Calderdale Council

Access to Education for Children and Young People with Health Needs

Contents

Introduction

Most pupils will, at some time, have a medical condition that may affect their participation in school activities. This may be a short-term situation e.g. finishing a course of medication or a long-term medical condition that, if not properly managed, could limit their access to education. Individual schools are required to develop their own policies to cover the needs of their own schools. This should include procedures for supporting pupils with health needs, including managing medication. Most pupils with long-term health needs are able to attend school regularly, and with some support from school, can take part in most normal school activities.

The aim of this guidance is to outline the role and responsibilities of the Local Authority and support schools to develop policies and procedures on managing medication and implementing effective management systems to ensure that individual pupils with health needs continue to be included in school life.

This guidance has been produced in consultation with:

Calderdale Children and Young People's Services Directorate

Calderdale Association of Secondary Headteachers

Calderdale Association of Primary Headteachers

Calderdale Union Federation

Calderdale Health Foundation Trust

Calderdale Legal Services

Calderdale Child and Adolescent Mental Health Team

(March 2002/revised November 2006/further revision July 2013)

1. This policy is designed to ensure that pupils with health needs receive the health related support to enable them to be included in school life.

   The key principles which underpin the provision of education for pupils with health needs include:

   - clear policy, procedures and standards of provision
   - early identification and intervention
   - continuity of educational provision
   - working together

- partnership with parents, pupils, schools and multi-agency professionals
- successful reintegration into school
- high quality educational provision

2. The policy relates to the inclusion agenda in Calderdale .

   Calderdale Council want to support all children and young people in Calderdale to achieve their full potential, through working together to ensure that children and young people:

   - start healthy and stay healthy
   - are safe at home, in school and in the community
   - enjoy school and achieve their best
   - make friends and take part in activities
   - stay in education and get a job

3. The following guidance and procedures have been written to support schools in the administration of medicines and in supporting pupils with health needs. The guidance also has due regard to DfES 'Ensuring a good education for children who cannot attend school because of health needs' (January 2013)(which has replaced the DFE's Guidance ' Access to Education (2011')); Section 19 of the Education DfES Act 1996 and Equality Act 2010.

Role and Responsibilities of the Local Authority

1. Local Authorities must have regard to the DfE Statutory Guidance 'Ensuring a good education for children who cannot attend school because of health needs' (January 2013) when carrying out their duty to arrange suitable full-time education (or part-time when appropriate for the child's needs) for children of compulsory school age who are unable to attend a mainstream or special school because of their health.

2. This duty applies to all children and young people who would normally attend mainstream schools, including Academies, Free Schools, Independent Schools and Special Schools, or where a child is not on the roll of a school. It applies equally whether a child cannot attend school at all or can only attend intermittently.

3. There will be a wide range of circumstances where a child has a health need but will receive suitable education that meets their needs without the intervention of the LA – for example, where the child can still attend school with some support; where the school has made arrangements to deliver suitable education outside of school for the child; or where arrangements have been made for the child to be educated in a hospital by an on-site hospital school. We would not expect the LA to become involved in such arrangements unless it had reason to think that the education being provided to the child was not suitable or, while otherwise suitable, was not full-time or for the number of hours the child could benefit from without adversely affecting their health. This might be the case where, for example, the child can attend school but only intermittently.

4. The law does not define full-time education but children with health needs should have provision which is equivalent to the education they would receive in school. If they receive 1:1 tuition, for example, the hours of face-to-face provision could be fewer as the provision is more concentrated.

   Where full-time education would not be in the best interests of a particular child because of reasons relating to their physical or mental health, LAs should provide part-time education on a basis they consider to be in the child's best interests. Full and part-time

education should still aim to achieve good academic attainment particularly in English, Maths and Science.

5. Provide such education as soon as it is clear that the child will be away from school from 15 days or more, whether consecutive or cumulative. They should liaise with appropriate medical professionals to ensure minimal delay in arranging appropriate provision for the child. The local authority should arrange provision at the latest by the sixth day of the absence, aiming to do so by the first day of absence.

   Ensure that the education children receive is of good quality, as defined in the statutory guidance Alternative Provision (2013), allows them to take appropriate qualifications, prevents them from slipping behind their peers in school and allows them to reintegrate successfully back into school as soon as possible.

6. The use of electronic media – such as 'virtual classrooms', learning platforms and so on – can provide access to a broader curriculum, but this should generally be used to complement face-to-face education, rather than as sole provision (though in some cases, the child's health needs may make it advisable to use only virtual education for a time).

7. LAs should maintain good links with all schools in their area and put in place systems to promote co-operation between them when children cannot attend school because of ill health. Schools can do a lot to support the education of children with health needs and the sharing of information between schools, health services and LAs is important. Schools can also play a big part in making sure that the provision offered to the child is as effective as possible and that the child can be reintegrated back into school successfully. Parents also have a vital role to play, and LAs should encourage schools to have a publicly accessible policy that sets out how schools will support children with health needs; it is also helpful if schools have a named person who can be contacted by the LA and by parents.

8. The LA should:
   - Have a named officer responsible for the education of children with additional health needs, and parents should know who that person is.

- Have a written, publicly accessible policy statement on their arrangements to comply with their legal duty towards children with additional health needs. The policy should make links with related services in the area – for example, Special Educational Needs and Disability Services (SEND), Child and Adolescent Mental Health Services (CAMHS), Education Welfare/Attendance Improvement Services, educational psychologists, and where relevant, school nurses.
- Review the provision offered regularly to ensure that it continues to be appropriate for the child and that it is providing suitable education.
- Have clear policies on the provision of education for children and young people under and over compulsory school age.

9. Where they have identified that alternative provision is required, LAs should ensure that it is arranged as quickly as possible and that it appropriately meets the needs of the child. In order to better understand the needs of the child, and therefore choose the most appropriate provision, LAs should work closely with medical professionals and the child's family, and consider the medical evidence. LAs should make every effort to minimise the disruption to a child's education. For example, where specific medical evidence, such as that provided by a medical consultant, is not quickly available, LAs should consider liaising with other medical professionals, such as the child's GP, and consider looking at other evidence to ensure minimal delay in arranging appropriate provision for the child.

   Once parents have provided evidence from a consultant, LAs should not unnecessarily demand continuing evidence from the consultant without good reason, even where a child has a long-term health problems. Evidence of the continuing additional health issues from the child's GP should usually be sufficient. In cases where a LA believes that a consultant's on-going opinion is absolutely necessary, they should give parents sufficient time to contact the consultant to obtain the evidence.

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Lead Agency

In Calderdale the named officer responsible for the education of children with additional health needs is the Virtual School Head – LAC and Vulnerable Children.

The Medical Needs Team (Virtual School) is the lead agency in ensuring that pupils with health needs have access to continued education.

Pupils remain the responsibility of the school for as long as they remain on the school roll. As a consequence school staff will be required to deliver or support the delivery of an appropriate curriculum during periods of absence attributable to health needs.

Definition

A "health need" is a clinically identified or diagnosed medical need which prevents a child or young person attending school for 15 working days or more.

Children and young people may experience various degrees of incapacity due to physical or mental health needs. The condition may be of limited duration but still sufficiently debilitating to prevent the pupil from accessing full-time educational provision or may be of a more protracted nature, which in some cases is of indeterminate length. The degree of incapacity may be of such a nature or extent as to require the delivery of an alternative and more flexible personalised curriculum.

Children and young people may:

- Be recovering from injury or surgical procedures
- Have a long term and recurring illness
- Have anxieties which prevent them from attending school and have been referred to CAMHS

Referral Procedure

- Referral to the Medical Needs Team (Virtual School) should originate from the school, with support from another agency, unless there are exceptional circumstances where a young person is not on a school roll. Other agencies may include:-
  - Early Intervention Locality Team (Education Welfare)
  - Special Education Needs Team
  - Childrens Social Care
  - Educational Psychology Service
  - Child and Adolescent Mental Health Service
  - Local/regional hospital
  - School Nursing Service

  Ref: Referral from Appendix 2

- When school staff become aware of a child or young person who is absent from school for fifteen days or more, or likely to be absent for this duration due to physical or mental ill health, consideration should be given to a referral to the Medical Needs Team (Virtual School). Prior to the referral, the school should have considered if the child's needs can be met from school resources, in line with the statutory DfE Guidance.

- Supporting evidence from a medical practitioner at consultant level is required to process the referral. In exceptional circumstances the Virtual School Head has the discretion to decide if teaching support is to be actioned to ensure continuity of provision.

Provision of medical needs teaching support

Upon receipt of a referral and supporting documentation and the agreement that teaching support is appropriate, the Medical Needs Team will:

- liaise with the referring school and agency/identify the named person at the school
- undertake a home visit to discuss with parents/carers
- meet the young person and incorporate their views in planning the educational provision
- undertake a risk assessment
- allocate a teacher within five working days
- confirm in writing to parents, school and agencies the agreed provision, including venue, and times of sessions
- set a meeting date for the first target setting and half-termly review
- ensure young people and carers are consulted and actively involved in decision making, through the planning and review process
- ensure that an integrated support programme is actioned, leading to a planned reintegration into school where appropriate

Responsibilites and Resources:-

The school retains the delegated funding for the child or young person and will remain responsible for:

i. a named person responsible for children and young people with medical needs
ii. ensuring planning is available in all national curriculum subjects which the child or young person would normally be studying;
iii. making available Individual Education Plans/Personal Education Plans and Health Care Plans where appropriate.
iv. the loan of appropriate resource materials and equipment where possible.
v. making arrangements for SATs and examinations (including entry fees)
vi. on-going assessment and target setting
vii. career interviews and work experience placements.
viii. ensuring that a named member of staff regularly liaises with the Medical Needs Team/attends half termly target setting and review meetings/facilitates and supports any planned reintegration programme.

Medical Needs teachers within the Virtual School are responsible for:

i. assessing, planning and delivering curriculum entitlement
ii. developing and contributing to the target setting process
iii. involving and consulting with the child/young person on educational progress and plans
iv. maintaining individual pupil records of intervention
v. liaising with parents/carers, the child/young person and other agency professionals regularly to ensure effective partnership working
vi. facilitating the reintegration of pupils into school, through the transfer of teaching support into the school, if agreed through a planned reintegration programme
vii. attending review meetings for young people to contribute to discussions on progress

The Medical Needs Team will ensure:-

i. high quality teaching including access to SATs/GCSE subjects, Asdan and alternative accreditations;
ii. all teachers in the Medical Needs Team have access to continuing professional development and are informed about the resources and support available to deliver high quality educational provision;
iii. wherever possible children and young people with health needs having access to the full national curriculum;
iv. teachers, children and young people have access to ICT to support learning through teacher's laptops, home computers and links to schools Virtual Learning environments;
v. access to a specialist Careers PA who meets the Co-ordinator of Medical Needs half termly.

Monitoring:-

Records and documentation associated with this policy will be audited and monitored by the Virtual School Head. Monitoring will ensure that the service is:

i. meeting the needs of children and young people with medical needs and monitoring their progress through individual pupils' records of intervention and the target setting and review system
ii. meeting the requirements of Section 19 of the Education Act 1996 and the statutory guidance.

Complaints:-
Any complaints regarding the service will be dealt with under the Council's complaints procedure.

School Policy – Health Needs/Administration of Medicines:-

All schools should have a written policy and procedures for dealing with the education of pupils with health needs, and the administration of medicines. It must be acknowledged that:-

1. Whilst all staff have a duty to take reasonable care for the health and safety of pupils in school, there is no contractual requirement for teachers to administer medicines and, therefore, any such role is voluntary on their part. The view of the Teacher Associations is that teachers do not have a duty to administer medicines and they will issue advice to their members as appropriate. Teachers have a responsibility for "duty of care" (in loco parentis) in the event of an accident or emergency, but not to take part in any planned procedures.

2. The Associations/Unions recognise that there is a requirement for schools to have a policy on the administration of medicines. Headteachers will ensure that all of their staff are made aware of the school policy. In certain cases, contracts for non-teaching staff may include reference to the administration of medicines or the undertaking of medical procedures. These will be agreed on an individual basis and all staff who are required to administer medication will receive training.

3. If a member of staff administers medicine to a pupil, or undertakes a medical procedure to support a pupil and, as a result, expenses, liability, loss, claim or proceedings arise, the Council as employer will indemnify the member of staff provided the following conditions apply:

    a. The member of staff is an employee of the Council;
    b. The medicine/procedure is administered by the member of staff in the course of their employment with the Council;
    c. The member of staff follows:
        i. these procedures;
        ii. the school's policy; and

iii. the procedure outlined in the individual pupil's health care plan and directions received through training

d. Except as set out in the note below, the expenses, liability, loss, claim or proceedings are not directly or indirectly caused by and do not arise from fraud, dishonesty or a criminal offence committed by the member of staff.

NOTE: Condition (d) does not apply in the case of criminal offence under the Health & Safety at Work Act 1974.

In this policy, the term employee includes persons contracted to work for the Council or Governing Body, but who are employees of an external agency or contractor. Exceptionally, this indemnity has been extended by the Council to apply to members of staff in voluntary aided schools who are employees of the governing body of the school rather than the Council.

Guidance on the Administration of Medicines:-

1. **Authorised Persons**
   The Headteacher is responsible for the operation of the school policy on the Administration of Medicines and is therefore the main person responsible for the administration of medicines. The Headteacher can authorise a named member of staff, with their agreement, to be responsible for the administration of medication (this member of staff is then the 'Authorised Person'). It is the duty of the Headteacher to ensure that all members of the teaching and non-teaching staff (including supply staff) are made aware of the school policy.

2. **Information for Parents**
   Reference to the school policy on medication should be included in the school brochure. Full copies of the policy on the Administration of Medicines should be made available to parents as required.

3. **Storage of Medicines**
   At school, all controlled drugs should be stored and locked in an appropriate place (this may include a refrigerator). However, asthma inhalers and epi-pens should be easily accessible, children should know where they are and these should be clearly marked with the individuals name.

4. **Injections and Invasive Procedures**
   It is unlawful for staff to administer medication by injection unless for the purpose of saving life in an emergency and invasive procedures will only be undertaken if included in a Health Care Plan. Suitable training will be given.

5. **Self-Administration of Medication**
   Wherever possible, pupils should be encouraged to self-administer medicines in an appropriate place, or under the supervision of an authorised member of staff, subject to a risk assessment by the school.

6. Procedures

6.1 The parent/carer is responsible for supplying the Headteacher with adequate medical information regarding their child's condition and medication. The Headteacher/authorised person will then initiate the Health Care Plan if appropriate.

6.2 This must be in writing, signed and current so that procedures for each individual case are known. It is recommended that each school also has a standard Medical Consent Form. It should be updated annually at the start of each academic year or earlier as and when appropriate, if medication is altered by the child's GP or Consultant.

6.3 Copies of this Consent Form should be kept in the child's main school file and in the Medication Administration Records File.

6.4 All medicines must be delivered to the school by parents/carers or authorised person. It is the parent/carers' responsibility to inform the Headteacher in writing when the medicine or the dosage is changed. The parent/carer/escort should sign the transfer of medication book on arrival at school.

6.5 After first receipt of medicines at school, additional medication may continue to be accepted without further notice, but any change in dosage etc, must be notified, in writing, to the Headteacher or accepted Authorised Person. "As required" medication, eg inhalers, will only be accepted if the above procedures have been followed. It is expected that pupils will keep inhalers on their person.

6.6 Each medicine must be delivered, **in the original container**, to the Headteacher or Authorised Person. It may be appropriate for the GP to prescribe a separate amount of medicine for school use. This should be negotiated with the parent/carer. Medicines in unlabelled containers will not be accepted. The school should record the delivery of medication in a special book on receipt.

6.7 Each container **must** be clearly labelled with the following:-

i name of medicine;
ii pupil's name;
iii dosage;
iv dosage frequency;
v date of dispensing;
vi storage requirements, if important;
vii expiry date;
viii any contra-indications.

6.8 It should be made clear by the parents/carers whether the medication should go with the pupil at the end of the school day or remain in school.

6.9 All pupils will have access to the National Curriculum unless medical advice specifically precludes it, or it is clearly impractical (for example, pupils who have epilepsy should participate in swimming lessons unless the school is specifically advised to the contrary by the pupil's Consultant).

6.10 When pupils who have a medical condition such as epilepsy go out of school, school staff will have access to a mobile telephone. School staff will take the pupil's medical card with them (the medical card lists details of all medications that the pupil is taking) and where necessary medication.

6.11 No medication should be left in an unattended situation.

6.12 Medicines should only be taken to school when essential where it would be detrimental to a child's health if it were not administered during the school day.

7. Training

7.1 Appropriate training for members of staff undertaking medical procedures is essential and any training required should be arranged through discussion with the school nurse, the Local Authority or specialist nursing teams in Calderdale. The School Nursing Service may deliver awareness raising sessions on the medical condition in school or signpost school staff to the most appropriate person. It should be made clear that the School Nursing Service are not "trained to train" and therefore cannot sign off on any training nor deliver CPR or first aid training.

7.2 Records of all training provided and of training updates must be maintained and retained by the school.

8. Partnership Working – School Nursing Service

8.1 Schools need to have entered into a School Health Improvement Plan with School Nursing Service to have established an agreement about support for the writing of individual Health Care Plans.

8.2 School Nursing Service as an integral part of the School Health Improvement Plan are required to meet key personnel in schools at the beginning of the school academic year to discuss children with complex medical needs and plan accordingly.

8.3 It would be beneficial for School Nursing Service to receive copies of individual health care plans for their schools.

Appendix 1

Medical Conditions Guidance:

- Asthma
- Epilepsy
- Diabetes
- Anaphylaxis

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

reaction (anaphylaxis). This appendix 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.

ASTHMA: www.asthma.org.uk/adviceline

What is Asthma?

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

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

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

Medicine and Control

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

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

Children who are able to use their inhalers themselves should be allowed to carry them with them. If the child is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe but readily accessible place, and clearly marked with the child's name.

Inhalers should always be available during physical education, sports activities and educational visits.

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

The signs of an asthma attack include:

- coughing
- shortness of breath
- wheezy breathing
- tightness in the chest
- being unusually quiet

The following advice does not apply to people using a Symbi cort inhaler on the Symbicort SMART regime.

When a child has an attack they should be treated according to their individual health care plan or asthma card.

How to help **If the child does not have a reliever inhaler with them call 999**	• **Make sure the child takes one or two puffs of their inhaler (usually blue).** • **Sit the child up and encourage them to take slow steady breaths.** • **Keep calm and reassure the child.**
If the child does not feel better	**Continue to give them <u>two puffs</u> of their reliever inhaler every two minutes, they can take 10 puffs.**
CALL 999 for an ambulance if:	• **The child does not feel better after taking the inhaler as above** • **YOU ARE WORRIED AT ANYTIME** • **If an ambulance does not arrive within 15 minutes repeat the steps in the green box above.**

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

taken. An Asthma School Card (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

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

Children should have a reliever inhaler with them when they are in school or in a setting.

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

Reluctance to participate in physical activities should be discussed with parents, staff and the child. However children with asthma should not be forced to take part if they feel unwell. Children should be encouraged to recognise when their symptoms inhibit their ability to participate. Children with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate. 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 o 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.

All staff, particularly PE teachers, should receive awareness raising 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: www.epilepsy.org.uk

What is Epilepsy?

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

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

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual. auditory stimulation, emotion (anxiety, upset).
- any unusual 'feelings' reported by the child prior to 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.

What the child experiences depends whether all or which part of the brain is affected. Not all seizures involve loss of consciousness. When only 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 mumblings sounds and chewing movements. They may not respond if spoken to. Afterwards, they may have little or no memory of the seizure.

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

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

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

Medicine and Control

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

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

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

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

An ambulance should be called during a convulsive seizure if:

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

Such information should be an integral part of the school or setting's emergency procedures and 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.

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

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

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? www.diabetes.org.uk

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

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

Each child may experience different symptoms and this should be discussed

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

Medicine and Control

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

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

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

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

Children with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class-time or prior to exercise. Schools may need to make special arrangements for pupils with diabetes if the school has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity sessions should be aware of the need for children with diabetes to have glucose tablets or a sugary drink to hand.

Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar – a **hypoglycaemic reaction** (hypo) in a child with diabetes:

- hunger
- sweating
- drowsiness

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

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 10-15 minutes
- 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.

Such information should be an integral part of the school or setting's emergency procedures and relate specifically to the child's individual health care plan.

Hypo – a *quick* guide

What causes a hypo

- too much insulin
- not enough food to fuel an activity
- too little food at any stage of the day
- a missed or delayed meal or snack
- cold weather
- vomiting.

Watch out for

- sweating
- trembling or shakiness
- drowsiness
- headache
- lack of concentration
- hunger
- pallor
- glazed eyes
- mood change, especially angry or aggressive behaviour.

What to do

Immediately give something **sugary**, eg:

• Lucozade	• glucose tablets
• fresh fruit juice	• fizzy drinks (non-diet).

The exact amount needed will vary from person to person and will depend on circumstances.

Hypostop, honey or jam can be massaged into the child's cheek if they are too drowsy to take anything themselves.

Follow this with some **starchy** food to prevent the blood glucose from dropping again:

• roll/sandwich	• cereal bar
• muffin	• portion of fruit
• one individual mini pack of dried fruit	• two biscuits, eg garibaldi, ginger nuts.

If the child still feels hypo afer 15 minutes, some more sugary food should be given. When the child has recovered, give some starchy food, as above.

If the child is **unconscious do not give them anything to eat or drink** and **call for an ambulance.**

Diabetes UK

The charity for people with diabetes

Diabetes UK Careline 020 7424 1030 **Website** www.diabetes.org.uk

Hypoglycaemia advice for schools

Calderdale and Huddersfield NHS Trust

Children with Diabetes
the management of
HYPOGLYCAEMIA

Blood Glucose below 4 mmols
But still able to take diet and fluids

Administer x2 dextrose tablets or ½ glass of sugary drink
Check blood level again in 15 minutes

If blood glucose still below 4 mmols
Repeat the above and then
Check blood level again in another 15 minutes

Once child returns to normal functioning and blood level above 4 mmols
Offer long acting carbohydrates
Biscuits/ milk or a sandwich

Return to lessons

Blood Glucose below 3.5 mmols
but will not take diet or fluids

Administer glucogel as instructed. Check blood level again in 10-15 minutes if over 4 mmols offer digestive biscuits/milk or sandwich

When back to normal functioning return to lessons

If the child is found unresponsive or unconscious DIAL 999
Ask ambulance crew to take the child direct to the children's ward at Calderdale Royal Hospital

Diabetes contact – Nancy Harrison
Children's Diabetes Nurse
Phone 01422 224126 or 07775538923

ANAPHYLAXIS www.anaphylaxis.org.uk

What is anaphylaxis?

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

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

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

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

Medicine and Control

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

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

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

from the child's leg. In cases of doubt it is better to give the injection than to hold back.

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

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

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

Important issues specific to anaphylaxis to be covered include:

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

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

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

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

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

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

Anaphylactic shock

Allergic Reactions

MINOR SYMPTOMS

- Urticarial rash – pink, raised, very itchy (HIVES, NETTLE RASH);
- Flushed face and neck
- Child otherwise unwell

SEVERE SYMPTOMS

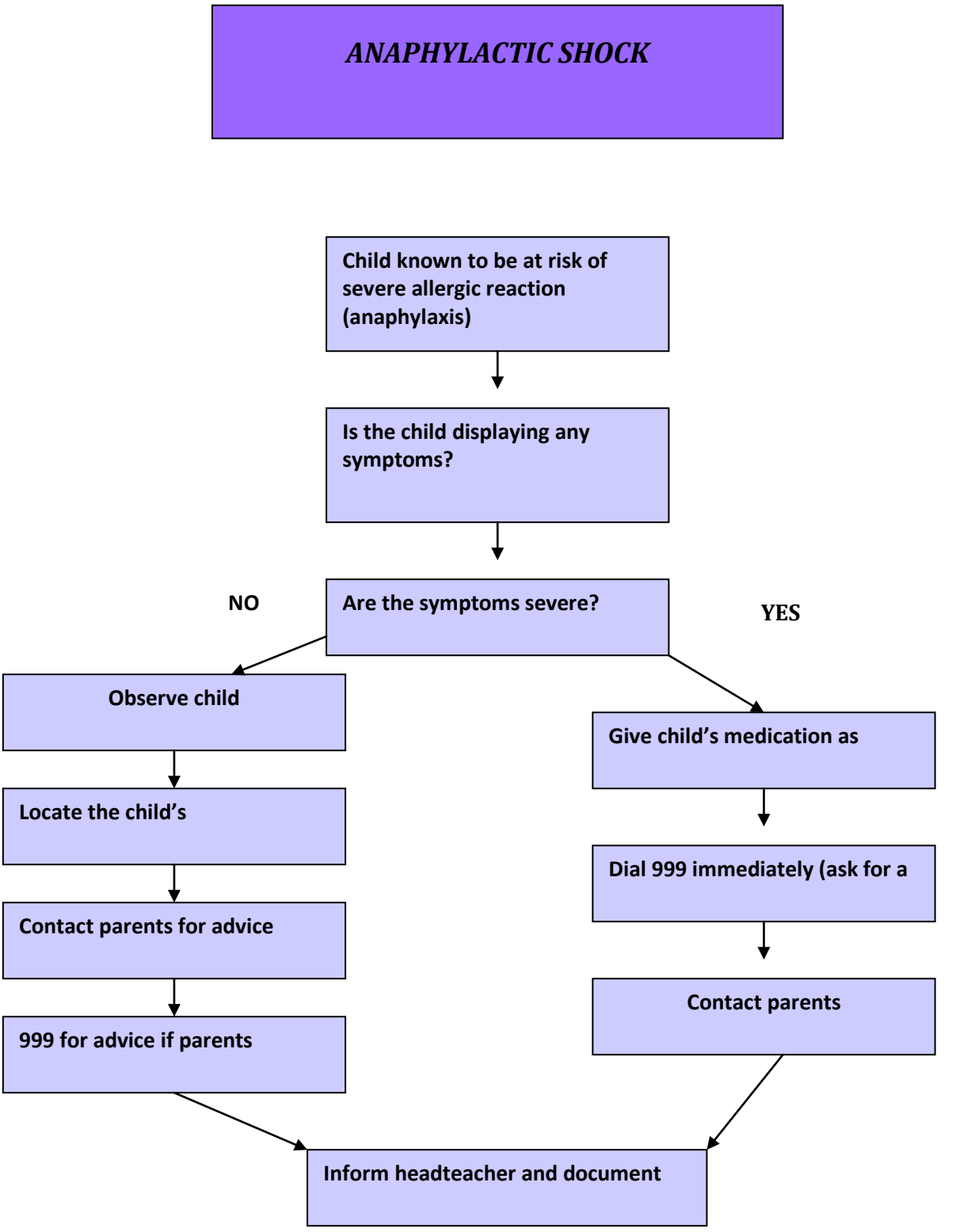
- Facial tingling leading to swelling of face, lips, tongue and eyes
- Hoarse voice and/or feeling of a lump in the throat
- Cough and/or noisy breathing
- Difficult breathing and/or swelling
- Feeling of faintness and/or fear
- Abdominal pain and nausea/vomiting

LEADING TO:-

- Loss of consciousness
- Rapid weak pulse
- Very laboured breathing
- Blue lips

Not All Symptoms Will Necessarily Be Experienced

IF IN ANY DOUBT DIAL 999 EVEN IF ONLY FOR ADVICE


ANAPHYLACTIC SHOCK
Child known to be at risk of severe allergic reaction (anaphylaxis)
Is the child displaying any symptoms?
Are the symptoms severe?
NO
YES
Observe child
Locate the child's
Contact parents for advice
999 for advice if parents
Give child's medication as
Dial 999 immediately (ask for a
Contact parents
Inform headteacher and document

Appendix 2

Referral Form

Calderdale Medical Needs Team

VIRTUAL SCHOOL
Medical Needs Team - Referral Form

Surname/Family Name:		***First/Other Name(s):***	
Previous Surname/AKA:		***Date of Birth:***	***Gender:*** **M / F**
Address: ***Post Code***		***E-mail:***	
Home Phone:	***Day Phone:***	***Mobile(s):*** *Student* *Parent/Carer*	
Parent/Carer:			
Address: *(if different from above)* ***Post Code***		***E-mail:***	
School: ***Tel No:***		***Named School Contact for Students with Medical Needs:***	
Year Group:	*Unique Pupil Number:*	***Year Head/ Primary Class Teacher:***	
National Curriculum Levels: KS2 / KS3 / KS4	***ENGLISH :***	***MATHEMATICS :***	***SCIENCE :***
SEN Status: ***School Action / School Action Plus / Statement of SEN***		***Family Doctor:*** ***Surgery Address:***	
Reason for referral: *(If appropriate, please include EDD)*		***Post Code:*** ***Phone:***	

(Continued overleaf)

Please note - Schools are required and have the responsibility to supply schemes of work and resources.

For Office Use Only			
Receipt Date of referral form:			
Date Allocated:			
Named MN Teacher / Key Worker:			
Closure Date:			
Reason:			

The Medical Needs Team fulfils the statutory duty of the Local Authority to provide an entitlement to education for pupils who are too ill to attend school.
Consequently, this is a core service and there is no charge to either maintained school or academies. However, all schools and provisions are charged when pupils with a statement of special educational needs receive medical needs teaching, due to the additional funding they receive.

Relevant agencies known to be working with this student, with named contact where possible.					
Education Welfare Officer:		***Consultant:***			
Autistic Spectrum Disorders:		***Family Support Team:***		***School Nurse:***	
Child and Adolescent Mental Health Service:		***Health Visitor:***		***Speech and Language Team:***	
Care Services:		***Virtual School:***		***Sensory Support:***	
Dietician:		***Midwife:***		***Youth Offending Team:***	
Educational Psychology Service:		***Occupational Therapy:***		***Young People's Service:***	
Family Nurse:		***Physiotherapy:***		***Other:***	

Ethnicity codes:			
White	A	British, Irish or Other White	
Mixed	B	White and Black Caribbean, White and Black African White and Asian or any other mixed background	
Asian or Asian British	C	Indian, Bangladeshi, Pakistani or any other black background	
Black or Black British	D	Caribbean, African or any other black background	
Chinese	E	Chinese or any other ethnic group	
Main language spoken at home:			

Parental Consent		
The information contained in this form will be processed in accordance with the Data Protection Act 1998 and specifically used to administer the Medical Needs referral system. Information on the form will only be shared with other support agencies where we have either a statutory duty or the explicit consent to do so. By signing this form you acknowledge that you have been given sight of this information.		
Name: **(please print)**	***Signature:***	***Date:***
Parent/Carer views on referral:		

Referral made by: _____Post title:_____
(*please print*)
Signature: _____Date_____

NB - All referrals require supporting documentation from a qualified medical practitioner before they can be accepted.

Please send completed forms f.a.o:
Maggie Priestley - Medical Needs Team Co-ordinator
Heath Training & Development Centre, Free School Lane, Halifax. HX1. 2PT
Enquires: (01422) 394137 Fax: (01422) 364899e-mail: maggie.priestley@calderdale.gov.uk

FORM A

PHOTO

Health Care Plan

Name of school/setting	
Name of Pupil	
Group/class/form/year group	
Date of birth	/ /
Address of pupil	
Medical diagnosis or condition	
Date Completed	/ /
Attendance at Meeting	
Review date	/ /

Family Contact Information

Name and Relationship	
Phone no. (work)	
(home)	
(mobile)	
Name and Relationship	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no.	

G.P.

Name and Telephone Number	

Describe medical needs and give details of child's symptoms

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

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

Follow up care

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

Form copied to: Signatures:

Parent:	Parent:
Named Person - School	Named Person – School:
School Nurse	

FORM B

Parental agreement for school/setting to administer medicine

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

Name of school/setting	
Name of pupil	
Date of birth	/ /
Group/class/form/year group	
Medical condition or illness	

Medicine

Name/type of medicine *(as described on the container)*	
Date dispensed	/ /
Expiry date	/ /
Agreed review date to be initiated by	[name of member of staff]
Dosage and method	
Timing	
Special precautions	
Are there any side effects that the school/setting needs to know about?	
Self administration	Yes/No
Procedures to take in an emergency	

Contact Details

Name and Relationship	
Daytime telephone no. (essential)	
Relationship to pupil	
Address	
I understand that I must deliver the medicine personally to	[agreed member of staff]

I accept that this is a service that the school/setting is not obliged to undertake.

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

Date _____ Parent(s) signature _____

FORM C

Head teacher/Head of setting agreement to administer medicine

Name of school/setting

It is agreed that _____[name of child] will receive _____ [quantity and name of medicine] every day at _____[time medicine to be administered e.g. lunchtime or afternoon break].

_____[Name of child] will be given/supervised whilst he/she takes their medication by _____ [name of member of staff].

This arrangement will continue until _____[either end date of course of medicine or until instructed by parents].

Date _____

Signed _____

(The Head teacher/Head of setting/named member of staff)

FORM D

Record of medicine administered to an individual pupil

Name of school/setting	
Name of pupil	
Date medicine provided by parent	/ /
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	/ /
Quantity returned	
Dose and frequency of medicine	

Staff signature _____

Signature of parent _____

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

FORM E

Record of medicines administered to all pupils

Name of school/setting

Date	Child's name	Time	Name of medicine	Dose given	Any reactions	Signature of staff	Print name
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							
/ /							

FORM F

Request for pupil to carry his/her own medicine

This form must be completed by parents/guardian

If staff have any concerns discuss this request with healthcare professionals

Name of school/setting	
Pupil's name	
Group/class/form/year group	
Address	
Name of medicine	
Procedures to be taken in an emergency	

Contact Information

Name	
Daytime phone no.	
Relationship to pupil	

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

Signed _____

Date _____

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

FORM G

Staff training record – administration of medicines

Name of school/setting	
Name	
Type of training received	
Date of training completed	/ /
Training provided by	
Profession and title	

I confirm that _____ [name of member of staff] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated _____[please state how often].

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

FORM H

Contacting Emergency Services

Request for an Ambulance

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

1. Your telephone number

2. Give your location as follows
   [insert school setting address]

3. State that the postcode is

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

5. Give your name

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

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

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

Put a completed copy of this form by the telephone