



Hebden Royd C.E. (VA) Primary &  
Nursery School

# Medicines & Medical Needs Policy

**Approved by:**

Headteacher &  
Governing Body

**Date:** May 2021

**Last reviewed on:**

May 2022

**Next review due by:**

May 2023

Parents have the prime responsibility for their child's health and should provide schools and settings with information about their child's medical condition. This question is first asked in the enrolment forms. Parents are expected to be honest regarding needs.

Hebden Royd Primary expects that every parent will inform us about any particular needs before a child is admitted, or when the child first develops a medical need. For children who attend hospital appointments on a regular basis, special arrangements may also be necessary.

In such cases a written health care plan for such children, involving the parents and relevant health professionals will be developed.

There is no legal duty that requires school or setting staff to administer medicines. However, staff at Hebden Royd have made a commitment to the children and have agreed to manage the administration of medicines only when it is truly necessary. Those who administer medicines have received support and training from our local health professionals. We currently have in school 3 children who have a care plan for allergies and who may require an epi pen to be used.

As a school we have asked that if medicines are prescribed in dose frequencies which enable it to be taken outside school hours that this occurs. It is to be noted that medicines that need to be taken three times a day could be taken in the morning, after school hours and at bedtime.

Hebden Royd only accepts medicines that have been prescribed by a doctor, dentist, nurse prescriber or pharmacist prescriber. Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions for administration and dosage and are checked against these criteria.

### **Procedures for managing prescription medicines which need to be taken during the school day**

Should a child need to be administered medicine during the day, parents are expected to inform the office in the morning and to fill in a green parental consent form and to detail the requirements for that child.

Staff who administer the medicine will then fill in the bottom half of the form to record the date and time the medicine is taken.

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

If in doubt about any procedure staff will not administer the medicines but check with the parents or a health professional before taking further action. If staff have any other concerns related to administering medicine to a particular child, the issue will be discussed with the parent, if appropriate, or with a health professional attached to the school or setting

*If a child refuses to take medicine, staff will not force them to do so, but will note this on the green form. Parents will be informed of the refusal on the same day. If a refusal to take medicines results in an emergency, the school or setting's emergency procedures should be followed.*

Medicines are clearly labelled with the child's name and then kept in the First aid box in the office where it is cool. For those medicines that need to be kept refrigerated there is a fridge

in the kitchen which is used. Medicines are returned to the adult with the child at the end of the day.

Adrenaline pens are kept in the child's classroom.

### **School trips and outings**

All our medical needs children are encouraged to participate in safely managed visits. We will make reasonable adjustments when necessary to enable full participation and safety on visits. These children will be taken into account of specifically on risk assessments.

Should medicines need to go on the trip with the child arrangements for this will also be taken into consideration.

Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures. A copy of any health care plans should be taken on visits in the event of the information being needed in an emergency.

**Children with inhalers will take them with them on any trip or outing beyond the school boundary, especially for sports on the school field.**

All medicines will be held by the group leader and will be administered as if at school by recording the date and time of administration on the green form.

## Appendix 1 DRAWING UP A HEALTH CARE PLAN

### Purpose of a Health Care Plan

1. The main purpose of an individual health care plan for a child with medical needs is to identify the level of support that is needed. Not all children who have medical needs will require an individual plan. A short-written agreement with parents may be all that is necessary such as Forms 3A or 3B and Form 4.
2. An individual health care plan clarifies for staff, parents and the child the help that can be provided. It is important for staff to be guided by the child's GP or paediatrician. Staff should agree with parents how often they should jointly review the health care plan. It is sensible to do this at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently.
3. Staff should judge each child's needs individually as children and young people vary in their ability to cope with poor health or a particular medical condition.
4. Developing a health care plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child.
5. In addition to input from the school health service, the child's GP or other health care professionals (depending on the level of support the child needs), those who may need to contribute to a health care plan include:

- the head teacher or head of setting
- the parent or carer
- the child (if appropriate)
- early years practitioner/class teacher (primary schools)/form tutor/head of year (secondary schools)
- care assistant or support staff (if applicable)
- staff who are trained to administer medicines
- staff who are trained in emergency procedures

The content of the plan should include:

- Detail of a child's condition
- Dietary needs
- Side effects which may be seen as a result of medicines
- What constitutes an emergency
- What is needed if an emergency is decided upon
- What not to do in the event of an emergency
- What staff role staff have

## Appendix 2

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

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

From April 2004 training for first aiders in early years settings must include recognising and responding appropriately to the emergency needs of babies and children with chronic medical conditions.

#### ASTHMA

##### What is Asthma?

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

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

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

##### Medicine and Control

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

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

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

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

**The signs of an asthma attack include:**

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

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

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

It is important to agree with parents of children with asthma how to recognise when their child's asthma gets worse and what action will be taken. An **Asthma School Card** (available from Asthma UK) is a useful way to store written information about the child's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and the child's doctor.

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

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

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

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

All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and medical needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from

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

All staff, particularly PE teachers, should have training or be provided with information about asthma once a year. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child has an asthma attack.

## **EPILEPSY**

### **What is Epilepsy?**

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

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

- any factors which might possibly have acted as a trigger to the seizure – e.g. visual/auditory stimulation, emotion (anxiety, upset)
- any unusual “feelings” reported by the child prior to the seizure
- parts of the body demonstrating seizure activity e.g. limbs or facial muscles
- the timing of the seizure – when it happened and how long it lasted
- whether the child lost consciousness
- whether the child was incontinent

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

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

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

may bite their tongue or cheek and may wet themselves.

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

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

## **Medicine and Control**

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

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

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

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

### **An ambulance should be called during a convulsive seizure if:**

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

Such information should be an integral part of the school or setting's emergency procedures as discussed at paragraphs 115 - 117 but also relate specifically to the child's individual health care plan. The health care plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.



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?**

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 10-15minutes**
- **the child becomes unconscious**

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

Such information should be an integral part of the school or setting's emergency procedures as discussed at paragraphs 115 – 117 but also relate specifically to the child's individual health care plan.

## **ANAPHYLAXIS**

### **What is anaphylaxis?**

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<sup>1</sup>, 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.

---

## Appendix 3

### LEGAL FRAMEWORK

#### The Law

SEN and Disability Act 2001

Health and Safety at Work etc Act 1974

The Management of Health and Safety at Work Regulations 1999

Control of Substances Hazardous to Health Regulations 2002

Misuse of Drugs Act 1971 and associated regulations

Medicines Act 1968

The Education (School Premises) Regulations 1999

The Education (Independent Schools Standards)(England) Regulations 2003

National Standards for under 8s day care and childminding – Premises

Special Education Needs – Education Act 1996

Care Standards Act 2000

#### Introduction

This part sets out the legal framework for schools and local education authorities in the management of medicines in schools and early years settings.

It summarises:

- the main legal provisions that affect schools' responsibilities for managing a pupil's medical needs
- the main legal provisions that affect early years settings' responsibilities for managing a child's medical needs

It is to be noted that this annex does not constitute an authoritative legal interpretation of the provisions of any enactments, regulations or common law: that is exclusively a matter for the Courts. It remains for Local Authorities, schools and settings to develop their policies in the light of their statutory responsibilities and their own assessment of local needs and resources.

#### GENERAL BACKGROUND

Local Authorities (LAs), schools and governing bodies are responsible for the health and safety of pupils in their care. The legal framework for schools dealing with the health and safety of **all** their pupils derives from health and safety legislation. **The law imposes duties on employers. Primary Care Trusts (PCTs) and NHS Trusts** also have legal responsibilities for the health of residents in their area.

The registered person in early years settings, which can legally be a management group rather than an individual, is responsible for the health and safety of the children in their care. The legal framework for registered early years settings is derived from both health and safety legislation and the national standards for under 8s day care. **The law imposes duties on employers.**

## **Staff administering medicine**

**There is no legal or contractual duty on staff to administer medicine or supervise a child taking it.** The only exceptions are set out in the paragraph below. Support staff may have specific duties to provide medical assistance as part of their contract. Of course, swift action needs to be taken by any member of staff to assist any child in an emergency. Employers should ensure that their insurance policies provide appropriate cover.

## **Staff 'duty of care'**

Anyone caring for children including teachers, other school staff and day care staff in charge of children have a common law duty of care to act like any reasonably prudent parent. Staff need to make sure that children are healthy and safe. In exceptional circumstances the duty of care could extend to administering medicine and/or taking action in an emergency. This duty also extends to staff leading activities taking place off site, such as visits, outings or field trips.

## **Admissions**

Children with medical needs have the same rights of admission to school as other children and cannot generally be excluded from school for medical reasons. Where a pupil's presence on the school site represents a serious risk to the health or safety of other pupils or school staff a head teacher may send the pupil home that day after consultation with the parents. This is not an exclusion and may only be done for medical reasons<sup>2</sup>.

## **THE LAW**

Legislation, notably the Education Act 1996, the Disability Discrimination Act 1995, the Care Standards Act 2000 and the Medicines Act 1968 are also relevant to schools and settings in dealing with children's medical needs. The following paragraphs outline the provisions of these Acts that are relevant to the health and safety of children attending early years settings and schools.

### **SEN and Disability Act (SENDA) 2001**

The SEN and Disability Act (SENDA) 2001 amended Part IV of the **Education Act 1996** making changes to the existing legislation, in particular strengthening the right of children with SEN to be educated in mainstream (as opposed to special) schools.

Schools and early years settings are both required to take "reasonable steps" to meet the needs of disabled children.

**SENDA** also amended Part 4 of the **Disability Discrimination Act (DDA) 1995** bringing access to education within the remit of the DDA, making it unlawful for schools and LEAs to discriminate against disabled pupils for a reason relating to their disability, without justification. This might include some children with medical needs. Part 4 duties apply to all schools; private or state maintained, mainstream or special and those early years settings constituted as schools.

Some medical conditions may be classed as a disability. The responsible body of a school

---

will need to consider what arrangements can reasonably be made to help support a pupil (or prospective pupil) who has a disability. The Disability Rights Commission has produced a Code of Practice for Schools<sup>3</sup>. Advice and training from local health professionals will help schools when looking at what arrangements they can reasonably make to support a pupil with a disability.

Since September 2002 schools and LEAs have been under a duty

- a. not to treat less favourably disabled pupils or students, without justification, than pupils and students who are not disabled
- b. to make reasonable adjustments to ensure that disabled pupils and students are not put at a substantial disadvantage in comparison to those who are not disabled.

Schools are not, however, required to provide auxiliary aids or services or to make changes to physical features. Instead, schools and LEAs are under a duty to plan strategically to increase access, over time, to schools. This duty includes planning to increase access to the school premises, to the curriculum and providing written material in alternative formats to ensure accessibility.

Part 4 duties cover discrimination in admissions, the provision of education and associated services and exclusions.

The reasonable adjustments duty in Part 4 includes provision of :

- auxiliary aids and services
- making physical alterations to buildings (from October 2004)

### **Health and Safety at Work etc Act 1974**

The Health and Safety at Work etc Act (HSWA) 1974 places duties on employers for the health and safety of their employees and anyone else on the premises. This covers the head teacher and teachers, non-teaching staff, children and visitors.

Who the employer is depends on the type of school, Hebden Royd is a voluntary-aided school and so the employer is the governing body

The employer of staff at a school or setting **must** do all that is reasonably practicable to ensure the health, safety and welfare of employees. The employer must also make sure that others, such as pupils and visitors, are not put at risk. The main actions employers must take under the Health and Safety at Work etc Act are to:

---

- prepare a written Health and Safety policy
- make sure that staff are aware of the policy and their responsibilities within that policy
- make arrangements to implement the policy
- make sure that appropriate safety measures are in place
- make sure that staff are properly trained and receive guidance on their responsibilities as employees

Most schools and settings will at some time have children on roll with medical needs. The responsibility of the employer is to make sure that safety measures cover the needs of **all** children at the school or setting. This may mean making special arrangements for particular children.

### **Management of Health and Safety at Work Regulations 1999**

The Management of Health and Safety at Work Regulations 1999, made under the HSWA, require employers of staff at a school or early years setting to:

- make an assessment of the risks of activities
- introduce measures to control these risks
- tell their employees about these measures

HSWA and the Management of Health and Safety at Work Regulations 1999 also apply to employees. Employees **must**:

- take reasonable care of their own and others' health and safety
- co-operate with their employers
- carry out activities in accordance with training and instructions
- inform the employer of any serious risk

In some cases, children with medical needs may be more at risk than other children. Staff may need to take additional steps to safeguard the health and safety of such children. In a few cases individual procedures may be needed. The employer is responsible for making sure that all relevant staff know about and are, if necessary, trained to provide any additional support these children require.

### **Control of Substances Hazardous to Health Regulations 2002**

The Control of Substances Hazardous to Health Regulations 2002 (COSHH) require employers to control exposures to hazardous substances to protect both employees and others. Some medicines may be harmful to anyone for whom they are not prescribed. Where a school or setting agrees to administer this type of medicine the employer **must** ensure that the risks to the health of staff and others are properly controlled.



## **Misuse of Drugs Act 1971 and associated regulations**

The supply, administration, possession and storage of certain drugs are controlled by the Misuse of Drugs Act 1971 and associated regulations. This is of relevance to schools and settings because they may have a child that has been prescribed a controlled drug. The Misuse of Drugs Regulations 2001 allow “any person” to administer the drugs listed in the Regulations.

## **Medicines Act 1968**

The Medicines Act 1968 specifies the way that medicines are prescribed, supplied and administered within the UK and places restrictions on dealings with medicinal products, including their administration. Anyone may administer a prescribed medicine, with consent, to a third party, so long as it is in accordance with the prescriber’s instructions. This indicates that a medicine may only be administered to the person for whom it has been prescribed, labelled and supplied; and that no-one other than the prescriber may vary the dose and directions for administration.

The administration of prescription-only medicine by injection may be done by any person but must be in accordance with directions made available by a doctor, dentist, nurse prescriber or pharmacist prescriber in respect of a named patient.

## **The Education (School Premises) Regulations 1999**

The Education (School Premises) Regulations 1999 require every school to have a room appropriate and readily available for use for medical or dental examination and treatment and for the caring of sick or injured pupils. It **must** contain a washbasin and be reasonably near a water closet. It **must not** be teaching accommodation. If this room is used for other purposes as well as for medical accommodation, the body responsible **must** consider whether dual use is satisfactory or has unreasonable implications for its main purpose.

The responsibility for providing these facilities in all maintained schools rests with the Local Authority.

## **The Education (Independent Schools Standards) (England) Regulations 2003**

The Education (Independent Schools Standards) (England) Regulations 2003 require that independent schools have and implement a satisfactory policy on First Aid and have appropriate facilities for pupils in accordance with the Education (School Premises) Regulations 1999. The 1999 Regulations specify the accommodation provisions that apply to boarding schools only, these state that a boarding school must have one or more sick rooms.

## **Special Educational Needs**

Section 312 of the **Education Act 1996** sets out that a child has special educational needs if he has a learning difficulty that calls for special educational provision to be made for him. Children with medical needs will not necessarily have special educational needs (SEN). For those who do, schools should refer to the DfES SEN guidance <sup>4</sup>.

---

Section 322 of the **Education Act 1996** requires that local health services **must** provide help to a LEA for a child with SEN (which may include medical needs), unless the health services consider that the help is not necessary to enable the LEA to carry out its duties or that it would not be reasonable to give such help in the light of the resources available to the local health services to carry out their other statutory duties. This applies whether or not a child attends a special school. Help from local health services could include providing advice and training for staff in procedures to deal with a child's medical needs if that child would otherwise have limited access to education. Local Authorities, schools and early years settings should work together, in close partnership with parents, to ensure proper support for children with medical needs.

## **FORM 1 - 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

## FORM 2 - Healthcare Plan

Name of School/Setting \_\_\_\_\_

Child's name \_\_\_\_\_

Group/Class/Form \_\_\_\_\_

Date of Birth \_\_\_\_\_

Child's Address \_\_\_\_\_

Medical Diagnosis or Condition \_\_\_\_\_

Date \_\_\_\_\_

Review date \_\_\_\_\_

### CONTACT INFORMATION

#### Family contact 1

#### Family contact 2

Name		Name	
Phone No. (work)		Phone No. (work)	
(home)		(home)	
(mobile)		(mobile)	

#### Clinic/Hospital contact

#### GP

Name \_\_\_\_\_ Name \_\_\_\_\_

Phone No. \_\_\_\_\_ Phone No. \_\_\_\_\_

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:

---

## USEFUL CONTACTS

Allergy UK  
Allergy Help Line: (01322) 619864  
Website: [www.allergyfoundation.com](http://www.allergyfoundation.com)

The Anaphylaxis Campaign  
Helpline: (01252) 542029  
Website: [www.anaphylaxis.org.uk](http://www.anaphylaxis.org.uk) and  
[www.allergyinschools.co.uk](http://www.allergyinschools.co.uk)

Association for Spina Bifida and Hydrocephalus  
Tel: (01733) 555988 (9am to 5pm)  
Website: [www.asbah.org](http://www.asbah.org)

Asthma UK (formerly the National Asthma Campaign)  
Adviceline: 08457 01 02 03 (Mon-Fri 9am to 5pm)  
Website: [www.asthma.org.uk](http://www.asthma.org.uk)

Council for Disabled Children (National Children's Bureau)  
Tel: (020) 7843 1900  
Website: <http://www.ncb.org.uk/cdc/>

Contact a Family (Information about caring for disabled and special needs children) Helpline:  
0808 808 3555.  
Website: [www.cafamily.org.uk](http://www.cafamily.org.uk)

Cystic Fibrosis Trust  
Tel: (020) 8464 7211 (Out of hours: 020 8464 0623)  
Website: [www.cftrust.org.uk](http://www.cftrust.org.uk)

Diabetes UK  
Careline: 0845 1202960 (Weekdays 9am to 5pm)  
Website: [www.diabetes.org.uk](http://www.diabetes.org.uk)

Department for Education and Skills  
Tel: 0870 000 2288  
Website: <http://www.dfes.gov.uk>

Department of Health  
Tel: (020) 7210 4850  
Website: <http://www.dh.gov.uk>

Disability Rights Commission (DRC)  
DRC helpline: 08457 622633.  
Textphone: 08457 622 644  
Fax: 08457 778878  
Website: [www.drc-gb.org](http://www.drc-gb.org)

Epilepsy Action

Freephone Helpline: 0808 800 5050

(Monday – Thursday 9am to 4.30pm, Friday 9am to 4pm)

Website: [www.epilepsy.org.uk](http://www.epilepsy.org.uk)

Health and Safety Executive (HSE)

HSE Infoline: 08701 545500 (Mon-Fri 8am-6pm)

Website: [www.hse.gov.uk](http://www.hse.gov.uk)

Health Education Trust

Tel: (01789) 773915

Website: <http://www.healthedtrust.com>

Hyperactive Children's Support Group

Tel: (01243) 551313

Website: [www.hacsg.org.uk](http://www.hacsg.org.uk)

MENCAP

Telephone: (020) 7454 0454

Website: [www.mencap.org.uk](http://www.mencap.org.uk)

National Eczema Society

Helpline: 0870 241 3604 (Mon-Fri 8am to 8pm)

Website: [www.eczema.org](http://www.eczema.org)

National Society for Epilepsy

Helpline: (01494) 601400 (Mon-Fri 10am to 4pm)

Website: [www.epilepsynse.org.uk](http://www.epilepsynse.org.uk)

Psoriasis Association

Tel: 0845 676 0076

(Mon-Thurs 9.15am to 4.45pm. Fri 9.15am to 16.15pm)

Website: <http://www.psoriasis-association.org.uk/>

Sure Start

Tel: 0870 0002288

Website: <http://www.surestart.gov.uk>