or asthma card as previously agreed. An ambulance should be called if:

143. It is important to agree with parents of children with asthma how to recognise when their child’s asthma gets worse and what action will be taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child’s asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child’s doctor.

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

145. Children with asthma should participate in all aspects of the school or setting ‘day’ including physical activities. They need to take their reliever inhaler with them on all off-site activities. Physical activity benefits children with asthma in the same way as other children. Swimming is particularly beneficial, although endurance work should be avoided. Some children may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.
coughing being short of breath wheezy breathing feeling of tight chest being unusually quiet the symptoms do not improve sufficiently in 5-10 minutes the child is too breathless to speak the child is becoming exhausted the child looks blue

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

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

148. All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and medical needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK). The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

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

**EPILEPSY**

**What is Epilepsy?**

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

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

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset) any unusual ‘feelings’ reported by the child prior to the seizure parts of the body demonstrating seizure activity e.g. limbs or facial muscles the timing of the seizure – when it happened
and how long it lasted whether the child lost consciousness whether the child was incontinent
This will help parents to give more accurate information on seizures and seizure frequency to the child’s specialist.

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

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

154. 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.

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

**Medicine and Control**

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

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

158. Children with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child and parents as part of the health care plan. During a seizure it is important to make sure the child is in a safe position, not to restrict a child’s movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under the child’s head
will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child should be placed in the recovery position and stayed with, until they are fully recovered.

159. An ambulance should be called during a convulsive seizure if:

it is the child’s first seizure the child has injured themselves badly they have problems breathing after a seizure a seizure lasts longer than the period set out in the child’s health care plan a seizure lasts for five minutes if you do not know how long they usually last for that child there are repeated seizures, unless this is usual for the child as set out in the child’s health care plan

160. Such information should be an integral part of the school or setting’s emergency procedures as discussed at paragraphs 115-117 but also relate specifically to the child’s individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

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

162. Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal diazepam. Instructions for use must come from the prescribing doctor. For more information on administration of rectal diazepam, see Form 9.

163. Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being provided.

**DIABETES**

**What is Diabetes?**

164. Diabetes is a condition where the level of glucose in the blood rises. This is either due to the lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child’s needs or the insulin is not working properly (Type 2 diabetes).
165. About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

166. Each child may experience different symptoms and this should be discussed when drawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents’ attention.

**Medicine and Control**

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

168. Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long-acting insulin at home, usually at bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten. They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this type of regime when they were confident that the child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

169. Children with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school lunch break, before PE or more regularly if their insulin needs adjusting. Most older children will be able to do this themselves and will simply need a suitable place to do so. However younger children may need adult supervision to carry out the test and/or interpret test results.

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

171. 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. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.
172. Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar – a hypoglycaemic reaction (hypo) in a child with diabetes:

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

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

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

175. An ambulance should be called if: the child’s recovery takes longer than 10-15 minutes he child becomes unconscious

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

177. Such information should be an integral part of the school or setting’s emergency procedures as discussed at paragraphs 115-117 but also relate specifically to the child’s individual health care plan.

**ANAPHYLAXIS**

**What is anaphylaxis?**

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

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

180. The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply, or severe asthma. Any symptoms affecting the breathing are serious.
181. Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

**Medicine and Control**

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

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

184. Staff that volunteer to be trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer’s instructions, are a well-understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child’s leg. In cases of doubt it is better to give the injection than to hold back.

185. The decision on how many adrenaline devices the school or setting should hold, and where to store them, has to be decided on an individual basis between the head, the child’s parents and medical staff involved.

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

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

188. Important issues specific to anaphylaxis to be covered include:
- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

**See paragraph 47**
189. Once staff have agreed to administer medicine to an allergic child in an emergency, a training session will need to be provided by local health services. Staff should have the opportunity to practice with trainer injection devices.

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

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

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

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