

## **Guidance**

All Local Authorities and all  
schools and early years settings  
and their employers

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# **MANAGING MEDICINES IN SCHOOLS AND EARLY YEARS SETTINGS**

Department for Education and Skills | Department of Health

## FOREWORD

As part of the government's agenda to improve the lives of children and young people, we are pleased to be able to introduce this updated guidance on managing medicines in school and early years settings, which replaces the earlier Department for Education and Employment and Department of Health *Supporting Pupils with Medical Needs: a good practice guide* and Circular 14/96 *Supporting Pupils with Medical Needs in School*, which were published in 1996.

This updated guidance sets a clear framework within which Local Authorities, NHS Primary Care Trusts, schools, early years settings and families are able to work together to develop policies to ensure that children requiring medicines receive the support they need. The guidance, which has been produced by the Department for Education and Skills in collaboration with the Department of Health, takes full account of the recommendations included in the Department of Health and Department for Education and Skills National Service Framework for Children, Young People and Maternity Services and is consistent with our Every Child Matters: Change for Children programme.

In updating this guidance we were very fortunate to be able to work closely with a number of voluntary bodies, including those that specialise in supporting children with particular medical needs, and with the Royal College of Paediatrics and Child Health, the Royal College of Nursing, school staff unions, Confed and the Local Government Association. We are grateful for their input in seeking to make this guidance as clear and helpful as possible.

We trust that this updated guidance will encourage and help early years settings, schools, Local Authorities and NHS Primary Care Trusts to

review their current policies and procedures involving children with medical needs in order to make sure that everyone, including parents, is clear about their respective roles

put in place effective management systems to help support individual children with medical needs

make sure that within early years and school settings medicines are handled responsibly

help ensure that all school staff are clear about what to do in the event of a medical emergency

All of us want all children to have successful and fulfilling lives. By implementing this guidance you will be helping to achieve our shared vision that all children and young people should be healthy, stay safe, enjoy and achieve, and be able to make a positive contribution. The measures outlined in this guidance are one more step towards ensuring that vision becomes a reality.

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## **INTRODUCTION**

1. This guidance is designed to help all schools and all early years settings and their employers develop policies on managing medicines, and to put in place effective management systems to support individual children with medical needs. Positive responses by schools and settings to a child's medical needs will not only benefit the child directly, but can also positively influence the attitude of their peers. This guidance replaces *Supporting Pupils with Medical Needs: a good practice guide* and Circular 14/96 *Supporting Pupils with Medical Needs in School* (DfEE/DH 1996).
2. It is for Local Authorities, schools and governing bodies, settings and management groups to work out their own policies in the light of statutory responsibilities and their own assessment of local needs and resources, but it is hoped that when doing so they will find this guidance useful. To help in this process, forms are provided at Annex B that can be photocopied or adapted for use.
3. This guidance is not a definitive interpretation of the law. Interpreting the law is a matter for the courts alone.

### **Children with Medical Needs**

4. Children with medical needs have the same rights of admission to a school or setting as other children. Most children will at some time have short-term medical needs, perhaps entailing finishing a course of medicine such as antibiotics. Some children however have longer term medical needs and may require medicines on a long-term basis to keep them well, for example children with well-controlled epilepsy or cystic fibrosis.
5. Others may require medicines in particular circumstances, such as children with severe allergies who may need an adrenaline injection. Children with severe asthma may have a need for daily inhalers and additional doses during an attack.
6. Most children with medical needs are able to attend school regularly and can take part in normal activities, sometimes with some support. However, staff may need to take extra care in supervising some activities to make sure that these children, and others, are not put at risk.
7. An individual health care plan can help staff identify the necessary safety measures to support children with medical needs and ensure that they and others are not put at risk. Detailed advice on how to develop an individual health care plan is set out in Chapter 4.

### **Access to Education and Associated Services**

8. Some children with medical needs are protected from discrimination under the Disability Discrimination Act (DDA) 1995. The DDA defines a person as having a disability if he has a physical or mental impairment which

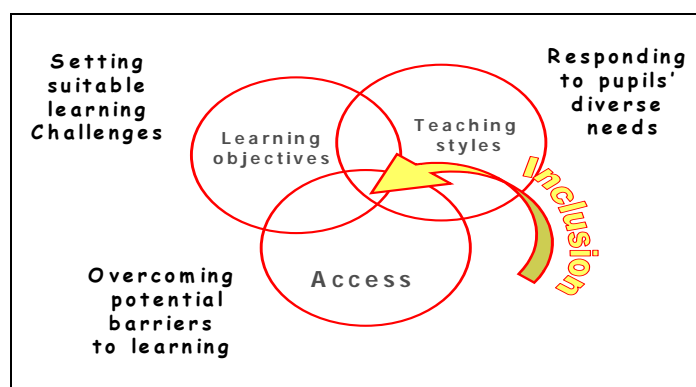
has a substantial and long-term adverse effect on his abilities to carry out normal day to day activities.

9. Under Part 4 of the DDA, responsible bodies for schools (including nursery schools) **must not** discriminate against disabled pupils in relation to their access to education and associated services – a broad term that covers all aspects of school life including school trips and school clubs and activities.<sup>1</sup> Schools should be making reasonable adjustments for disabled children including those with medical needs at different levels of school life; and for the individual disabled child in their practices and procedures and in their policies.

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

11. Early years settings not constituted as schools, including childminders and other private, voluntary and statutory provision are covered by Part 3 of the DDA. Part 3 duties cover the refusal to provide a service, offering a lower standard of service or offering a service on worse terms to a disabled child<sup>2</sup>. This includes disabled children with medical needs. Like schools, early years settings should be making reasonable adjustments for disabled children including those with medical needs. However, unlike schools, the reasonable adjustments by early years settings will include alterations to the physical environment as they are not covered by the Part 4 planning duties.

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



<sup>1</sup> The *Code of Practice for Schools – DDA 1995: Part 4* (Disability Rights Commission, 2002) explains the duties schools have and shows responsible bodies how they might meet the duties that apply to them.

<sup>2</sup> The Disability Rights Commission (DRC) has issued a Code of Practice covering Rights of Access to Goods, Facilities, Services and Premises, under Part 3 of the DDA.

## Support for Children with Medical Needs

13. Parents<sup>3</sup> have the prime responsibility for their child's health and should provide schools and settings with information about their child's medical condition. Parents, and the child if appropriate, should obtain details from their child's General Practitioner (GP) or paediatrician, if needed. The school doctor or nurse or a health visitor and specialist voluntary bodies may also be able to provide additional background information for staff.

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

15. Local Authorities and other employers, schools (including community nursery schools) should consider the issue of managing administration of medicines and supporting children with more complex health needs as part of their accessibility planning duties. It will greatly assist the smooth integration of children into the life of the school or setting.

16. There is no legal duty that requires school or setting staff to administer medicines. A number of schools are developing roles for support staff that build the administration of medicines into their core job description. Some support staff may have such a role in their contract of employment. Schools should ensure that they have sufficient members of support staff who are appropriately trained to manage medicines as part of their duties.

17. Conditions of employment are individual to each non-maintained early years setting. The registered person has to arrange who should administer medicines within a setting, either on a voluntary basis or as part of a contract of employment.

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

19. Some children and young people with medical needs have complex health needs that require more support than regular medicine. It is important to seek medical advice about each child or young person's individual needs.<sup>4</sup>

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<sup>3</sup> Here, and throughout this document, 'parents' should be taken to include all those with parental responsibility, including parents and carers. See also 'Parents and Carers' [paragraphs 67–72).

<sup>4</sup> *Including Me: Managing Complex Health Needs in Schools and Early Years Settings*

## CHAPTER 1: DEVELOPING MEDICINES POLICIES

### Introducing a Policy

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

21. The employer has the responsibility for devising the policy. However schools and settings, acting on behalf of the employer, should develop policies and procedures that draw on the employer's overall policy but are amended for their particular provision. Policies should, as far as possible, be developed in consultation with heads, and with governing bodies or management groups where they are not the employer. All policies should be reviewed and updated on a regular basis.

22. Policies should aim to enable regular attendance. Formal systems and procedures in respect of administering medicines, developed in partnership with parents and staff should back up the policy.

23. A policy needs to be clear to all staff, parents and children. It could be included in the prospectus, or in other information for parents. A policy should cover:

- procedures for managing prescription medicines which need to be taken during the school or setting 'day'
- procedures for managing prescription medicines on trips and outings
- a clear statement on the roles and responsibility of staff managing administration of medicines, and for administering or supervising the administration of medicines
- a clear statement on parental responsibilities in respect of their child's medical needs
- the need for prior written agreement from parents<sup>5</sup> for any medicines to be given to a child
- the circumstances in which children may take any non-prescription medicines
- the school or setting policy on assisting children with long- term or complex medical needs
- policy on children carrying and taking their medicines themselves
- staff training in managing medicines safely and supporting an identified individual child
- record keeping
- safe storage of medicines
- access to the school's emergency procedures
- risk assessment and management procedures

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(Council for Disabled Children, 2005 ) provides practical advice on supporting children with more complex needs

<sup>5</sup> For early years settings prior permission is a mandatory requirement



24. Parents should provide full information about their child's medical needs, including details on medicines their child needs.

### **Prescribed Medicines**

25. Medicines should only be taken to school or settings when essential; that is where it would be detrimental to a child's health if the medicine were not administered during the school or setting 'day'. Schools and settings should only accept 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.

**26. Schools and settings should never accept medicines that have been taken out of the container as originally dispensed nor make changes to dosages on parental instructions.**

27. It is helpful, where clinically appropriate, if medicines are prescribed in dose frequencies which enable it to be taken outside school hours. Parents could be encouraged to ask the prescriber about this. 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.

28. The Medicines Standard of the National Service Framework (NSF) for Children<sup>6</sup> recommends that a range of options are explored including:

Prescribers consider the use of medicines which need to be administered only once or twice a day (where appropriate) for children and young people so that they can be taken outside school hours

Prescribers consider providing two prescriptions, where appropriate and practicable, for a child's medicines: one for home and one for use in the school or setting, avoiding the need for repackaging or relabelling of medicines by parents

### **Controlled Drugs**

29. The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act and its associated regulations (see Annex A). Some may be prescribed as medicine for use by children, e.g. methylphenidate.

30. Any member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber's instructions.

31. A child who has been prescribed a controlled drug may legally have it in their possession. It is permissible for schools and settings to look after a

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<sup>6</sup> *National Service Framework for Children and Young People and Maternity Services: Medicines for Children and Young People* (Department of Health/DfES, 2004)

controlled drug, where it is agreed that it will be administered to the child for whom it has been prescribed.

32. Schools and settings should keep controlled drugs in a locked non-portable container and only named staff should have access. A record should be kept for audit and safety purposes.

33. A controlled drug, as with all medicines, should be returned to the parent when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label).

34. Misuse of a controlled drug, such as passing it to another child for use, is an offence. Schools should have a policy in place for dealing with drug misuse.<sup>7</sup>

### **Non-Prescription Medicines**

35. Staff should **never** give a non-prescribed medicine to a child unless there is specific prior written permission from the parents. Where the head agrees to administer a non-prescribed medicine it **must** be in accordance with the employer's policy. The employer's policy should set out the circumstances under which staff may administer non-prescribed medicines. Staff should check that the medicine has been administered without adverse effect to the child in the past and that parents have certified this is the case – a note to this effect should be recorded in the written parental agreement for the school/setting to administer medicine. A short written agreement with parents may be all that is necessary – forms 3A and 3B (see Annex B). Criteria, in the national standards for under 8s day care providers, make it clear that non-prescription medicines should not normally be administered. Where a non-prescribed medicine is administered to a child it should be recorded on a form such as Form 5 or 6 (see Annex B) and the parents informed. If a child suffers regularly from frequent or acute pain the parents should be encouraged to refer the matter to the child's GP.

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

### **Short-Term Medical Needs**

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

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<sup>7</sup> *Drugs: Guidance for Schools* (DfES/0092/ 2004)

## Long-Term Medical Needs

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

39. The Special Educational Needs (SEN) Code of Practice 2001 advises that a medical diagnosis or a disability does not necessarily imply SEN. It is the child's educational needs rather than a medical diagnosis that **must** be considered.<sup>8</sup>

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

- details of a child's condition
- special requirement e.g. dietary needs, pre-activity precautions
- and any side effects of the medicines
- what constitutes an emergency
- what action to take in an emergency
- what not to do in the event of an emergency
- who to contact in an emergency
- the role the staff can play

41. Form 2 provides an example of a health care plan that schools and settings may wish to use or adapt.

## Administering Medicines

42. No child under 16 should be given medicines without their parent's written consent. Any member of staff giving medicines to a child should check:

- the child's name
- prescribed dose
- expiry date

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<sup>8</sup> 'SEN Code of Practice' (DfES/0581/ 2001) paragraphs 7.64 – 7.67

- written instructions provided by the prescriber on the label or container<sup>9</sup>

43. If in doubt about any procedure staff should 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 should be discussed with the parent, if appropriate, or with a health professional attached to the school or setting

44. Early years settings **must** keep written records each time medicines are given. Schools should also arrange for staff to complete and sign a record each time they give medicine to a child. Form 5 or 6 can be used for this purpose. Good records help demonstrate that staff have exercised a duty of care. In some circumstances such as the administration of rectal diazepam, it is good practice to have the dosage and administration witnessed by a second adult.

### **Self-Management**

45. It is good practice to support and encourage children, who are able, to take responsibility to manage their own medicines from a relatively early age and schools should encourage this. The age at which children are ready to take care of, and be responsible for, their own medicines, varies. As children grow and develop they should be encouraged to participate in decisions about their medicines and to take responsibility.

46. Older children with a long-term illness should, whenever possible, assume complete responsibility under the supervision of their parent. Children develop at different rates and so the ability to take responsibility for their own medicines varies. This should be borne in mind when making a decision about transferring responsibility to a child or young person. There is no set age when this transition should be made. There may be circumstances where it is not appropriate for a child of any age to self-manage. Health professionals need to assess, with parents and children, the appropriate time to make this transition.

47. If children can take their medicines themselves, staff may only need to supervise. The policy should say whether children may carry, and administer (where appropriate), their own medicines, bearing in mind the safety of other children and medical advice from the prescriber in respect of the individual child. A suggested parental consent form is provided in Form 7.

48. Where children have been prescribed controlled drugs staff need to be aware that these should be kept in safe custody. However children could access them for self-medication if it is agreed that it is appropriate.

### **Refusing Medicines**

49. If a child refuses to take medicine, staff should not force them to do so,

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<sup>9</sup> It is to be noted that adrenaline pens include manufacturer's instructions

but should note this in the records and follow agreed procedures. The procedures may either be set out in the policy or in an individual child's health care plan. Parents should 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.

## Record Keeping

50. Parents should tell the school or setting about the medicines that their child needs to take and provide details of any changes to the prescription or the support required. However staff should make sure that this information is the same as that provided by the prescriber.

51. Medicines should always be provided in the original container as dispensed by a pharmacist and include the prescriber's instructions. In all cases it is necessary to check that written details include:

- name of child
- name of medicine
- dose
- method of administration
- time/frequency of administration
- any side effects
- expiry date

52. It may be helpful to give parents a form similar to Form 3A or 3B to record details of medicines in a standard format. Staff should check that any details provided by parents, or in particular cases by a paediatrician or specialist nurse, are consistent with the instructions on the container.

53. Form 4 could be used to confirm, with the parents, that a member of staff will administer medicine to their child.

54. All early years settings **must** keep written records of all medicines administered to children, and make sure that parents sign the record book to acknowledge the entry.

55. Although there is no similar legal requirement for schools to keep records of medicines given to pupils, and the staff involved, it is good practice to do so. Records offer protection to staff and proof that they have followed agreed procedures. Some schools keep a logbook for this. Forms 5 and 6 provide example record sheets.

## Educational Visits

56. It is good practice for schools to encourage children with medical needs to participate in safely managed visits. Schools and settings should consider what reasonable adjustments they might make to enable children with medical needs to participate fully and safely on visits. This might include reviewing and

revising the visits policy and procedures so that planning arrangements will include the necessary steps to include children with medical needs. It might also include risk assessments for such children.

57. Sometimes additional safety measures may need to be taken for outside visits. It may be that an additional supervisor, a parent or another volunteer might be needed to accompany a particular child. Arrangements for taking any necessary medicines will also need to be taken into consideration. Staff supervising excursions should always be aware of any medical needs, and relevant emergency procedures. A copy of any health care plans should be taken on visits in the event of the information being needed in an emergency.

58. If staff are concerned about whether they can provide for a child's safety, or the safety of other children on a visit, they should seek parental views and medical advice from the school health service or the child's GP. See DfES guidance on planning educational visits.<sup>10</sup>

59. The national standards for under 8s day care and childminding mean that the registered person **must** take positive steps to promote safety on outings.

### **Sporting Activities**

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

61. Some children may need to take precautionary measures before or during exercise, and may also need to be allowed immediate access to their medicines such as asthma inhalers. More details about specific health conditions can be found in Chapter 5. Staff supervising sporting activities should consider whether risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative medicine that may need to be taken and emergency procedures.

### **Home to School Transport**

62. Local Authorities arrange home to school transport where legally required to do so. They **must** make sure that pupils are safe during the journey. Most pupils with medical needs do not require supervision on school transport, but Local Authorities should provide appropriate trained escorts if

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<sup>10</sup> *Health and Safety of Pupils on Educational Visits: a good practice guide* (DfES, 1998) paragraphs 100–106.

they consider them necessary<sup>11</sup>. Guidance should be sought from the child's GP or paediatrician.

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

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

65. Some pupils are at risk of severe allergic reactions (see Chapter 5). Risks can be minimised by not allowing anyone to eat on vehicles. As noted above, all escorts should have basic first aid training and should be trained in the use of an adrenaline pen for emergencies where appropriate.

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<sup>11</sup>See *Home to school travel for pupils requiring special arrangements* (DfES/0261/2004)

## **CHAPTER 2: ROLES AND RESPONSIBILITIES**

### **INTRODUCTION**

66. It is important that responsibility for child safety is clearly defined and that each person involved with children with medical needs is aware of what is expected of them. Close co-operation between schools, settings, parents, health professionals and other agencies will help provide a suitably supportive environment for children with medical needs. An overview of the relevant legislation can be found in Annex A.

### **Parents and Carers**

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

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

69. It is important that professionals understand who has parental responsibility for a child. The Children Act 1989 introduced the concept of parental responsibility. The Act uses the phrase "parental responsibility" to sum up the collection of rights, duties, powers, responsibilities and authority that a parent has by law in respect of a child. In the event of family breakdown, such as separation or divorce, both parents will normally retain parental responsibility for the child and the duty on both parents to continue to play a full part in the child's upbringing will not diminish. In relation to unmarried parents, only the mother will have parental responsibility unless the father has acquired it in accordance with the Children Act 1989. Where a court makes a residence order in favour of a person who is not a parent of the child, for example a grandparent, that person will have parental responsibility for the child for the duration of the Order.

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



Where a child is looked after by a local authority day-to-day responsibility may be with foster parents, residential care workers or guardians.

71. Parents should be given the opportunity to provide the head with sufficient information about their child's medical needs if treatment or special care needed. They should, jointly with the head, reach agreement on the school's role in supporting their child's medical needs, in accordance with the employer's policy. Ideally, the head should always seek parental agreement before passing on information about their child's health to other staff. Sharing information is important if staff and parents are to ensure the best care for a child.

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

### **The Employer**

73. Under the Health and Safety at Work etc Act 1974, employers, including Local Authorities and school governing bodies, **must** have a health and safety policy<sup>12</sup>. This should incorporate managing the administration of medicines and supporting children with complex health needs, which will support schools and settings in developing their own operational policies and procedures.

74. With the exception of Local Authorities, employers **must** take out Employers Liability Insurance<sup>13</sup> to provide cover for injury to staff acting within the scope of their employment. Local Authorities may choose instead to "self-insure" although in practice most take out Employers Liability Insurance.

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

76. In most instances, the Local Authority, a school or an early years setting will directly employ staff. However, some care or health staff may be employed by a local health trust or Social Services department, or possibly through the voluntary sector. In such circumstances, appropriate shared Governance arrangements should be agreed between the relevant agencies.

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<sup>12</sup> *Health and Safety: Responsibilities and Powers* (DfES/0803/2001) includes information on responsibilities for health and safety in schools

<sup>13</sup> *Insurance – A guide for schools* (DfES/0256/2003)

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

78. NHS Primary Care Trusts (PCTs) have the discretion to make resources available for any necessary training. Employers should also consider arranging training for staff in the management of medicines and policies about administration of medicines. Complex medical assistance is likely to mean that the staff will need specialised training. This should be arranged in conjunction with local health services or other health professionals. Managing medicines training could be provided by Local Authorities, Regional Consortia, Pharmacists and other training providers.

### **The Governing Body**

79. Individual schools should develop policies to cover the needs of their own school. The policies should reflect those of their employer. The governing body has general responsibility for all of the school's policies even when it is not the employer. The governing body will generally want to take account of the views of the head teacher, staff and parents in developing a policy on assisting pupils with medical needs. Where the Local Authority is the employer, the school's governing body should follow the health and safety policies and procedures produced by the Local Authority .

80. Criteria under the national standards for under 8s day care make it clear that day care providers should have a clearly understood policy on the administration of medicines. If the administration of prescription medicines requires technical or medical knowledge then individual training should be provided to staff from a qualified health professional. Training is specific to the individual child concerned. Ofsted's guidance on this standard sets out the issues that providers need to think through in determining the policy.

### **The Head Teacher or Head of Setting**

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

82. The employer **must** ensure that staff receive proper support and training where necessary. Equally, there is a contractual duty on head teachers to ensure that their staff receive the training. As the manager of staff it is likely to be the head teacher who will agree when and how such training takes place.

83. The head should make sure that all parents and all staff are aware of the policy and procedures for dealing with medical needs. The head should also

make sure that the appropriate systems for information sharing are followed. The policy should make it clear that parents should keep children at home when they are acutely unwell. The policy should also cover the approach to taking medicines at school or in a setting. Head teachers and governors of schools may want to ensure that the policy and procedures are compatible and consistent with any registered day care operated either by them or an external provider on school premises.

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

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

### **Teachers and Other Staff**

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

87. All staff should be aware of the likelihood of an emergency arising and what action to take if one occurs. Back up cover should be arranged for when the member of staff responsible is absent or unavailable. At different times of the day other staff may be responsible for children, such as lunchtime supervisors. It is important that they are also provided with training and advice. Form 8 provides an example of confirmation that any necessary training has been completed.

88. Many voluntary organisations specialising in particular medical conditions provide advice or produce packs advising staff on how to support children. Annex D lists contact details.

### *School Staff Giving Medicines*

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

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

### *Early Years Staff Giving Medicines*

91. For registered day care the conditions of employment are individual to each setting. It is therefore for the registered person to arrange who should administer medicines within a setting, either on a voluntary basis or as part of a contract of employment.

### **The Local Authority**

92. In community, community special and voluntary controlled schools and community nursery schools, the Local Authority, as the employer, is responsible for all health and safety matters. For local authority day nurseries, out of school clubs (including open access schemes), holiday clubs and play schemes the registered person, which may be the authority itself, is responsible for all health and safety matters.

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

94. Local Authorities have a duty under the Children Act 1989 to provide advice and training for day care providers. However providers should seek appropriate training from qualified professionals to deal with the needs of specific children.

### **Primary Care and NHS Trusts**

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

96. PCTs **must** ensure that there is a medical officer with specific responsibility for children with special educational needs (SEN)<sup>14</sup>. Some of these children may have medical needs. PCTs and NHS Trusts, usually through the school health service, may provide advice and training for staff in providing for a child's medical needs.

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<sup>14</sup> SEN Code of Practice (DfES/0581/2001) paragraphs 10:24 – 10:26

## Health Services

97. The nature and scope of local health services to schools and settings varies between Health Trusts. They can provide advice on health issues to children, parents, teachers, education welfare officers and Local Authorities. The main health contact for schools is likely to be a school nurse, whilst early years settings usually link with a health visitor. The school health service may also provide guidance on medical conditions and, in some cases, specialist support for a child with medical needs.

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

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

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

101. Most NHS Trusts with school health services have pharmacists. They can provide pharmaceutical advice to school health services. Some work closely with local authority education departments and give advice on the management of medicines within schools and settings. This could involve helping to prepare policies related to medicines in schools and training school staff. In particular, they can advise on the storage, handling and disposal of medicines.

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

## Ofsted

103. During an inspection Ofsted will check that day care providers have adequate policies and procedures in place regarding the administration and storage of medicines. Regulations require that parents give their consent to medicines being given to their child and that the provider keeps written records.

104. During school inspections Ofsted inspectors must evaluate and report on how well schools ensure pupils' care, welfare, health and safety. Ofsted will look to see whether 'administration of medicines follows clear procedures'.<sup>15</sup> The Commission for Social Care Inspection (CSCI) already has a regular programme of inspections for care homes and other types of residential establishment such as special residential and boarding schools. Specialist pharmacy inspectors are available for follow-up visits if the generic inspection reveals any cause for concern.

105. During LEA inspections Ofsted will look at support for health and safety, welfare and child protection. Ofsted will look to see that 'Schools are well supported in developing their health and safety policies and receive comprehensive guidance on dealing with medical needs.'<sup>16</sup> From September 2005, LEAs' services will be inspected within multi-inspectorate joint area reviews of children's services. Inspectors propose to assess that steps are taken to provide children and young people with a safe environment, including that the safe storage and use of medicines is promoted.

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<sup>15</sup> Ofsted *'Inspecting schools – Handbook for inspecting nursery and primary schools; Inspecting schools – Handbook for inspecting secondary schools; Inspecting schools – Handbook for inspecting special schools and pupil referral units* (all Ofsted 2003). These include "Judgements about the care, welfare, health and safety of pupils."

<sup>16</sup> Ofsted Inspection Guidance Document *LEA Framework 2004 - Support for health and safety, welfare and child protection* (Ofsted, 2004)

## **CHAPTER 3: DEALING WITH MEDICINES SAFELY**

### **Safety Management**

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

### **Storing Medicines**

107. Large volumes of medicines should not be stored. Staff should only store, supervise and administer medicine that has been prescribed for an individual child. Medicines should be stored strictly in accordance with product instructions (paying particular note to temperature) and in the original container in which dispensed. Staff should ensure that the supplied container is clearly labelled with the name of the child, the name and dose of the medicine and the frequency of administration. This should be easy if medicines are only accepted in the original container as dispensed by a pharmacist in accordance with the prescriber's instructions. Where a child needs two or more prescribed medicines, each should be in a separate container. Non-healthcare staff should never transfer medicines from their original containers.

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

109. A few medicines need to be refrigerated. They can be kept in a refrigerator containing food but should be in an airtight container and clearly labelled. There should be restricted access to a refrigerator holding medicines.

110. Local pharmacists can give advice about storing medicines.

### **Access to Medicines**

111. Children need to have immediate access to their medicines when required. The school or setting may want to make special access arrangements for emergency medicines that it keeps. However, it is also important to make sure that medicines are only accessible to those for whom they are prescribed. This should be considered as part of the policy about children carrying their own medicines.

## **Disposal of Medicines**

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

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

## **Hygiene and Infection Control**

114. All staff should be familiar with normal precautions for avoiding infection and follow basic hygiene procedures<sup>17</sup>. Staff should have access to protective disposable gloves and take care when dealing with spillages of blood or other body fluids and disposing of dressings or equipment. Ofsted guidance provides an extensive list of issues that early years providers should consider in making sure settings are hygienic.

## **Emergency Procedures**

115. As part of general risk management processes all schools and settings should have arrangements in place for dealing with emergency situations. This could be part of the school's first aid policy and provision<sup>18</sup>. Other children should know what to do in the event of an emergency, such as telling a member of staff. All staff should know how to call the emergency services. Guidance on calling an ambulance is provided in Form 1. All staff should also know who is responsible for carrying out emergency procedures in the event of need. A member of staff should always accompany a child taken to hospital by ambulance, and should stay until the parent arrives. Health professionals are responsible for any decisions on medical treatment when parents are not available.

116. Staff should never take children to hospital in their own car; it is safer to call an ambulance. In remote areas a school might wish to make arrangements with a local health professional for emergency cover. The national standards require early years settings to ensure that contingency arrangements are in place to cover such emergencies.

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

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<sup>17</sup> See *Guidance on infection control in schools and nurseries* (Department of Health/Department for Education and Employment/Public Health Laboratory Service, 1999)

<sup>18</sup> See *Guidance on First Aid for Schools: a good practice guide* (DfES, 1998)



## CHAPTER 4: DRAWING UP A HEALTH CARE PLAN

### Purpose of a Health Care Plan

118. 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.

119. 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.

120. 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.

121. 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. Form 2 can be used or adapted.

122. 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
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123. Early years settings should be aware that parents may provide them with a copy of their Family Service Plan, a feature of the Early Support Family Pack promoted through the government's Early Support Programme<sup>19</sup>. Whilst the plan will be extremely helpful in terms of understanding the wider picture of the child's needs and services provided, it should not take the place of an individual health care plan devised by the setting with input from a health professional, or indeed the record of a child's medicines (see Forms 2 and 3A and B in Annex B).

<sup>19</sup> *Early Support Family Pack* (DfES, 2004).

## Co-ordinating Information

124. Coordinating and sharing information on an individual pupil with medical needs, particularly in secondary schools, can be difficult. The head teacher should decide which member of staff has specific responsibility for this role. This person can be a first contact for parents and staff, and liaise with external agencies. It would be helpful if members of staff with this role attended training on managing medicines and drawing up policies on medicines. Local Authorities Regional Consortia and others provide such training.

## Information for Staff and Others

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

### *Off-site education or work experience*

126. Schools are responsible for ensuring, under an employer's overall policy, that work experience placements are suitable for students with a particular medical condition. Schools are also responsible for pupils with medical needs who, as part of key stage 4 provision, are educated off-site through another provider such as the voluntary sector, E2E training provider or further education college. Schools should consider whether it is necessary to carry out a risk assessment before a young person is educated off-site or has work experience.

127. Schools have a primary duty of care for pupils and have a responsibility to assess the general suitability of all off-site provision including college and work placements. This includes responsibility for an overall risk assessment of the activity, including issues such as travel to and from the placement and supervision during non-teaching time or breaks and lunch hours. This does not conflict with the responsibility of the college or employer to undertake a risk assessment to identify significant risks and necessary control measures when pupils below the minimum school leaving age are on site.

128. Schools should refer to guidance from DfES<sup>20</sup>, the Health and Safety Executive and the Learning and Skills Council for programmes that they are funding (e.g. Increased Flexibility Programme). Generally schools should undertake an overall risk assessment of the whole activity and schools or placement organisers should visit the workplace to assess its general suitability. Responsibility for risk assessments remain with the employer or the college. Where students have special medical needs the school will need to ensure that such risk assessments take into account those needs. Parents and pupils must give their permission before relevant medical information is shared on a confidential basis with employers.

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<sup>20</sup> *Work Related Learning and the Law* (DfES/0475/ 2004)

## **Staff Training**

129. A health care plan may reveal the need for some staff to have further information about a medical condition or specific training in administering a particular type of medicine or in dealing with emergencies. Staff should not give medicines without appropriate training from health professionals. When staff agree to assist a child with medical needs, the employer should arrange appropriate training in collaboration with local health services. Local health services will also be able to advise on further training needs. In every area there will be access to training, in accordance with the provisions of the National Service Framework for Children, Young People and Maternity Services<sup>21</sup>, by health professionals for all conditions and to all schools and settings.

## **Confidentiality**

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

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<sup>21</sup> Section 10, *Standard 10: Medicines Management for Children and Young People* (DH/DfES, 2004)

## **CHAPTER 5: COMMON CONDITIONS – PRACTICAL ADVICE ON ASTHMA, EPILEPSY, DIABETES AND ANAPHYLAXIS**

### **INTRODUCTION**

131. The medical conditions in children that most commonly cause concern in schools and settings are asthma, diabetes, epilepsy and severe allergic reaction (anaphylaxis). This chapter provides some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children are assessed on an individual basis.

132. Further information, including advice specifically for schools and settings, is available from leading charities listed in Annex D.

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

### **ASTHMA**

#### **What is Asthma?**

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

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

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

#### **Medicine and Control**

137. There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child will only need a reliever during the school day. **Relievers** (blue inhalers) are medicines taken immediately to relieve asthma symptoms and are taken during an asthma attack. They are sometimes taken

before exercise. Whilst **Preventers** (brown, red, orange inhalers, sometimes tablets) are usually used out of school hours.

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

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

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

141. The signs of an asthma attack include:

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

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

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

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

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

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

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

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

148. All schools and settings should have an asthma policy that is an integral part of the whole school or setting policy on medicines and medical needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK). The school environment should be asthma friendly, by removing as many potential triggers for children with asthma as possible.

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

## **EPILEPSY**

### **What is Epilepsy?**

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

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

communicated to parents including:

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

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

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

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

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

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

## **Medicine and Control**

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

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

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

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

159. An ambulance should be called during a convulsive seizure if:

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

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

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

162. Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intra-nasally, may be prescribed as an alternative to rectal Diazepam. Instructions for use **must** come from the prescribing doctor. For more information on administration of rectal diazepam, see Form 9.



163. Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills. If arrangements can be made for two adults, at least one of the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies. The criteria under the national standards for under 8s day care requires the registered person to ensure the privacy of children when intimate care is being provided.

## **DIABETES**

### **What is Diabetes?**

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

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

166. Each child may experience different symptoms and this should be discussed when drawing up the health care plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff will naturally wish to draw any such signs to the parents' attention.

### **Medicine and Control**

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

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

child was competent. The child is then responsible for the injections and the regime would be set out in the individual health care plan.

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

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

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

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

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

173. Each child may experience different symptoms and this should be discussed when drawing up a health care plan.

174. If a child has a hypo, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

175. An ambulance should be called if:

- the child's recovery takes longer than 10-15minutes

- the child becomes unconscious

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

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

## **ANAPHYLAXIS**

### **What is anaphylaxis?**

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

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

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

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

### **Medicine and Control**

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

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

**should always be called.**

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

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

186. Where children are considered to be sufficiently responsible to carry their emergency treatment on their person<sup>22</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.

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

188. Important issues specific to anaphylaxis to be covered include:

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

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

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

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

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<sup>22</sup> See paragraph 47

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

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

## **ANNEX A: LEGAL FRAMEWORK**

### **CONTENTS**

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#### **General Background**

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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

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<sup>23</sup> Acts of the UK Parliament since 1988 can be viewed at Her Majesty's Stationery Office (HMSO) website <http://www.hmso.gov.uk/acts.htm>

## INTRODUCTION

1. This part sets out the legal framework for schools and local education authorities in the management of medicines in schools and early years settings.
2. 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

3. 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

4. Local Education Authorities (LEAs), 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.
5. 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

6. **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'

7. 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<sup>24</sup>**

8. 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>25</sup>.

### **THE LAW**

9. 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**

10. 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.
11. Schools and early years settings are both required to take "reasonable steps" to meet the needs of disabled children.

### *LEAs and Schools*

12. **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.
13. Part 4 duties apply to all schools; private or state maintained, mainstream or special and those early years settings constituted as schools.
14. Some medical conditions may be classed as a disability. The

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<sup>24</sup> *School Admissions Code of Practice* (DfES/0031/2003)

<sup>25</sup> *Improving Attendance and Behaviour: Guidance on Exclusion from Schools and Pupil Referral Units* (DfES/0354/2004)



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>26</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.

15. 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.
16. 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.
17. Part 4 duties cover discrimination in admissions, the provision of education and associated services and exclusions.
18. The reasonable adjustments duty in Part 4 includes provision of :  
auxiliary aids and services  
making physical alterations to buildings (from October 2004)

#### *Early years settings*

19. Early years settings, not constituted as schools, **must** comply with Part 3 of the DDA; this includes day nurseries, family centres, pre-schools, playgroups and childminders (including those in a childminding network). The duties cover the refusal to provide a service, offering a lower standard of service or offering a service on worse terms to a disabled child.
20. Under Parts 3 and 4 of the DDA all settings are required not to treat a disabled child “less favourably” than any other child for a reason relating to their disability. There may sometimes be justification for less favourable treatment, but it may not be possible to justify if there is a reasonable adjustment that might have been made but was not.

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

21. The Health and Safety at Work etc Act (HSWA) 1974 places duties on

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<sup>26</sup> *Code of Practice for Schools – DDA 1995: Part 4* (Disability Rights Commission, 2002)

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.<sup>27</sup>

22. Who the employer is depends on the type of school:

For community schools, community special schools, voluntary controlled schools, maintained nursery schools and pupil referral units the employer is the LEA

for foundation schools, foundation special schools and voluntary-aided schools the employer is the governing body

for academies and city technology colleges the employer is the governing body

for non-maintained special schools the employer is the trustees

for other independent schools the employer is usually the governing body, proprietor or trustees

23. The employer for registered day care will depend on the way it has been set up. Settings may be run by private individuals, charities, voluntary committees, Local Authorities, school governors, the proprietor or the trustees in some independent schools, and companies that provide day care as an additional service to customers (e.g. crèches in shops or sports clubs).

24. 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

25. 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

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<sup>27</sup> *Health and Safety: Responsibilities and Powers* (DfES/0803/ 2001)

children.

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

26. 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

27. The national standards for day care settings make it clear that the registered person **must** comply with all relevant health and safety legislation. Registered persons in early years settings are also required under the national standards to take positive steps to promote safety. Supporting criteria under the safety standard includes undertaking risk assessments.

28. HWSA 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

29. 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**

30. 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**

31. 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**

32. 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.
33. 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 <sup>28</sup>**

34. 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.
35. The responsibility for providing these facilities in all maintained schools rests with the Local Authority.

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

36. 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

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<sup>28</sup> *Standards for School Premises* (DFEE/0029/2000)

boarding school must have one or more sick rooms.

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

37. The national standards do not require day care settings to have a separate first aid room but they do cover the promotion of good health and taking positive steps to prevent the spread of infection. Such settings should also have one washbasin for every ten children over two years of age.
38. The national standards also require premises to be safe, secure and suitable for their purpose. They must provide adequate space in an appropriate location, be welcoming to children and offer all the necessary facilities for a range of activities that promote their development. Supporting criteria under the standard includes space standards, outdoor play areas, toilets, staff facilities, kitchens and laundry facilities. The standards do not require settings to have a separate first aid room but they do cover the promotion of good health and taking positive steps to prevent the spread of infection.

### **Special Educational Needs**

39. 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>29</sup>.
40. 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.

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<sup>29</sup> *SEN Code of Practice* (DfES/0581/ 2001) paragraphs 7:64 – 7:67.

## Care Standards Act 2000

### *Schools*

41. Residential special schools are required to register with the Commission for Social Care Inspection (CSCI) and are subject to the requirements set out in the Children's Homes Regulations 2001. In respect of medication, this is set out in Regulation 21 and places a duty on the registered person to make 'suitable arrangements for the recording, handling, safekeeping, safe administration and disposal of ... medicines'. The Department of Health has also published National Minimum Standards (NMS) that set out guidance of how the Regulations may be met (Standard 13).
42. CSCI also works in conjunction with Ofsted to monitor health and social welfare in boarding schools. There are also NMS for boarding schools although such schools are not subject to these Regulations under the Care Standards Act.

### *Day care provision*

43. The Children Act 1989 was amended by the Care Standards Act 2000 by the introduction of Part XA. In accordance with 79B in Part XA of the Children Act the Office for Standards in Education (Ofsted) registers day care provision (day nurseries, crèches, out of school clubs and pre-school provision) and childminders. As regulator, Ofsted ensures that those who provide day care or childminding services are suitable and that the requirements set out in the national standards for under 8s day care and childminding are met. The registered person in early years settings in the private and voluntary sectors **must** meet the requirements of the national standards for under 8s day care and childminding.
44. The national standards for under 8s day care and childminding require that the registered person in an early years setting promotes the good health of children and takes positive steps to prevent the spread of infection and appropriate measures when they are ill (Standard 7).
45. The criteria for this standard sets out that the registered person has a clear policy, understood by all staff and discussed with parents, regarding the administration of medicines. If the administration of prescription medicine requires technical/medical knowledge then individual training **must** be provided for staff from a qualified health professional and that training **must** be specific to the individual child concerned.
46. There is a requirement in the national standards for under 8s day care and childminding that the registered person must take positive steps to promote safety within the setting and on outings and ensure proper precautions are taken to prevent accidents (Standard 6).

47. For day care settings, the criteria sets out that the registered person must take reasonable steps to ensure that hazards to children on the premises, both inside and outside, are minimised and is aware of, and complies with, health and safety regulations. Staff must be trained to have an understanding of health and safety requirements for the environment in which they work.
48. The national standards do not override the need for providers to comply with other legislation such as that covering health and safety, food hygiene and so on. The registered person would therefore need to be aware of all other legislative requirements as set out in this annex.

## **ANNEX B: FORMS**

- Form 1**      Emergency planning - request for an ambulance
- Form 2**      Healthcare Plan
- Form 3 A**    Parental agreement for school/setting to administer medicines
- Form 3 B**    Parental agreement for school/setting to administer medicines
- Form 4**      Head teacher/Head of setting agreement to administer medication
- Form 5:**      Record of medicine administered to an individual
- Form 6:**      Record of medicines administered to all children
- Form 7:**      Request for child to carry his/her own medicine
- Form 8:**      Staff training record - administration of medicines
- Form 9:**      Authorisation for administration of rectal diazepam

All forms set out below are examples that schools and settings may wish to use or adapt according to their particular policies on administering medicines.

Versions of these forms are available from  
<http://www.teachernet.gov.uk/medical>



## **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:

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

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

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Follow up care:

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Who is responsible in an Emergency: (State if different for off-site activities)

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Form copied to:

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**FORM 3A**

**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 staff can administer medicine

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

Name of Child: \_\_\_\_\_

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

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

Medical condition/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 (delete as appropriate)

Procedures to take in an Emergency: \_\_\_\_\_

**Contact Details**

Name:

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Daytime Telephone No:

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Relationship to Child:

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Address:

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I understand that I must deliver the medicine personally to [agreed member of staff] and accept that this is a service that the school/setting is not obliged to undertake.

I understand that I must notify the school/setting of any changes in writing.

Date:

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Signature(s):

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Relationship to child:

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## FORM 3B

### 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 staff can administer medicine.

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

Date \_\_\_\_\_

Child's Name \_\_\_\_\_

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

Name and strength of medicine \_\_\_\_\_

Expiry date \_\_\_\_\_

How much to give ( i.e. dose to be given) \_\_\_\_\_

When to be given \_\_\_\_\_

Any other instructions \_\_\_\_\_

Number of tablets/quantity to be given to school/setting \_\_\_\_\_

**Note: Medicines must be the original container as dispensed by the pharmacy**

Daytime phone no. of parent or adult contact \_\_\_\_\_

Name and phone no. of GP \_\_\_\_\_

Agreed review date to be initiated by [name of member of staff]: \_\_\_\_\_

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.

Parent's signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

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

**FORM 4**

**Confirmation of the Head's 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 5**

**Record of medicine administered to an individual child**

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

Name of Child \_\_\_\_\_

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 \_\_\_\_\_

Parent signature \_\_\_\_\_

Date \_\_\_\_\_

Time Given \_\_\_\_\_

Dose Given \_\_\_\_\_

Name of member of  
staff \_\_\_\_\_

Staff initials \_\_\_\_\_



Date \_\_\_\_\_

Time Given \_\_\_\_\_

Dose Given \_\_\_\_\_

Name of member of staff \_\_\_\_\_

Staff initials \_\_\_\_\_

Date \_\_\_\_\_

Time Given \_\_\_\_\_

Dose Given \_\_\_\_\_

Name of member of staff \_\_\_\_\_

Staff initials \_\_\_\_\_

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 6**

**Record of medicines administered in school/setting to all children**

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

<b>Print Name</b>									
<b>Signature of Staff</b>									
<b>Any Reactions</b>									
<b>Dose given</b>									
<b>Name of Medicine</b>									
<b>Time</b>									
<b>Child's Name</b>									
<b>Date</b>									

**FORM 7**

**Request for child to carry his/her medicine**

**THIS FORM MUST BE COMPLETED BY PARENTS/GUARDIAN**

**If staff have any concerns discuss request with school healthcare professionals**

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

Child's Name: \_\_\_\_\_

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

Address: \_\_\_\_\_

\_\_\_\_\_

Name of Medicine: \_\_\_\_\_

Procedures to be taken in an emergency: \_\_\_\_\_

**Contact Information**

Name: \_\_\_\_\_

Daytime Phone No: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

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 8**

**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 9**

**Authorisation for the administration of rectal diazepam**

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

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

Date of birth \_\_\_\_\_

Home address \_\_\_\_\_

GP \_\_\_\_\_

Hospital consultant \_\_\_\_\_

\_\_\_\_\_ [*name of child*] should be given Rectal Diazepam \_\_\_\_\_ mg. If he/she has a \*prolonged epileptic seizure lasting over \_\_\_\_\_ minutes

**OR**

\*serial seizures lasting over \_\_\_\_\_ minutes.

An Ambulance should be called for \*at the beginning of the seizure

**OR**

If the seizure has not resolved \*after \_\_\_\_\_ minutes.

(\* please delete as appropriate)

Doctor's signature: \_\_\_\_\_

Parent's signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

### **NB: Authorisation for the Administration of Rectal Diazepam**

As the indications of when to administer the diazepam vary, an individual authorisation is required for each child. This should be completed by the child's GP, Consultant and/or Epilepsy Specialist Nurse and reviewed regularly. This ensures the medicine is administered appropriately.

The Authorisation should clearly state:

when the diazepam is to be given e.g. after 5 minutes; and

how much medicine should be given.

Included on the Authorisation Form should be an indication of when an ambulance is to be summoned.

**Records of administration should be maintained using Form 5 or similar**

## ANNEX C: RELATED DOCUMENTS

DfES unpriced documents can be ordered from DfES Publications. Tel: 0845 6022260. Email: [dfes@prolog.uk.com](mailto:dfes@prolog.uk.com). Please quote the publication reference when ordering.

### Early Years Settings

*Disability Discrimination Act 1995 - Code of Practice - Rights of Access - Goods, Facilities, Services and Premises* (Disability Rights Commission, 2002). Price: £13.95. Order: The Stationery Office. Tel: 0870 600 5522  
DRC Code of Practice webpage: <http://www.drc-gb.org/thelaw/practice.asp>

*Early Support Family Support Pack and Early Support Professional Guidance.* (DfES, 2004). Ref: ESPP1. Website: <http://www.earlysupport.org.uk>

*Including Me - Managing Complex Health Needs in Schools and Early Years Settings* (Council for Disabled Children, due for publication in summer 2005). Council for Disabled Children tel (020) 7843 1900.

*National standards for under 8s day care and childminding* (DfES/DWP, 2003) – *Childminding* Ref: DfES/0649/2003 ; *Creches* Ref: DfES/0650/2003 ; *Full day care* Ref: DfES/0651/2003 ; *Out of school care* Ref: DfES/0652/2003 ; *Sessional care* Ref: DfES/0653/2003.  
<http://www.surestart.gov.uk/ensuringquality/standardsandregulation/>

### Schools

*Code of Practice for Schools – Disability Discrimination Act 1995: Part 4* (Disability Rights Commission, 2002). Ref: COPSH. <http://www.drc-gb.org/thelaw/practice.asp>  
Order: Disability Rights Commission Tel: 08457 622 633.

*Drugs: Guidance for Schools* (DfES, 2004) Ref: DfES/0092/2004  
<http://www.teachernet.gov.uk/drugs/>

*Guidance on First Aid for Schools: a good practice guide* (DfES, 1998)  
Ref: GFAS98. <http://www.teachernet.gov.uk/firstaid>

*Health and Safety: Responsibilities and Powers* (DfES, 2001)  
Ref: DfES/0803/2001  
<http://www.teachernet.gov.uk/responsibilities/>

*Health and Safety of Pupils on Education Visits: a good practice guide* (DfES, 1998) Ref: HSPV. <http://www.teachernet.gov.uk/visits/>. Also three part supplement: *Part 1 - Standards for LEAs in Overseeing Educational Visits* (DfES, 2002) REF: DfES/0564/2002; *Part 2 - Standards for Adventure* (DfES, 2002) REF: DfES/0565/2002; *Part 3 - Handbook for Group Leaders* (DfES, 2002) REF: DfES /0566/2002.

*Home to school travel for pupils requiring special arrangements* (DfES, 2004)  
Ref: LEA/0261/2004  
<http://www.teachernet.gov.uk/wholeschool/sen/sentransport/>

*Improving Attendance and Behaviour: Guidance on Exclusion from Schools and Pupil Referral Units* (DfES, 2004) Ref: DfES/0354/2004  
<http://www.teachernet.gov.uk/exclusion>

*Insurance – A guide for schools* (DfES, 2003) Ref: DfES/0256/2003  
<http://www.teachernet.gov.uk/management/atoz/i/insurance/index.cfm?code=keyd>

*School Admissions Code of Practice* (DfES, 2003) Ref: DfES/0256/2003  
<http://www.dfes.gov.uk/sacode/>

*Special Educational Needs Code of Practice* (DfES, 2001) Ref: DfES/0581/2001  
<http://www.teachernet.gov.uk/teachinginengland/detail.cfm?id=390>

*Standards for School Premises* (DfEE, 2000) Ref: DFEE/0029/2000  
<http://www.teachernet.gov.uk/sbregulatoryinformation>

*Work Related Learning and the Law* (DfES, 2004) Ref: DfES/0475/2004  
<http://www.dfes.gov.uk/qualifications/document.cfm?SID=2>

## **Department of Health (including joint publications)**

*Guidance on infection control in schools and nurseries* (Department of Health/Department for Education and Employment/Public Health Laboratory Service, 1999) Download only from: Wired for Health website  
<http://www.wiredforhealth.gov.uk/doc.php?docid=7199>

*National Service Framework for Children, Young People and Maternity Services: Medicines for Children and Young People*  
Website: <http://www.dh.gov.uk/healthtopics> (click on 'Children's services').  
Order: DH Publications Tel: 08701 555 455.

## **Ofsted**

*Inspecting schools – Handbook for inspecting nursery and primary schools* Ref: HMI 1359; *Inspecting schools – Handbook for inspecting secondary schools* Ref: HMI 1360; *Inspecting schools – Handbook for inspecting special schools and pupil referral units* Ref: HMI 1361. All Ofsted 2003. Priced documents. Order: The Stationery Office, tel: 0870 600 5522. Or view online at <http://www.ofsted.gov.uk/schools>

*LEA Framework 2004 - Support for health and safety, welfare and child protection* (Ofsted, 2004) Website only:  
<http://www.ofsted.gov.uk/lea/index.cfm?fuseaction=inspectionGuidance>



## **ANNEX D: 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>