



<b>Policy Title</b>	Medical Treatment of Students Policy
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#### **Revisions Table**

<b>Version</b>	<b>Date</b>	<b>Edited by</b>	<b>Description of Change</b>
Summer 2018	Summer 2018	Simon Kellie	Following items were amended: 1.3 2.3, 2.4 6.1.2 7.4.2 8.8.4 9.6 10.2.4

The master copy of this document can be found on the FBS Google Drive, under the “Policies” folder. This is one of a number of policies that are reviewed by the Governing Body, the full list can be found on the FBS Google Drive in the Policies Folder. Minor revisions that just adjust factual items (eg contact details / names) can be made by the author without formal review, and must be recorded in the Revisions table above. Revisions table front sheet was added to all policies during policy review of Summer 2018.



# THE FULHAM BOYS SCHOOL

## MEDICAL TREATMENT OF STUDENTS POLICY

**Date of Next Review: Summer 2019**

### 1. INTRODUCTION

1.1 The Fulham Boys School recognises the need for a clear policy understood and accepted by staff, parents and boys that provides a sound basis for ensuring that boys with medical needs receive proper care and support in school.

1.2 This policy is based upon the legislation in:

- 1.2.1 The SEN and Disability Act 2001
- 1.2.2 The Health and Safety at Work etc Act 1974
- 1.2.3 The Management of Health and Safety at Work Regulations 1999
- 1.2.4 Control of Substances Hazardous to Health Regulations 2002
- 1.2.5 The Misuse of Drugs Act 1971 and associated regulations
- 1.2.6 The Medicines Act 1968
- 1.2.7 The Education (School Premises) Regulations 1999
- 1.2.8 The Education (Independent Schools Standards)(England) Regulations 2003
- 1.2.9 The Special Education Needs – Education Act 1996
- 1.2.10 The Care Standards Act 2000

1.3 We believe boys with medical needs have the same rights of admission to our school as other boys.

1.4 This policy aims to enable regular attendance.

1.5 Formal systems and procedures in respect of administering medicines, developed in partnership with parents and staff back up the policy.

1.6 This policy deals with:

- 1.6.1 procedures for managing prescription medicines which need to be taken during the school day
- 1.6.2 procedures for managing prescription medicines on trips and outings
- 1.6.3 the roles and responsibility of staff managing administration of medicines, and for administering or supervising the administration of medicines
- 1.6.4 parental responsibilities in respect of their son's medical needs
- 1.6.5 the need for prior written agreement from parents for any medicines to be given to a child
- 1.6.6 the circumstances in which boys may take any non-prescription medicines

- 1.6.7 the school or setting policy on assisting children with long- term or complex medical needs
- 1.6.8 boys carrying and taking their medicines themselves
- 1.6.9 staff training in managing medicines safely and supporting an identified individual child
- 1.6.10 record keeping
- 1.6.11 safe storage of medicines
- 1.6.12 access to the school's emergency procedures

## **2. PRESCRIBED MEDICINES**

- 2.1 Medicines should only be brought to school or settings when essential; that is where it would be detrimental to a boy's health if the medicine were not administered during the school day.
- 2.2 We will only accept medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber.
- 2.3 Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions for administration and dosage or parental consent provided to the school along with written instructions on how students should take medicines.
- 2.4 Where clinically appropriate and practically possible, medicines that are prescribed in dose frequencies should be taken outside school hours. Parents are encouraged to ask the prescriber about this. It is to be noted that medicines that need to be taken three times a day could be taken in the morning, after school hours and at bedtime.

## **3. CONTROLLED DRUGS**

- 3.1 The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated regulations. Some may be prescribed as medicine for use by children, e.g. methylphenidate.
- 3.2 Any member of staff that is First Aid trained may administer a controlled drug to the boy for whom it has been prescribed and should do so in accordance with the prescriber's instructions.
- 3.3 A boy who has been prescribed a controlled drug may legally have it in their possession but we agree to look after a controlled drug, where it is agreed that it will be administered to the boy for whom it has been prescribed.
- 3.4 We will always keep controlled drugs in a locked non-portable container and only named staff will have access.
- 3.5 We will keep a record for audit and safety purposes (see Appendix 4)
- 3.6 A controlled drug, as with all medicines, will be returned to the parent when no longer required

3.7 Misuse of a controlled drug, such as passing it to another child for use, is an offence (see Drug Misuse policy).

#### **4. NON-PRESCRIPTION MEDICINES**

4.1 Staff should **never** give a non-prescribed medicine to a boy unless there is specific prior written permission from the parents.

4.2 Staff should check that the medicine has been administered without adverse effect to the child in the past and that parents have certified this is the case – a note to this effect should be recorded in the written parental agreement for the school to administer medicine (see Appendix 3)

4.3 **A child under 16 should never be given aspirin-containing medicine unless prescribed by a doctor.**

#### **5. MEDICAL NEEDS**

5.1 We acknowledge that most boys will at some time have short term medical needs, perhaps entailing finishing a course of medicine such as antibiotics.

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

5.3 Some boys however have longer term medical needs and may require medicines on a long-term basis to keep them well, for example children with well-controlled epilepsy or cystic fibrosis.

5.4 At FBS we believe it is important to have sufficient information about the medical condition of any boy with long-term medical needs before he is admitted, or when he first develops a medical need.

5.5 For boys who attend hospital appointments on a regular basis, special arrangements may also be necessary.

5.6 We will develop a written health care plan for such boys, involving the parents and relevant health professionals (see Appendix 2)

#### **6. ADMINISTERING MEDICINES**

##### **6.1 By Staff**

6.1.1 No boy under 16 should be given medicines without their parent's written consent.

6.1.2 Only members of staff trained in First Aid should administer medicines to students and when doing so should check:

The boy's name

Prescribed dose

Expiry date

Written instructions by the prescriber on the label container

- 6.1.3 If in doubt about any procedure staff should not administer the medicines but check with the parents or a health professional before taking further action.
- 6.1.4 Staff will complete and sign a record each time they give medicine to a boy (see appendix 4)

### **6.2 Self-Management**

- 6.2.1 We will support and encourage boys, who are able, to take responsibility to manage their own medicines, especially those with long term illness (see Appendix 5).
- 6.2.2 Where boys have been prescribed controlled drugs staff need to be aware that these should be kept in safe custody. However children could access them for self-medication if it is agreed that it is appropriate.

### **6.3 Refusing Medicines**

- 6.3.1 If a boy refuses to take medicine, staff should not force them to do so, but should note this in the records and follow agreed procedures.
- 6.3.2 Parents will be informed of the refusal on the same day.
- 6.3.3 If a refusal to take medicines results in an emergency, the school's emergency procedures should be followed (see Emergency Procedures policy).

## **7. SAFETY**

### **7.1 Storing Medicines**

- 7.1.1 Boys need to have immediate access to their medicines when required.
- 7.1.2 It is also important to make sure that medicines are only accessible to those for whom they are prescribed.
- 7.1.3 Large volumes of medicines should not be stored.
- 7.1.4 Staff should only store, supervise and administer medicine that has been prescribed for an individual child.
- 7.1.5 Medicines should be stored strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed.
- 7.1.6 Boys should know where their own medicines are stored and who holds the key.
- 7.1.7 All emergency medicines, such as asthma inhalers and adrenaline pens will not be locked away but be readily available to the boys who need them. We will allow boys to carry their own inhalers.
- 7.1.8 Other non-emergency medicines will be kept in a secure place not accessible to boys.
- 7.1.9 Some medicines need to be refrigerated. They can be kept in a refrigerator containing food but should be in an airtight container and clearly labelled. There should be restricted access to a refrigerator holding medicines.

### **7.2 Disposing medicines**

- 7.2.1 Staff should not dispose of medicines.
- 7.2.2 Parents are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal.
- 7.2.3 If parents do not collect all medicines, they should be taken to a local pharmacy for safe disposal.
- 7.2.4 Sharps boxes would always be used for the disposal of needles and we would arrange collection with local environmental services if necessary.

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

- 7.3.1 All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures. Where students present with symptoms consistent with vomiting and /or diarrhoea school will make efforts to isolate the student concerned in the Medical Room and where possible ask parents to collect students and take them home.
- 7.3.2 Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment.

### **7.4 Emergency Procedures**

- 7.4.1 Other boys should know what to do in the event of an emergency, such as telling a member of staff.
- 7.4.2 All staff that spend time on school reception desks should know how to call the emergency services. (Guidance on calling an ambulance is provided in Appendix 1 and this information is displayed in both school reception areas).
- 7.4.3 All staff should also know who is responsible for carrying out emergency procedures in the event of need. The designated staff member is the Headmaster
- 7.4.4 A member of staff should always accompany a boy taken to hospital by ambulance, and should stay until the parent arrives.
- 7.4.5 Health professionals are responsible for any decisions on medical treatment when parents are not available.

## **8. EDUCATIONAL VISITS**

- 8.1 FBS will encourage boys with medical needs to participate in safely managed visits.
- 8.2 We will do what we can to include the necessary steps to include children with medical needs. It might also include risk assessments for such children (see Offsite and Residential policy).
- 8.3 Sometimes additional safety measures may need to be taken for outside visits. It may be that an additional supervisor, a parent or another volunteer might be needed to accompany a particular boy.
- 8.4 Arrangements for taking any necessary medicines will also need to be taken into consideration.
- 8.5 Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures.
- 8.6 A copy of any health care plans should be taken on visits in the event of the information being needed in an emergency.
- 8.7 If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek parental views and medical advice from the school health service or the child's GP.
- 8.8 School trips abroad:
  - 8.8.1 It is important to acknowledge that the position with regard to consent to medical treatment may be different in other countries.

- 8.8.2 The group leader of the trip should know and understand how to contact the emergency services in the country concerned as part of the planning process for the trip.
- 8.8.3 Parents should be warned that medics in some countries could *refuse to offer lifesaving treatment*, if they are made aware that the parents do not consent to such treatment; equally they may administer treatment *even if consent has not been given*.
- 8.8.4 Prior to a school trip, parents will be asked to provide the school with information on any medical conditions their son has or medication they may currently be taking.
- 8.8.5 If a parent does not agree to the provision of certain treatment or procedures, it would be advisable for the school to draw up an agreed medical emergency plan with the parent prior to the trip abroad. The plan should make clear that the school's position is non-negotiable.
- 8.8.6 If parents do not agree to this, the Headmaster may decide to withdraw the boy from the visit, given the additional responsibility this would entail for the group leader

## **9. SPORTING ACTIVITIES**

- 9.1 We expect most boys with medical conditions to participate in physical activities and co-curricular sport.
- 9.2 We believe that for many, physical activity can benefit their overall social, mental and physical health and well-being.
- 9.3 Any restrictions on a boy's ability to participate in PE will be recorded in their individual health care plan. A health care plan is provided if necessary/appropriate to a boy's need.
- 9.4 All adults should be aware of issues of privacy and dignity for boys with particular needs.
- 9.5 Some boys may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their medicines such as asthma inhalers.
- 9.6 Staff supervising sporting activities should consider whether risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative medicine that may need to be taken and emergency procedures. When sports staff take students off The Fulham Boys School site during the school week they will ensure that they will take with them any relevant preventative medicine for students under their care.

## **10. RESPONSIBILITIES**

### **10.1 *Parents/Carers***

- 10.1.1 Parents have the prime responsibility for their son's health and should provide the school with information about their son's medical condition including details on medicines their son needs.
- 10.1.2 Parents, and the boy if appropriate, should obtain details from their son's General Practitioner (GP) or paediatrician, if needed.
- 10.1.3 It only requires one parent to agree to or request that medicines are administered. Where parents disagree over medical support, the disagreement must be resolved by the Courts. We will continue to administer the medicine in line with the consent given

and in accordance with the prescriber's instructions, unless and until a Court decides otherwise.

## **10.2            *The School***

- 10.2.1 FBS understands its legal duty to support boys with complex health needs
- 10.2.2 The Governing Body has overall responsibility for this policy
- 10.2.3 The Headmaster is responsible for putting this policy into practice
- 10.2.4 In the event of legal action over an allegation of negligence the employer, rather than the employee, is likely to be held responsible. We have taken out Employers Liability Insurance
- 10.2.5 Anyone caring for children including teachers, other school staff and day care staff in charge of children have a common law duty of care to act like any reasonably prudent parent. Staff need to make sure that children are healthy and safe. In exceptional circumstances the duty of care could extend to administering medicine and/or taking action in an emergency. This duty also extends to staff leading activities taking place off site, such as visits, outings or field trips.
- 10.2.6 We believe, therefore, the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.
- 10.2.7 We will ensure that staff have appropriate knowledge and training to support boys with medical needs (see Appendix 6 for practical guidance on dealing with common conditions). The type of training will depend on individual needs
- 10.2.8 We will ensure that there are appropriate systems for sharing information about children's medical needs
- 10.2.9 The head and staff will always treat medical information confidentially





## Appendix 2 –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

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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

### Appendix 3



#### Parental Agreement for the Fulham Boys School to administer medicine

The school 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/setting	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

#### Medicine

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

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

#### Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[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 \_\_\_\_\_



## **Appendix 5**

### **Request for a boy to carry his medicine**

**THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN**

**If staff have any concerns discuss request with school healthcare professionals**

Name of School/Setting:

Boy's Name:

Form/House:

Address:

Name of Medicine:

Procedures to be taken in an emergency:

### **Contact Information**

Name:

Daytime Phone No:

Relationship to boy:

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

Signed:

Date:

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

## Appendix 6

### Common Medical Conditions

#### ASTHMA

##### What is Asthma?

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

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

However 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

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

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

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.

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

The signs of an asthma attack include:

- coughing
- being short of breath

- wheezy breathing
- feeling of tight chest
- being unusually quiet

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

- the symptoms do not improve sufficiently in 5-10 minutes
- the child is too breathless to speak
- the child is becoming exhausted
- the child looks blue

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. 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.

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

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

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

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

The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

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?

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

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children experience. Parents and health care professionals should provide information to 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
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This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

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

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

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

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such absence

seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

### **Medicine and Control**

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

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

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

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

An ambulance should be called during a convulsive seizure if:

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

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

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intranasally, 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.

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.

## **DIABETES**

### **What is Diabetes?**

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

About one in 550 school-age children have diabetes. The majority of children have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

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

### **Medicine and Control**

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

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

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

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

Children with diabetes need to be allowed to eat regularly during the day.

This may include eating snacks during class-time or prior to exercise. 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.

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

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

An ambulance should be called if:

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

the child becomes unconscious

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

## **ANAPHYLAXIS**

### **What is anaphylaxis?**

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

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

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

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

### **Medicine and Control**

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

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

Staff 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.

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

Where children are considered to be sufficiently responsible to carry their emergency treatment 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.

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

Important issues specific to anaphylaxis to be covered include:

- anaphylaxis – what may trigger it
- what to do in an emergency
- prescribed medicine
- food management
- precautionary measures

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

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

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

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

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