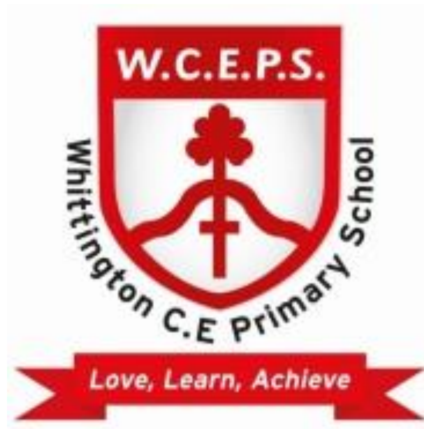


MANAGEMENT OF MEDICAL CONDITIONS POLICY

Reviewed: May 2019

Adopted by the Governing Body: 20th June 2019
Review due: Summer Term 2021

MANAGEMENT OF MEDICAL CONDITIONS POLICY

Children with Medical Needs

Children with medical needs have the same rights of admission to a school or setting as other children. Most children will at some time have short-term medical needs, perhaps entailing finishing a course of medicine such as antibiotics. Some children 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.

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

Most children with medical needs are able to attend school regularly and can take part in normal activities, sometimes with some support. However, staff may need to take extra care in supervising some activities to make sure that these children, and others, are not put at risk.

An individual health care plan can help staff identify the necessary safety measures to support children with medical needs and ensure that they and others are not put at risk.

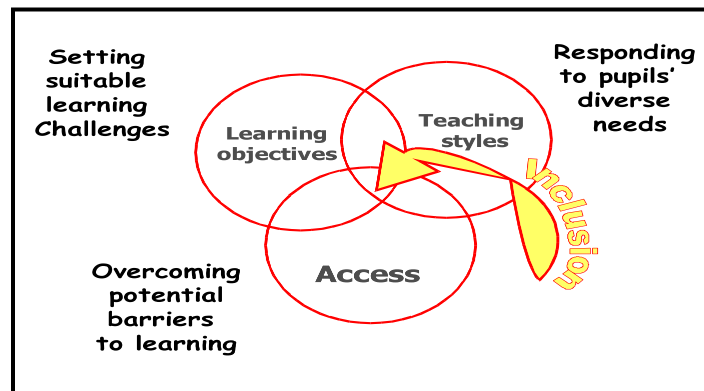
Access to Education and Associated Services

Some children with medical needs are protected from discrimination under the Disability Discrimination Act (DDA) 1995. The DDA defines a person as having a disability if he has a physical or mental impairment which has a substantial and long-term adverse effect on his abilities to carry out normal day to day activities.

Under Part 4 of the DDA, responsible bodies for schools (including nursery schools) must not discriminate against disabled pupils in relation to their access to education and associated services – a broad term that covers all aspects of school life including school trips and school clubs and activities. Schools should be making reasonable adjustments for disabled children including those with medical needs at different levels of school life; and for the individual disabled child in their practices and procedures and in their policies.

Schools are also under a duty to plan strategically to increase access, over time to schools. This should include planning in anticipation of the admission of a disabled pupil with medical needs so that they can access the school premises, the curriculum and the provision of written materials in alternative formats to ensure accessibility.

The National Curriculum Inclusion Statement 2000 emphasises the importance of providing effective learning opportunities for all pupils and offers three key principles for inclusion:



Support for Children with Medical Needs

Parents have the prime responsibility for their child's health and should provide the school with full information about their child's medical condition/needs. Parents should obtain details from their child's General Practitioner (GP) or paediatrician, if needed, including details on medicines their child needs. The school doctor or nurse or a health visitor and specialist voluntary bodies may also be able to provide additional background information for staff.

The school health service can provide advice on health issues to children, parents, education and early years staff, education officers and Local Authorities. NHS Primary Care Trusts (PCTs) and NHS Trusts, Local Authorities, Early Years Development and Childcare Partnerships and the governing body should work together to make sure that children with medical needs and the school and setting staff have effective support.

Staff managing the administration of medicines and those who administer medicines should receive appropriate training and support from health professionals. There should be robust systems in place to ensure that medicines are managed safely. There must be an assessment of the risks to the health and safety of staff and others and measures put in place to manage any identified risks.

Some children with medical needs have complex health needs that require more support than regular medicine. It is important to seek medical advice about each child's individual needs.

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

Short-Term Medical Needs

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

Long-Term Medical Needs

It is important to have sufficient information about the medical condition of any child with long-term medical needs. If a child's medical needs are inadequately supported this may have a significant impact on a child's experiences and the way they function in or out of school or a setting. The impact may be direct in that the condition may affect cognitive or physical abilities, behaviour or emotional state. Some medicines may also affect learning leading to poor concentration or difficulties in remembering. The impact could also be indirect; perhaps disrupting access to education through unwanted effects of treatments or through the psychological effects that serious or chronic illness or disability may have on a child and their family.

Schools and settings need to know about any particular needs before a child is admitted, or when a child first develops a medical need. For children who attend hospital appointments on a regular basis, special arrangements may also be necessary. It is often helpful to develop a written health care plan for such children, involving the parents and relevant health professionals.

Educational Visits

It is good practice for schools to encourage children with medical needs to participate in safely managed visits. The school will consider what reasonable adjustments they might make to enable children with medical needs to participate fully and safely on visits. This might include reviewing and revising the visits policy and procedures so that planning arrangements will include the necessary steps to include children with medical needs. It might also include risk assessments for such children. 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 child. Arrangements for taking any necessary medicines will also need to be taken into consideration. Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures. A copy of any health care plans should be taken on visits in the event of the information being needed in an emergency.

If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek parental views and medical advice from the school health service or the child's GP.

Sporting Activities

Most children with medical conditions can participate in physical activities and extra-curricular sport. There should be sufficient flexibility for all children to follow in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical health and well-being. Any restrictions on a child's ability to participate in PE should be recorded in their individual health care plan. All adults should be aware of issues of privacy and dignity for children with particular needs.

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

Home to School Transport

Local Authorities arrange home to school transport where legally required to do so. They must make sure that pupils are safe during the journey. Most pupils with medical needs do not require supervision on school transport, but Local Authorities should provide appropriate trained escorts if they consider them necessary. Guidance should be sought from the child's GP or paediatrician.

Drivers and escorts should know what to do in the case of a medical emergency. They should not generally administer medicines but where it is agreed that a driver or escort will administer medicines (i.e. in an emergency) they must receive training and support and fully understand what procedures and protocols to follow. They should be clear about roles, responsibilities and liabilities.

Where pupils have life threatening conditions, specific health care plans should be carried on vehicles. The school will be well placed to advise the Local Authority and its transport contractors of particular issues for individual children. Individual transport health care plans will need input from parents and the responsible medical practitioner for the pupil concerned. The care plans should specify the steps to be taken to support the normal care of the pupil as well as the appropriate responses to emergency situations. All drivers and escorts should have basic first aid training. Additionally trained escorts may be required to support some pupils with complex medical needs. These can be healthcare professionals or escorts trained by them.

Some pupils are at risk of severe allergic reactions. Risks can be minimised by not allowing anyone to eat on vehicles. As noted above, all escorts should have basic first aid training and should be trained in the use of an adrenaline pen for emergencies where appropriate.

ROLES AND RESPONSIBILITIES

It is important that responsibility for child safety is clearly defined and that each person involved with children with medical needs is aware of what is expected of them. Close cooperation between the school, settings, parents, health professionals and other agencies will help provide a suitably supportive environment for children with medical needs.

Parents and Carers

Parents, as defined in section 576 of the Education Act 1996, include any person who is not a parent of a child but has parental responsibility for or care of a child. In this context, the phrase 'care of the child' includes any person who is involved in the full-time care of a child on a settled basis, such as a foster parent, but excludes baby sitters, child minders, nannies and school staff.

It only requires one parent to agree to or request that medicines are administered. As a matter of practicality, it is likely that this will be the parent with whom the school has day-to-day contact. Where parents disagree over medical support, the disagreement must be resolved by the Courts. The school or setting should continue to administer the medicine in line with the consent given and in accordance with the prescriber's instructions, unless and until a Court decides otherwise.

It is important that professionals understand who has parental responsibility for a child. The Children Act 1989 introduced the concept of parental responsibility. The Act uses the phrase "parental responsibility" to sum up the collection of rights, duties, powers, responsibilities and authority that a parent has by law in respect of a child. In the event of family breakdown, such as separation or divorce, both parents will normally retain parental responsibility for the child and the duty on both parents to continue to play a full part in the child's upbringing will not diminish. In relation to

unmarried parents, only the mother will have parental responsibility unless the father has acquired it in accordance with the Children Act 1989. Where a court makes a residence order in favour of a person who is not a parent of the child, for example a grandparent, that person will have parental responsibility for the child for the duration of the Order.

If a child is 'looked after' by a local authority, the child may either be on a care order or be voluntarily accommodated. A Care Order places a child in the care of a local authority and gives the Local Authority parental responsibility for the child. The local authority will have the power to determine the extent to which this responsibility will continue to be shared with the parents. A local authority may also accommodate a child under voluntary arrangements with the child's parents. In these circumstances the parents will retain parental responsibility acting so far as possible as partners of the local authority. Where a child is looked after by a local authority day to-day responsibility may be with foster parents, residential care workers or guardians.

Parents should be given the opportunity to provide the head with sufficient information about their child's medical needs if treatment or special care needed. They should, jointly with the head, reach agreement on the school's role in supporting their child's medical needs, in accordance with the employer's policy. Ideally, the head should always seek 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.

Some parents may have difficulty understanding or supporting their child's medical condition themselves. Local health services can often provide additional assistance in these circumstances.

The Employer

Under the Health and Safety at Work etc. Act 1974, employers, including Local Authorities and school governing bodies, must have a health and safety policy.

In the event of legal action over an allegation of negligence the employer, rather than the employee, is likely to be held responsible. Employers should therefore make sure that their insurance arrangements provide full cover in respect of actions which could be taken by staff in the course of their employment. It is the employer's responsibility to make sure that proper procedures are in place; and that staff are aware of the procedures and fully trained. Keeping accurate records is helpful in such cases. Employers should support staff to use their best endeavours at all times, particularly in emergencies. In general, the consequences of taking no action are likely to be more serious than those of trying to assist in an emergency.

The employer is responsible for making sure that staff have appropriate training to support children with medical needs. Employers should also ensure that there are appropriate systems for sharing information about children's medical needs in each school or setting for which they are responsible. Employers should satisfy themselves that training has given staff sufficient understanding, confidence and expertise and that arrangements are in place to up-date training on a regular basis. A health care professional should provide written confirmation of proficiency in any medical procedure.

NHS Primary Care Trusts (PCTs) have the discretion to make resources available for any necessary training. Employers should also consider arranging training for staff in the management of medicines and policies about administration of medicines. Complex medical assistance is likely to mean that the staff will need specialised training. This should be arranged in conjunction with local

health services or other health professionals. Managing medicines training could be provided by Local Authorities, Regional Consortia, Pharmacists and other training providers.

The Governing Body

The governing body has general responsibility for all of the school's policies. The governing body will generally want to take account of the views of the head teacher, staff and parents in developing a policy on assisting pupils with medical needs.

The Head Teacher

The head is responsible for putting the employer's policy into practice and for developing detailed procedures. Day to day decisions will normally fall to the head or to whosoever they delegate this to.

There is a contractual duty on head teachers to ensure that their staff receive the training. As the manager of staff it is likely to be the head teacher who will agree when and how such training takes place.

The head should make sure that all parents and all staff are aware of the policy and procedures for dealing with medical needs. The head should also make sure that the appropriate systems for information sharing are followed. The policy should make it clear that parents should keep children at home when they are acutely unwell. The policy should also cover the approach to taking medicines at school or in a setting.

For a child with medical needs, the head will need to agree with the parents exactly what support can be provided. Where parents' expectations appear unreasonable, the head should seek advice from the school nurse or doctor, the child's GP or other medical advisers and, if appropriate, the employer. In early years settings advice is more likely to be provided by a health visitor.

If staff follow documented procedures, they should be fully covered by their employer's public liability insurance should a parent make a complaint. The head should ask the employer to provide written confirmation of the insurance cover for staff who provide specific medical support.

Teachers and Other Staff

Some staff may be naturally concerned for the health and safety of a child with a medical condition, particularly if it is potentially life threatening. Staff with children with medical needs in their class or group should be informed about the nature of the condition, and when and where the children may need extra attention. The child's parents and health professionals should provide this information.

All staff should be aware of the likelihood of an emergency arising and what action to take if one occurs. Back up cover should be arranged for when the member of staff responsible is absent or unavailable. At different times of the day other staff may be responsible for children, such as lunchtime supervisors. It is important that they are also provided with training and advice.

School Staff Giving Medicines

Teachers' conditions of employment do not include giving or supervising a pupil taking medicines. Schools should ensure that they have sufficient members of support staff who are employed and appropriately trained to manage medicines as part of their duties.

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

The Local Authority

The Local Authority should provide a general policy framework to guide schools in developing their own policies on supporting pupils with medical needs. Many Local Authorities find it useful to work closely with their Primary Care Trusts (PCTs) when drawing up a policy. The Local Authority may also arrange training for staff in conjunction with health professionals.

Primary Care and NHS Trusts

PCTs have a statutory duty to purchase services to meet local needs. PCTs and NHS Trusts may provide these services. PCTs, Local Authorities and the school governing body should work in cooperation to determine need, plan and co-ordinate effective local provision within the resources available.

PCTs must ensure that there is a medical officer with specific responsibility for children with special educational needs (SEN). Some of these children may have medical needs. PCTs and NHS Trusts, usually through the school health service, may provide advice and training for staff in providing for a child's medical needs.

Health Services

The Health Trust can provide advice on health issues to children, parents, teachers, education welfare officers and Local Authorities. The main health contact for schools is likely to be a school nurse. The school health service may also provide guidance on medical conditions and, in some cases, specialist support for a child with medical needs.

Most schools will have contact with the health service through a school nurse or doctor. The school nurse or doctor should help schools draw up individual health care plans for pupils with medical needs, and may be able to supplement information already provided by parents and the child's GP. The nurse or doctor may also be able to advise on training for school staff on administering medicines, or take responsibility for other aspects of support. In early years settings, including nursery schools, a health visitor usually provides the support and advice.

Every child should be registered with a GP. GPs work as part of a primary health care team. Parents usually register their child with a local GP practice. A GP owes a duty of confidentiality to patients, and so any exchange of information between a GP and a school or setting should normally be with the consent of the child if appropriate or the parent. Usually consent will be given, as it is in the best interests of children for their medical needs to be understood by school staff. The GP may share this information directly or via the school health service.

Many other health professionals may take part in the care of children with medical needs. Often a community paediatrician will be involved. These doctors are specialists in children's health, with special expertise in childhood disability, chronic illness and its impact in the school setting. They may be directly involved in the care of the child, or provide advice to schools and settings in liaison with the other health professionals looking after the child.

Most NHS Trusts with school health services have pharmacists. They can provide pharmaceutical advice to school health services. Some work closely with local authority education departments and give advice on the management of medicines within schools and settings. They can also advise on the storage, handling and disposal of medicines.

Some children with medical needs receive dedicated support from specialist nurses or community children's nurses, for instance a children's oncology nurse. These nurses often work as part of a NHS Trust or PCT and work closely with the primary health care team. They can provide advice on the medical needs of an individual child, particularly when a medical condition has just been diagnosed and the child is adjusting to new routines.

DEALING WITH MEDICINES SAFELY

Safety Management

All medicines may be harmful to anyone for whom they are not appropriate. Where the school or setting agrees to administer any medicines the employer must ensure that the risks to the health of others are properly controlled. This duty is set out in the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

Storing Medicines

Large volumes of medicines should not be stored. Staff should only store, supervise and administer medicine that has been prescribed for an individual child. Medicines should be stored strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed. Staff should 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. This should be easy if medicines are only accepted in the original container as dispensed by a pharmacist in accordance with the prescriber's instructions. Where a child needs two or more prescribed medicines, each should be in a separate container.

Children should know where their own medicines are stored and who holds the key. The head is responsible for making sure that medicines are stored safely. All emergency medicines, such as asthma inhalers and adrenaline pens, should be readily available to children and should not be locked away. Many schools and settings allow children to carry their own inhalers. Other non-emergency medicines should generally be kept in a secure place not accessible to children. Criteria under the national standards for under 8s day care require medicines to be stored in their original containers, clearly labelled and inaccessible to children.

A few 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.

Access to Medicines

Children need to have immediate access to their medicines when required. The school has special access arrangements for emergency medicines that it keeps. However, it is also important to make sure that medicines are only accessible to those for whom they are prescribed.

Disposal of Medicines

Staff should not dispose of medicines. Parents are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal. They should also collect medicines held at the end of each term. If parents do not collect all medicines, they should be taken to a local pharmacy for safe disposal.

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

Hygiene and Infection Control

All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures1. 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. Ofsted guidance provides an extensive list of issues that early years providers should consider in making sure settings are hygienic.

Emergency Procedures

As part of general risk management processes the school has arrangements in place for dealing with emergency situations. Other children should know what to do in the event of an emergency, such as telling a member of staff. All staff should know how to call the emergency services. All staff should also know who is responsible for carrying out emergency procedures in the event of need. A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent arrives. Health professionals are responsible for any decisions on medical treatment when parents are not available.

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

Individual health care plans should include instructions as to how to manage a child in an emergency, and identify who has the responsibility in an emergency, for example if there is an incident in the playground a lunchtime supervisor would need to be very clear of their role.

Health Care Plan

The main purpose of an individual health care plan for a child with medical needs is to identify the level of support that is needed. Not all children who have medical needs will require an individual plan. A short written agreement with parents may be all that is.

An individual 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. Staff should 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.

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

Developing a health care plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child.

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 plan include:

• the head teacher • the parent or carer • the child (if appropriate) • class teacher • care assistant or support staff (if applicable) • staff who are trained to administer medicines • staff who are trained in emergency procedures

Early years settings should be aware that parents may provide them with a copy of their Family Service Plan, a feature of the Early Support Family Pack promoted through the government's Early Support Programme. Whilst the plan will be extremely helpful in terms of understanding the wider picture of the child's needs and services provided, it should not take the place of an individual health care plan devised by the setting with input from a health professional, or indeed the record of a child's medicines.

Co-ordinating Information

The head teacher should decide which member of staff has specific responsibility for coordinating and sharing information on an individual pupil with medical needs. This person can be a first contact for parents and staff, and liaise with external agencies. It would be helpful if members of staff with this role attended training on managing medicines and drawing up policies on medicines.

Staff Training

A health care plan may reveal the need for some staff to have further information about a medical condition or specific training in administering a particular type of medicine or in dealing with emergencies. Staff should not give medicines without appropriate training from health professionals. When staff agree to assist a child with medical needs, the employer should arrange appropriate training in collaboration with local health services. Local health services will also be able to advise on further training needs. In every area there will be access to training, in accordance with the provisions of the National Service Framework for Children, Young People and Maternity Services, by health professionals for all conditions and to all schools and settings.

Confidentiality

The head and staff should always treat medical information confidentially. The head should agree with the parent who else should have access to records and other information about a child. If information is withheld from staff they should not generally be held responsible if they act incorrectly in giving medical assistance but otherwise in good faith.

COMMON CONDITIONS – PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS

The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis).

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 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.

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.

EPILEPSY 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. This will help parents to give more accurate information on seizures and seizure frequency to the child's specialist.

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. 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.

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.

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.

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

Common triggers of anaphylaxis 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 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 are trained in the use of these devices. 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.

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.

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.

Staff 'duty of care' Anyone caring for children including teachers and other school staff 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.