



Policy for Supporting Pupils
with Medical
Needs/Administration of
Medicine

Introduction:

This policy has been designed to ensure effective management systems are put in place to support individual children with medical needs. It will provide a sound basis for ensuring that children with medical needs receive proper care and support in our school. It has been agreed by staff and governors and its contents have been shared with parents and children.

Children with medical needs have the same rights of admission to our school 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 epilepsy or diabetes. 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 can attend school regularly and take part in usual activities, sometimes with 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 will be put in place to identify the necessary safety measures to support children with medical needs and ensure that they and others are not put at risk (see attached documents).

Prescribed Medicines:

- Medicines should only be brought to school when essential; that is where it would be detrimental to a child's health if the medicine were not administered during the school day.
- Our school will only accept medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber. (Individual cases regarding non-prescribed medicines can be discussed with the Headteacher).
- Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions for administration.
- **Our school will not accept medicines that have been taken out of the container as originally dispensed.**
- Parents will be encouraged to administer the medication outside school hours. We will encourage the parent to ask the prescriber about this. It is noted that medicines that need to be taken three times a day could be taken in the morning, after school hours and at bedtime.

Non-Prescription Medicines:

- The Headteacher/Deputy Headteacher will discuss the administration of non-prescribed medicines with the parent/guardian. Written permission from parents will always be obtained.
- If a child needs a non-prescribed medicine (for example; a painkiller or cough medicine or calpol) the parent will be encouraged to attend school to administer the medicine. Alternatively, the child could go home for lunch in order for the non-prescribed medicine to be administered.
- The Headteacher/Deputy Headteacher will, if necessary, administer non-prescribed medicines. Consent will be obtained from parents beforehand.
- If a parent sends a non-prescribed medicine to school they will be contacted immediately to be discuss the administration of the medication. The parent can then decide if the medicine needs to be taken or not and can make any further arrangements (i.e. to attend school to administer the medicine).

Controlled Drugs:

- The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act. Some may be prescribed as medication for use by children, e.g. methylphenidate.
- The Headteacher/Deputy Headteacher may administer a controlled drug to a child for whom it has been prescribed. The medicine will be administered in accordance with the prescriber's instructions.
- A child who has been prescribed a controlled drug may legally have it in their possession.
- The controlled drug/s will be kept in a secure location and only named staff will have access.
- A controlled drug/s will be returned to the parent when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, the drug will be returned to the dispensing pharmacist (details will be on the label).

Short-Term Medical Needs:

- Many children will need to take medicines during the day at some time during their time in school. This will usually be for a short period only, perhaps to finish a course of antibiotics or to apply a lotion. Such medication will be administered in school however if the child is poorly he/she may clearly need to remain at home until the course has been completed.

Long-Term Medical Needs:

- It is vitally important that school has sufficient information about the medical condition of any child with long-term medical needs. This information may be provided by parents, the school nurse or other medical professional.
- 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. 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.
- The Special Educational Needs (SEN) Code of Practice 2001 advises that a medical diagnosis or a disability does not necessarily imply SEN. It is the child's educational needs rather than a medical diagnosis that must be considered.
- Our school will 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 may be appropriate to develop a written health care plan for such children, involving the parents and relevant health professionals.
- Information relating to long-term medical needs is attached to this policy; Practical Advice on Asthma, Epilepsy, Diabetes and Anaphylaxis.
- A separate policy and plan is available for Asthma.

Confidentiality:

The Headteacher, Deputy Headteacher and staff will always treat medical information confidentially. The Headteacher will agree with the child, where appropriate, or otherwise the parent, who else should have access to records and other information about a child.

Information for Staff and Others:

Staff who may need to deal with an emergency will need to know about a child's medical needs. The Headteacher/Deputy Headteacher will make sure that supply staff know about any medical needs.

Staff Training:

The school nurse will support the school by providing information about a medical condition or may provide specific training in administering a particular type of medicine or in dealing with emergencies. Parental support will also be sought i.e. to provide information relating to the

medical condition and how it affects their child. Whole staff meetings may also be arranged to discuss any specific issues or to share information.

Procedures For Managing Prescription Medicines which need to be taken during the school day:

- ❖ There is no legal duty that requires school to administer medicines.
- ❖ No child will be given medicines without their parent's written consent (See Annex A). The Headteacher/Deputy Headteacher will check any details provided by parents.
- ❖ Prescribed medicines will be administered (parent can request administration of non-prescribed medicines and Headteacher will consider individual cases).
- ❖ Non-prescription medicines may be administered (following discussions with parent: see above).
- ❖ The Headteacher/Deputy Headteacher will administer the medication and good hygiene will be maintained.
- ❖ Teaching staff/Learning Support Assistants will not administer medicines unless specifically trained (i.e. for Diabetes, insulin injections).
- ❖ The Headteacher/Deputy Headteacher will check:
 - The child's name
 - Name of medicine
 - Prescribed dose
 - Method of administration
 - Any side effects
 - Expiry date
 - Written instructions provided by the prescriber on the label or container.
- ❖ The medicine will only be administered if it is provided in its original container, with the prescriber's instructions for administration. School will **never** accept medicines that have been taken out of the container as originally dispensed.
- ❖ If in doubt about any procedure, the Headteacher/Deputy Headteacher will not administer the medicines but will check with the parents or a health professional before taking further action.
- ❖ If the Headteacher/Deputy Headteacher have any other concerns related to administering medicine to a particular child, the issue will be discussed with the parent, if appropriate, or with a health professional attached to the school.
- ❖ Written records will be kept each time medicines are given (See Annex A).
- ❖ The medicines will be kept in a secure location (in the Headteacher's office).

- ❖ If a child refuses to take medicine, they will not be forced to do so. A note will be made in the records and parents will be informed of the refusal on the same day. If a refusal to take medicines results in an emergency the school emergency procedures will be followed (see Annex A).

Parental Responsibilities In Respect Of Their Child's Medical Needs:

- ❖ Parents have the prime responsibility for their child's health and should provide school with information about their child's medical condition and needs.
- ❖ Parents, and the child (if appropriate), should obtain details from the child's GP or paediatrician, if needed.
- ❖ Parents will be required to complete a parental agreement for school to administer medicine (see Annex A). School will not give the medicine unless the form is completed and signed by the parent.
- ❖ Parents must agree to supply the medicine in its original container as dispensed by a pharmacist and will include the prescriber's instructions for administration.
- ❖ If necessary, parents must agree to be involved in the formation of a health care plan.
- ❖ Parents may be expected to administer non-prescribed medicines if deemed to be essential during the school day as it is school policy to administer prescribed medicines only.
- ❖ It is the parent's responsibility to ensure the prescribed medicines are in school and that they are collected at the end of the school day. It may be a good idea to ask the prescriber for two prescriptions (where appropriate and practicable): one for home and one for use in school – this is particularly useful given the CoVid-19 pandemic.

Procedures For Managing Prescription Medicines On Trips And Outings:

- ❖ We will encourage children with medical needs to participate in safely managed visits.
- ❖ School will consider what reasonable adjustments need to be made to enable children with medical needs to participate fully and safely on visits. This may include a risk assessment for children with medical needs.
- ❖ If additional safety measures are needed, an additional supervisor, a parent or another volunteer might be needed to accompany a particular child.
- ❖ Arrangements for taking any necessary medicines will be taken into consideration.
- ❖ Staff supervising excursions will be aware of any medical needs and relevant emergency procedures.
- ❖ A copy of any health care plans will 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, parental views will be sought, as will medical advice from the school nurse or the child's GP.

Sporting Activities:

- ❖ Most children with medical conditions can participate in physical activities and extra curricular sport. There will 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 will be recorded in their individual health care plan. All adults will 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. (Information relating to specific health conditions can be found in Annex B).

Self-Management:

- ❖ Children will be supported and encouraged to take responsibility to manage their own medicines from a relatively early age. There will be liaison with parents to discuss this and to agree when most appropriate.
- ❖ If children can take their own medicines themselves, the Headteacher/Deputy Headteacher will only supervise.

This Policy has been equality impact assessed and is compliant with the Equality Act 2010. All protected characteristics have been considered including age, disability, gender reassignment, race, religion or belief, gender, sexual orientation, pregnancy or maternity, marriage or civil partnership, poverty and carers with no impact determined. A copy of this policy in another language (e.g. Welsh) is only available on request. (September 2021).

Adopted by the staff and ratified by the Governing Body.

For and on behalf of the Governing Body _____

Headteacher: *R L Billington*

Date: March 2022

Date for Review: March 2024



Appendix A:

Practical Advice on Asthma, Epilepsy, Diabetes and Anaphylaxis

*Department of Health
Department for education and skills
Date of Issue – March 2005*

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:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet

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:

- 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

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.

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
- the child becomes unconscious

176. 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.

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 person²⁴, 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

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.