

Maple Tree Lower School



Policy	Supporting Pupils with Medical Conditions and the Administration of Medicines
Committee	Management
Review Date	March 2017



**MAPLE TREE LOWER SCHOOL
SUPPORTING PUPILS WITH MEDICAL CONDITIONS AND
ADMINISTRATION OF MEDICINES
POLICY STATEMENT**

Statement Document History

Issue	Date	Comment
1	September 2014	Approval by Management Committee

Introduction

Maple Tree Lower School wishes at the very least to comply with guidance regarding the care of children with specific medical conditions and the administration of medicines within school.

The objectives of this policy are:

- To respond appropriately, effectively and consistently whenever a pupil requires specific care and or medication in school

- To provide guidelines for teachers and other staff to offer care and administer medicines by following certain strictly controlled guidance.

POLICY:	This policy sets out to provide guidelines for all those in school who may need to both care for the specific needs or administer medicines to pupils in school.
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Monitoring & Review

This policy statement and procedures are the responsibility of the Governing Body's Management Committee and are authorised by the Governing Body.

The Committee will review the policy statement on a regular basis and will do so in discussion with teaching staff and governors.

Policy for Supporting Pupils with Medical Conditions

This policy is written in regard to Section 100 of the Children and Families Act 2014 which places a duty on governing bodies to make arrangements for supporting pupils at their school with medical conditions.

Aims

- To ensure pupils at school with medical conditions, in terms of both physical and mental health, are properly supported so they can play a full and active role in school life, remain healthy and achieve their academic potential.
- To ensure the needs of children with medical conditions are effectively supported in consultation with health and social care professionals, their parents and the pupils themselves.

Policy

At Maple Tree Lower School, the headteacher is the named person with overall responsibility for the implementation of this policy and will ensure:

- sufficient staff are suitably trained
- all relevant staff are made aware of a child's condition
- cover arrangements in case of staff absence/turnover is always available
- supply teachers are briefed
- risk assessments for visits and activities out of the normal timetable are carried out
- individual healthcare plans are monitored (at least annually)
- transitional arrangements between schools are carried out
- if a child's needs change, the above measures are adjusted accordingly

Where children are joining Maple Tree Lower School at the start of a new academic year, these arrangements should be in place for the start of term. Where a child joins mid-term or a new diagnosis is given, arrangements should be in place as soon as possible, ideally within two weeks. Any pupil with a medical condition requiring medication or support in school should have an individual healthcare plan which details the support that child needs. The flowchart at Appendix A will assist the decision making.

Individual Healthcare Plans (IHPs)

The following information should be considered when writing an individual healthcare plan which will be created in partnership with parents, relevant health care professionals and staff:

- the medical condition, its triggers, signs, symptoms and treatments
- the pupil's resulting needs, including medication and other treatments, times, facilities, equipment, testing, dietary requirements and environmental issues
- specific support for the pupil's educational, social and emotional needs
- the level of support needed including in emergencies
- who will provide support, their training needs, expectation of their role, confirmation of their proficiency and cover arrangements
- who in school needs to be aware of the child's condition and the support required
- arrangements for written permission from parents and the head teacher for medication to be administered by a member of staff or self-administered (children who are competent should be encouraged to take responsibility for managing their own medicines and procedures, with an appropriate level of supervision)
- separate arrangements or procedures required for school trips or other school activities outside of the normal school timetable that will ensure the child can participate
- confidentiality
- what to do if a child refuses to take medicine or carry out a necessary procedure
- what to do in an emergency, who to contact and contingency arrangements
- where a child has SEN but does not have an Education, Health and Care plan, their special educational needs should be mentioned in their individual healthcare plan

Roles and Responsibilities

Supporting a child with a medical condition during school hours is not the sole responsibility of one person. The school will work collaboratively with any relevant person or agency to provide effective support for the child.

The Governing Body

- must make arrangements to support pupils with medical conditions and ensure this policy is developed and implemented
- must ensure sufficient staff receive suitable training and are competent to support children with medical conditions
- must ensure the appropriate level of insurance is in place and appropriately reflects the level of risk

The Head Teacher

- should ensure all staff are aware of this policy and understand their role in its implementation
- should ensure all staff who need to know are informed of a child's condition
- should ensure sufficient numbers of staff are trained to implement the policy and deliver IHPs, including in emergency and contingency situations, and they are appropriately insured
- is responsible for the development of IHPs
- should contact the school nursing service in the case of any child with a medical condition who has not been brought to the attention of the school nurse

School Staff

- any staff member may be asked to provide support to pupils with medical conditions, including the administering of medicines, although they cannot be required to do so
- should receive sufficient and suitable training and achieve the necessary level of competency before taking on the responsibility of supporting children with medical conditions
- any staff member should know what to do and respond accordingly when they become aware that a pupil with a medical condition needs help

School Nurses

- are responsible for notifying the school when a child has been identified as having a medical condition which will require support in school
- may support staff on implementing a child's IHP and provide advice and liaison

Other healthcare professionals

- should notify the school nurse when a child has been identified as having a medical condition that will require support at school
- may provide advice on developing healthcare plans
- specialist local teams may be able to provide support and training for particular conditions (eg. Asthma, diabetes)

Pupils

- should, wherever possible, be fully involved in discussions about their medical support needs and contribute to, and comply with, their IHP

Parents

- must provide the school with sufficient and up-to-date information about their child's medical needs
- are the key partners and should be involved in the development and review of their child's IHP
- should carry out any action they have agreed to as part of the IHP implementation

Notes

- The school does not have to accept a child identified as having a medical condition at times when it would be detrimental to the health of that child or others to do so.
- The following practice is considered not acceptable:
 - preventing children from easily accessing their medication and administering it when and where necessary
 - assuming children with the same condition require the same treatment
 - ignoring the views of the child, their parents; ignoring medical advice or opinion
 - sending children with medical conditions home frequently or prevent them from staying for normal school activities (unless specified in IHP)
 - penalizing children for their attendance record if their absences are related to their medical condition that is recognized under this policy
 - preventing children from drinking, eating or taking toilet breaks whenever they need to in order to manage their medical condition effectively
 - to require parents to attend school to administer medication or provide medical support to their child, including toileting issues (no parent should have to give up working because the school is failing to support their child's medical needs)
 - preventing children from participating, or create unnecessary barriers to children participating in any aspect of school life, including school trips (such as requiring parents to accompany the child)

Managing Medicines in School

Where it is necessary for a child to receive medication in school whether this is for a short or long term period the following points will be taken into consideration to ensure that the correct policy and procedures are followed:

- medicines should only be administered at school when it would be detrimental to a child's health or school attendance not to do so.
- no child under 16 should be given prescription or non-prescription medicines without their parent's written consent. The Governors at Maple Tree Lower School have agreed that only prescribed medications will be administered.
- a child under 16 should never be given medicine containing aspirin unless prescribed by a doctor. Medication, eg for pain relief unless prescribed will not be administered in school.
- where clinically possible, medicines should be prescribed in dose frequencies which enable them to be taken outside school hours
- school will only accept prescribed medicines that are in-date, labelled, provided in the original container as dispensed by a pharmacist and include instructions for administration, dosage and storage. The exception to this is insulin which must still be in date, but will generally be available to schools inside an insulin pen or a pump, rather than in its original container.
- parents will have the right to make arrangements to come into school to administer medicine to their own child should they choose to do so.
- all medicines should be stored safely – this will either be in the staff room fridge if required to be kept cold or in a locked non-movable cabinet in the medical room. Children will have access to their own medication under the supervision of an adult in school. Medicines and devices such as asthma inhalers, blood glucose testing meters and adrenaline pens should be always readily available for children and not locked away. When children are taken out of school for trips or events, their medication needs must be considered and suitable arrangements made to make these available.
- where a child who has been prescribed a controlled drug monitoring arrangements may be necessary. School will keep controlled drugs that have been prescribed for a pupil securely stored in a non-portable container and only named staff will have access. Controlled drugs should be easily accessible in an emergency. A record should be kept of any doses used and the amount of the controlled drug held in school
- school staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicines should do so in accordance with the prescriber's instructions. School will keep a record of all medicines administered to individual children, stating what, how and how much was administered, when and by whom. Any side effects of the medication to be administered at school should be noted
- when no longer required, medicines should be returned to the parent to arrange for safe disposal. Sharps boxes should always be used for the disposal of needles and other sharps

Administration

- The label on the medicine container should be checked against the school medicine record. Any discrepancy should be queried with the parent before administering a medicine. **Parents should confirm any changes of dose and the reason for it in writing.**
- For liquid medicines make sure a 5 ml medicine spoon or an oral dose dispenser (for quantities less than 5 ml) together with instructions has been sent in by the parent:-
- Confirm the identity of the pupil.

- Check the school medicine record to see if the medicine is being given at the right time e.g. midday, before or after food etc, and has not already been given by another member of staff.
- Check the name of the medicine on the container against the name on the school record.
- Check the dose, e.g. 1 or 2 tablets, 5 or 10 mls, 1 or 2 puffs.
- Measure the dose, without handling the medicine. If it is a liquid, shake the bottle before measuring and pour away from the label. If it is a soluble or dispersible tablet, add to half a glass of water and wait for it to dissolve or disperse.
- Give the medicine to the pupil and watch him/her take it. Always give the pupil a glass of water to “wash” the medicine into the stomach.
- Wash the spoon or oral dose dispenser if used.
- Return the medicine and spoon etc to the appropriate storage area.

Record Keeping

- Parents must give written permission for school staff to administer medicines and this should be done using the permission form at Appendix B
- The administration of medicines will be recorded and signed by staff according to the form at Appendix C

Emergency Procedures

- Where a child has an individual healthcare plan, this should clearly define what constitutes an emergency and explain what to do, including ensuring that all relevant staff are aware of emergency symptoms and procedures. Other pupils in the school should know what to do in general terms, such as informing a teacher immediately if they think help is needed.
- If a child needs to be taken to hospital, staff should stay with the child until the parent arrives, or accompany a child taken to hospital by ambulance.
- In the case of an emergency staff will make a decision as to the severity of the incident. In cases of concern, an initial contact with the parent may be made to make a mutual decision.

Day Trips, residential and sporting activities

All children should have the opportunity to participate in such events and any medical needs must not prevent them from doing so. Arrangements should be suitably flexible for everyone to join in according to their own abilities and with any reasonable adjustments. Where required, risk assessments will be carried out to ensure that events are planned and adapted to suit. For some children this may require consultation with the parents or carers.

Insurance Cover

The school purchases insurance cover and this includes

Complaints

- Should parents or pupils be dissatisfied with the support provided they should discuss their concerns directly with the school. If this does not resolve the issue, they may make a formal complaint via the school's complaints procedure.

This policy will be reviewed every two years.

Appendix 1

SCHOOL MEDICINE RECORD

Child's Name _____

Class/tutor Group _____

Name of medicine _____

Strength of medicine if appropriate _____

How much to give (i.e.dose) _____

When to be given _____

Any other instructions (include details for inhalers if any) _____

Phone No. of parent or adult contact _____

Tick appropriate box

Medicine to be left at school

Medicine to be taken home each day

e.g. antibiotics

In consideration for the Headteacher or the school staff agreeing to give medication to my/our above named child during school hours, I/we agree to indemnify the Headteacher, the school staff and the Local Authority against all claims. Costs, actions and demands whatsoever resulting from the administration of the medicine unless such claims, costs, actions or demands result out of the negligence of the Headteacher, the school staff or the Local Authority.

Parent/Carer's signature. _____

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

DATE													
TIME GIVEN													
SIGN													

Date medicine returned to parent on completion of course of medicine. _____

EPILEPSY

1. Definition/Description

- 1.1 Epilepsy results from abnormal electrical activity in the brain causing physical effects which depend on the area of brain involved (fits, seizures).
- 1.2 There are many kinds of epilepsy and definitions and terminology are constantly changing.

The most common kinds are:-

- a) Absences (petit mal) - The child appears vacant for a few seconds, but does not fall to the ground or twitch. He/she then carries on as if nothing has happened, and is usually unaware of the 'absence'.
- b) Major seizures (tonic-clonic convulsion, grand mal, fit) - There is generalised twitching or jerking with loss of consciousness and often incontinence. On recovery the child may be drowsy, have a headache, be anxious or confused. Major seizures are alarming to witness.
- c) Focal or partial seizures - These may involve twitching of one area of the body, without loss of consciousness, or simply behaviour changes and/or a state of unaltered consciousness (dazed appearance).
- d) Note c) can progress to b), and some children have more than one type of attack.

2. Frequency

- 2.1 About 6 in every 1000 children have epilepsy. Most are well controlled and will never have a fit in school (some only have fits during sleep).
- 2.2 A very few have frequent fits.

3. Treatment

- 3.1 There are several anti-epileptic drugs in common use, and a lot more being evaluated.

- 3.2 Different drugs work best for different kinds of epilepsy.
- 3.3 Most children will take their medication twice a day at home, but a few will need a dose in school.
- 3.4 The regular medication will not cut short an existing seizure. Other medication such as rectal valium (diazepam) may do so. If a child has been prescribed rectal valium, members of staff may wish to learn how to administer it. Some children can be vulnerable to consecutive fits which, if left uncontrolled, can result in permanent damage. In an emergency situation it is necessary for rectal diazepam to be administered.

4. Implications of Epilepsy

- 4.1 Epilepsy is common in children with learning difficulties: the converse is not true.
- 4.2 Uncontrolled 'absences' can be very frequent, merging into each other (non-convulsive status epilepticus) producing a withdrawn child who cannot learn. Establishing control may produce a dramatic difference.
- 4.3 Most anti-epileptic drugs can have side effects, particularly drowsiness and poor concentration. It may be necessary to tolerate some side-effects, and their effect on learning, in order to maintain control, but marked drowsiness, or frequent seizures should be reported to parents so that they can inform the doctor and consider changes in treatment.
- 4.4 Some epileptic children may be "triggered" by flashing lights. They may not be able to watch TV or use VDUs, or extra care may need to be taken about distance from the screen and ambient lighting. Check with parents and school doctor/nurse if this is suspected.
- 4.5 Most epileptic children can participate safely in most activities, but will need extra supervision for swimming, PE activities involving climbing and practical classes (science, technology). A few severely affected children may not be able to do these things, and may need to wear protective headgear.
- 4.6 There are career implications, and epileptic pupils should receive careers advice as early as possible.
- 4.7 The effect of epilepsy on the child's friends should be remembered, and it may be necessary to organise discussions for their benefit (do not embarrass the sufferer).

5. Management of a Major Seizure

- 5.1 These are alarming to witness and other children may need a lot of reassurance afterwards.
- 5.2 When a fit occurs, try to prevent injury – if possible move the furniture rather than the child. Do not try to force anything into the mouth.
- 5.3 As soon as possible (when major twitching stops) put the child in the recovery position. Keep calm, and try to keep the rest of the class away – if possible screen the area where the child is.
- 5.4 As the child starts to come round, talk reassuringly, but encourage him/her to continue resting quietly. Many children like to sleep for a time after a fit, but some can rejoin normal activities within a few minutes.
- 5.5 It is not necessary to send the child home unless very drowsy or confused, but each instance should be judged individually.
- 5.6 If the fit persists for more than 5-10 minutes then call an ambulance.
- 5.7 If a child has been prescribed rectal valium and a named member of staff has been trained on a volunteer basis to administer it then it should be given in accordance with the specific training for that child. This will greatly benefit the child. There would have been discussion with parent and doctor of this issue prior to the event.
- 5.8 Always inform the parent that a fit has occurred, even if the child does not need to go home or to hospital. A note to take home at the end of the day will often suffice.

6.0 Further Information

- 6.1 The National Society for Epilepsy produces a number of helpful leaflets and a video for teachers. The British Epilepsy Association also provides informative material.

National Society for Epilepsy
Chesham Lane

Chalfont St Peter

Bucks

SL9 ORJ

Tel: 01494 601300

UK Epilepsy Helpline: Tel: 01494 601400

British Epilepsy Association

New Anstey House

Gateway Drive

Yeadon

Leeds

LS19 7XY

Tel: 0113 2108800

Email epilepsy@bea.org.uk

Freephone Helpline: 0808 800 5050

Email helpline: helpline@bea.org.uk

DIABETES

1.0 Definition

Diabetes occurs when the body's production of insulin is inadequate to deal with the sugars and starches derived from food and circulating in the blood.

2.0 Treatment

2.1 Insulin has to be supplied (by injection) and the amount balanced against food intake and energy requirements.

2.2 This is a complex process and many different regimes are in use, tailored to the individual in terms of diet, as well as type and frequency of insulin injections. It is not always beneficial to try to reduce the frequency of injections.

2.3 Control is easier to establish in some children than others.

2.4 If the balance between insulin, food and activity is not maintained, the blood sugar will rise or fall. Both may cause problems, but the effects of high blood sugar occurs fairly slowly and are not usually relevant in school.

2.5 Low blood sugar (hypoglycaemia, insulin reaction) occurs much more quickly and requires prompt treatment with some form of sugar. If a diabetic child is unwell, it is safe to assume low blood sugar and give sugar. If you are right, the child will recover rapidly; if you are wrong, a little extra sugar will do no harm.

3.0 Recognition of Low Blood Sugar (Hypo)

3.1 A 'hypo' often occurs after exercise or before a meal, but not exclusively so. Diabetic children must therefore have their meals punctually.

3.2 The symptoms of a 'hypo' are variable. Most diabetic children will know when an attack is starting and how to treat it.

- 3.4 Parents will know how their child is affected, and should be asked to complete a card giving these details (cards are available from the British Diabetic Association) which should be readily available for reference.

Signs to look for are paleness, sweating, anxiety, drowsiness, confusion, behaviour changes (some may be tearful, some aggressive and rude). Sufferers may complain of blurred vision, headaches or nausea.

4.0 Treatment of a 'Hypo'

- 4.1 Give sugar in an easily absorbed form (3 Dextrosol tablets, 55 mls Lucozade,) or, if the child is well enough to eat, whatever snack is usually carried. If there is no improvement within a few minutes, repeat the treatment.
- 4.2 If there is still no improvement, or if at any stage the child becomes unconscious or has a fit, then call an ambulance. Inform the parents but do not send the child home unless recovery is complete.
- 4.3 Never send a child who has had a 'hypo' home alone in case of another one, and never send an unwell diabetic child to the medical room unaccompanied in case of fainting on the way.
- 4.4 It is important to give sugar quickly, and therefore a supply should be available wherever a diabetic child is (older children may carry their own).
- 4.5 Because of the effect of exercise, it is vital that the PE teachers of diabetic children have a supply of sugar available on playing fields and at swimming pools, which may be some distance from the school buildings. This also applies on school trips, when extra food should also be taken in case of unexpected delays.
- 4.6 Remember to inform parents of all 'hypos' as their frequency is a guide as to how good control of the diabetes is.

5.0 General Considerations

- 5.1 Many diabetic children are advised to take a snack before exercise to prevent 'hypos'. This must always be allowed, and a supply of whatever the child likes kept in school.

- 5.2 It must also be understood that diabetic children must not be delayed at mealtimes and that there may be occasions when they need to eat a sweet in class to prevent a 'hypo'.
- 5.3 Most diabetic children can go on all school trips, but extra food should always be carried in case of unexpected delays.

6.0 Further Information

- 6.1 The Community Dietician can help with school meals and general advice.
- 6.2 The hospital diabetic clinic can provide a great deal of information and advice.
- 6.3 Diabetes UK produces a number of leaflets and a School Pack.
Diabetes UK, 0207 636 6112, 10 Queen Anne Street, London W1M OBD.
- 6.4 Diabetes Information Centre, 01582 497152, 6/8 Lewsey Road, Luton.
Community Dietician (Luton), 01582 497162, Luton and Dunstable Hospital.

HEART PROBLEMS

1.0. Description

- 1.1 Children with heart problems need to maintain basic fitness as far as they are able, and overprotection can be just as harmful as pushing them too hard.
- 1.2 Most such children have a good idea of their abilities, and, unless there are specific instructions to the contrary, verified by a doctor, they should be allowed to take part in all normal school activities, including games and PE (indoor and outdoor) as far as they feel able. However, they must also be allowed to drop out and rest if they need to do so and must not be pushed into continuing until they feel ready. Very few will misuse this facility.
- 1.3 Some children with heart problems go blue very readily. This is alarming but not necessarily serious especially in cold weather. The normal colour will usually return once the child is warm and rested. If not, and if there are other symptoms (unusual breathlessness, dizziness, chest pain), then the parents should be contacted.

2.0 Further Information

From your school doctor and nurse.

British Heart Foundation 0207 79350185, 14 Fitzhardinge Street, London W1H 6DH.

ATTENTION DEFICIT (HYPERACTIVITY) DISORDER – AD(H)D

1.0 Description

- 1.1 This disorder is characterised by inattention, impulsivity and hyperactivity. All three components are usually present, but in varying degree. The usual age of onset is 3-7 years, though it may be present from birth. There may be a hereditary element, particularly in girls. Recent work has shown abnormally low levels of neurotransmitter substances in the brains (especially the frontal lobes) of AD(H)D sufferers. A reduced level of glucose utilisation during brain activity has also been demonstrated.

- 1.2 Inattention is manifested by difficulty in concentrating, poor short term memory, appearing not to listen, constantly forgetting and losing things. Some children, particularly girls, frequently day dream, and may be thought to have “absences”.

- 1.3 Impulsivity is a tendency to act before thinking. These children interrupt, blurt out answers, have difficulty taking turns, may be easily led, and fail to recognise danger until too late.

- 1.4 Hyperactive children are always on the move, fidget even while seated, leave their seats on the slightest pretext, and are often noisy and talkative.

- 1.5 Only symptoms which have been present for at least 6 months, in at least two situations, (e.g. home and school) and are causing significant impairment, can be regarded as relevant. It is vital to remember this when completing checklists, as most of the symptoms of AD(H)D occur sometimes in most children.

- 1.6 Management is most appropriately arranged through a multi-disciplinary approach.

- 1.7 Teachers can help by providing a structured environment, breaking work into small manageable chunks, and making sure the child actually listens to instructions, which should be as short as possible. Rewards are more effective than punishment.

- 1.8 Behaviour management strategies can be suggested by the LA EBD Team and by the Child and Family Psychiatric Services.

A few children may be helped by dietary manipulation.

For those children who have not responded to the above measures, medication may be suggested.

2.0 Medication

- 2.1 This usually takes the form of stimulants, which have been shown to increase the amount of neurotransmitter substances available in the brain.
- 2.2 The most commonly used are Ritalin (methylphenidate), which is the same chemical family as amphetamines (speed) and is therefore a controlled drug, even though there is no evidence of addictive properties. Schools are advised to keep no more than a week's supply of Ritalin tablets for each pupil (residential schools may be exempt) and must be kept in a locked cupboard.
- 2.3 Ritalin is short acting – each dose lasts only about 4 hours, sometimes less. It is normally given in the morning and at lunchtime, and sometimes at teatime. The total dose, and the exact timing will vary from child to child. Schools may take the parents' word for the dose, but may prefer to get written confirmation from the child's medical advisor.
- 2.4 Ritalin is best given with or after food, in order to avoid appetite suppression and in general is not advised late in the day as it may prevent sleep (though a few children sleep better with a dose shortly before bedtime).
- 2.5 It is effective in 70-90% of cases and the effect is often dramatic. The best results are obtained when it is combined with behaviour management strategies.

3.0 Further Information

- 3.1 There is a very large volume of information available (including a website). Anyone interested should contact AD(H)D Information Service, P.O.Box 340, Edgware, Middlesex, HA8 9HL, Telephone 020 8905 2013. School nurses and doctors can also provide information.

ANAPHYLAXIS

1.0 Description

- 1.1 This is a severe allergic reaction in which the body endangers itself in trying to get rid of a foreign substance. When a school becomes aware that a child is known to suffer from severe allergies, it is advisable to arrange a meeting with parents, relevant school staff, school doctor/nurse in order to draw up guidelines which meet the individual needs of the child and to arrange training for staff as appropriate.
- 1.2 It is important to realise that the stages described below may merge into each other as the reaction develops. If there is doubt about the stages and symptoms, the administration of medication is safe and should not be withheld. **Even if it is given through misdiagnosis, it will do no harm.**

2.0 Main Symptoms

Mild	Moderate	Severe
Skin rash	Difficulty in breathing	Severe difficulty in breathing
Mild swelling of face	Tightness in throat	Abdominal cramps, nausea
Generalised itching	Metallic taste	Pale and floppy
		Unconscious

Reactions may vary in severity on different occasions.

3.0 Trigger Substances

- 3.1 Nuts, especially peanuts, bee and wasp stings, fish, eggs, milk proteins, some drugs (e.g. penicillin), some fruits.
- 3.2 The reaction can be caused by unbelievably small amounts of the substance – some children will react just sitting next to someone with a peanut butter sandwich.

4.0 Prevention

- 4.1 Prevention is the mainstay of management. The sufferer should avoid all contact with the substance (if peanuts, it is wise to avoid all nuts as there may be cross-reactions).

- 4.2 If the child has school dinners, kitchen staff need to be aware that nuts should be avoided, including food where peanut oil is used in preparation (also known as groundnut oil or arachis oil). Many manufacturers will supply a list of nut-free products on request, and the community dieticians will also help.
- 4.3 In cookery/home economics classes, every effort should be made to avoid the offending substance. If unavoidable, the sufferer should probably not attend the lesson when the substance is used, as a reaction may be caused by other people using it.
- 4.4 Some children may not need quite such stringent avoidance, and will be able to participate using a different recipe. Seek advice from parents and from your school nurse or doctor.
- 4.5 If nuts are the problem, avoid using them in collage work.
- 4.6 Discuss with parents whether or not the rest of the class should know about the allergy – they can be very helpful in spotting the early stages of a reaction, but if they are to be told, they must also be told on no account to ‘test’ the child with the substance.

5.0 Treatment comes into play if prevention fails.

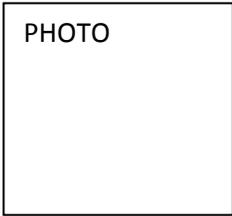
- 5.1 Even if treatment is successful, the child should be checked at hospital, both to make sure that he/she is all right, and in case symptoms recur when the medication wears off. Therefore, whenever the treatment programme is started, someone should also call an ambulance (saying anaphylactic reaction and emergency). It is also important to inform parents, but do not delay starting treatment in order to contact them.
- 5.2 It is important that as many people as possible know the emergency instructions for each child and know where the medication is kept. This should be somewhere where it is safe, but can be obtained quickly. Even people who do not wish to learn to administer the treatment should know where it is kept, so that they can fetch it for someone else if necessary.
- 5.3 Always take the medication to the child, not the child to the medication.
- 5.4 For some children the first line is an antihistamine (e.g. Piriton) in tablet or syrup form. This needs to be taken at the first sign of a reaction as it is fairly slow acting.
- 5.5 Some children have adrenaline injections. The EpiPen has a concealed spring-loaded needle, and is very easy to administer (even through clothing). The Anapen is similar. No other adrenaline injections are appropriate for use in schools.

5.6 Should an incident occur, replacement medication/equipment should be arranged immediately. It is essential that only adrenaline prescribed for the named person is used. A follow up meeting with relevant school staff, school nurse and parents should take place to evaluate the emergency instructions and provide additional support for staff is required.

Sample chart of Emergency Instructions for Allergic Reaction attached.

www.anaphylaxis.org.uk This site provides general information about anaphylaxis, links to further information and frequently asked questions.

CHILD'S NAME



DOB

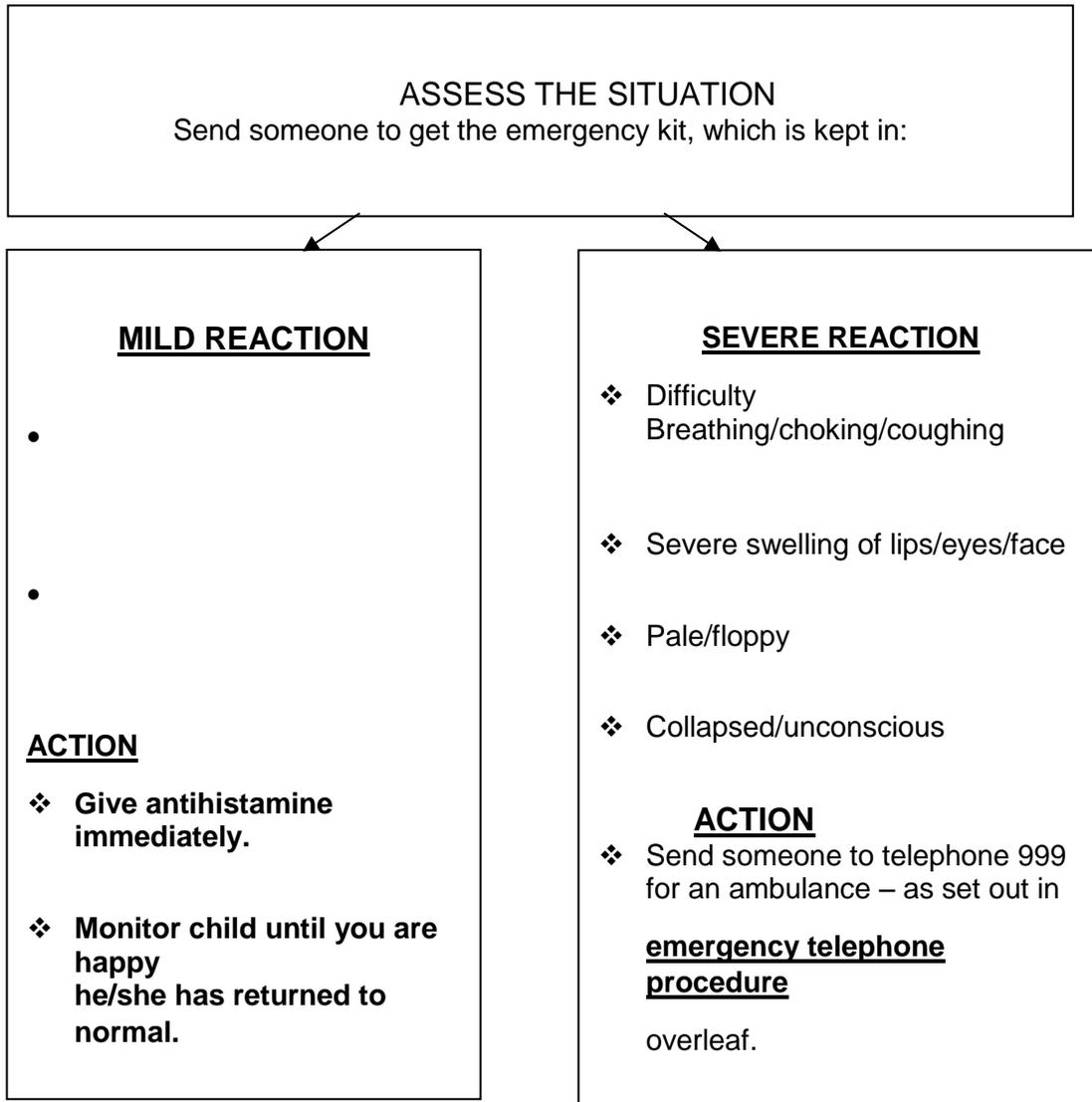
EMERGENCY INSTRUCTIONS FOR AN ALLERGIC REACTION

_____ has had an allergic reaction to _____



All foods containing nuts should be avoided. A severe reaction can cause swelling of the mouth, tongue and throat leading to difficulty breathing and collapse (known as anaphylactic shock).

IT IS IMPORTANT TO REALISE THAT THE STAGES DESCRIBED BELOW MAY MERGE INTO EACH OTHER RAPIDLY AS A REACTION DEVELOPS.



Lie the child down and remove their trousers if they are made of thick material.



Take EpiPen – remove grey cap



Restrain child's leg firmly. Push black tip of EpiPen firmly into outer aspect of mid-thigh.

MAKE SURE A CLICK IS HEARD.



Remain with child until ambulance arrives.

NB Give used EpiPen to ambulance staff – do not touch the needle. If you do prick yourself, wash the wound under running water and contact your GP.

EMERGENCY
TELEPHONE PROCEDURE

- 1. DIAL 999.** Tell the operator you need an ambulance Immediately. Tell them you have a case of anaphylaxis (ana-fil-ac-sis) and that a child is having difficulty breathing and is losing consciousness.
- 2. Phone**Surgery on Tell them you have an emergency with a child having an anaphylactic reaction.
- 3. Family contact numbers:**

Mother: