



Managing Chronic Health Conditions & Infection Control in Schools

East Riding of Yorkshire Council

**Primary Behaviour &
Attendance Partnership**

**Secondary Behaviour &
Attendance Partnership**

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Table of Common Conditions

Remember, if a parent is concerned about any aspect of their child's health they should consult a health professional via NHS direct, a local chemist, walk in centre, GP or a referral should be made to the school nurse.

Common Conditions	Recommended period for child to be kept away from school
Coughs & Colds	Coughs, colds. A child with a minor cough or cold may attend school. If the cold is accompanied by a raised temperature, shivers or drowsiness, the child should stay off school and consult their GP.
Diarrhoea and/or Vomiting Illness	24 hours from last episode of diarrhoea <u>or</u> vomiting (when no other symptoms present). If there is no improvement, they should consult their GP.
Earache	If a child has earache they should consult their GP.
Headache	None. If the headache is more severe and accompanied by other symptoms, they should consult their GP.
Head Lice	None. However, they may be taken out of school for treatment. This takes no longer than two hours, once treated they must return to school. If the child does not return the absence will not be authorised.
Sore Throat	If a child has a sore throat with no other symptoms then they are usually well enough to attend school. It is only in severe cases that there may be good reason for them to stay at home.
Temperature	You can usually identify a raised temperature through your child looking or feeling shivery. There are lots of reasons for a raised temperature and if symptoms persist you should seek medical attention. As soon as your child is feeling better they can return to school.
Toothache	School attendance should be maintained until your child can be seen by a dentist.

Rashes and skin infections	Recommended period for child to be kept away from school
Chicken Pox*	5 days from the onset of rash (or until the last blister has burst and crusted over which usually takes five or six days after the rash begins). Contact with pregnant women and newborn babies should be avoided.
Eczema	None. Children can attend school even when it is being treated. Pupils should only be absent from school if advised by the G.P. because it is so severe.
German Measles* (Rubella)	6 days from the onset of rash
Hives	None.
Impetigo	48 hours after consulting a GP and commencing antibiotic treatment. They will need to be kept off school until the sores have scabbed over and are healing.
Measles*	4 days from the onset of rash.
Ringworm	Absence not usually required. However, treatment should be sort.
Scabies	Child can return after first treatment.
Scarlet Fever	Child can return 24 hours after commencing appropriate antibiotic treatment.
Slapped Cheek Disease*	None (when no other symptoms present).
Shingles	Absence only if rash is weeping and cannot be covered.
Thread Worms	Absence not usually required. However, treatment should be sort.
Warts and Verrucae	None. However, treatment should be sort.

*Harmful to pregnant staff / pupils (see 'Female Staff & Pupils' advice on page 42).

For advice and procedures for reporting cases or suspected cases of infectious disease in schools and other educational establishments contact Public Health England: <https://www.gov.uk/government/organisations/public-health-england>
Telephone: 01904 687100

Respiratory Infections	Recommended period for child to be kept away from school
Flu	Until recovered.
Tuberculosis	Always consult the Health Protection Unit.
Whooping Cough	5 days from commencing antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment.

Other infections	Recommended period for child to be kept away from school
Conjunctivitis	None. If a child has, or you suspect a child may have conjunctivitis you will need to seek medical attention. Once treated there is no need to be kept off school.
Diphtheria	Absence is essential. Always consult with your local Health Protection Unit.
Ecoli Typhoid Dysentery	48 hours from last episode of diarrhoea. Further absence may be required for some children until they are no longer excreting.
Glandular Fever	None (when no other symptoms present).
Hand, Foot and Mouth	None. School may consider absence if a large number of children are affected.
Hepatitis A	Absence until seven days after onset of jaundice (or seven days after symptom onset if no jaundice).
Hepatitis B, C, HIV/AIDS	None.
Meningococcal Meningitis/Septicaemia	Until recovered.
Meningitis due to other bacteria	Until recovered.
Meningitis Viral	None (when no other symptoms present).
Mumps	Absence for 5 days after onset of swelling.
Tonsillitis	None (when no other symptoms present).

Further information: <http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/>

Anaphylaxis Information

Hay Fever

As with all pollen allergies, those who suffer with hay fever typically will sneeze, feel congestion and have itchy eyes and noses. It is good to note that hayfever can be a reaction to tree, grass or weed pollen. All these have differing times of pollination. Although symptoms are usually limited to the nose and eyes, some who is severely allergic to grass may also get hives upon contact with its pollen (itchy skin producing a red raised area anywhere on the body). In the most dangerous cases, they can experience a reaction that is close to anaphylaxis.

What is Anaphylaxis?

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

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

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

Medicine and Control

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

Any, or all, of the following symptoms and signs may be present in an acute allergic reaction.

Antihistamine should be given at the first sign of an allergic reaction and the child closely observed. Antihistamine dose may need to be repeated if the patient vomits. For a child who has asthma, if there is any sign of breathing difficulty then their reliever inhaler (usually blue) should be administered.

Minor reactions (needing oral antihistamine):

- Feeling hot/flushing
- Itching
- "Nettle sting like" rash/welts/hives (urticaria)
- Red, itchy watery eyes
- Itchy, runny or congested nose or sneezing
- Swelling: face, lips, eyes, hands
- Tummy pain
- Vomiting or diarrhoea
- Metallic (funny) taste in the mouth

Even where mild symptoms are present the child should be watched carefully as they may be heralding the start of a more serious reaction.

If the reaction continues to progress despite antihistamine and any of the following symptoms/signs are seen, then the EpiPen®/Anapen® should be administered into the muscle of the upper outer thigh and an AMBULANCE CALLED IMMEDIATELY.

Severe reactions (needing EpiPen/Anapen):

- Difficult/nosy breathing, wheeze, breathlessness, chest tightness, persistent cough
- Difficulty talking, change in voice, hoarseness
- Swelling, tightness, itchiness of the throat (feeling of 'lump in throat')
- Impaired circulation - pale clammy skin, blue around the lips and mouth, decreased level of consciousness
- Sense of impending doom ("I feel like I am going to die')
- Becoming pale/floppy
- Collapse

If an EpiPen®/Anapen® is administered, the child should be kept lying down, with feet raised (e.g.: on a chair) to assist circulation.

They should transfer to hospital in this "head-down" position.

Raising the patient's head or assisting them to sit or stand up can result in an acute severe deterioration of the allergic reaction.

Occasionally, a second EpiPen®/Anapen® may be required if there has been no improvement in the child's condition 5 to 10 minutes after administering the first EpiPen/Anapen.

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

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

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

In other circumstances (with an appropriate Patient Group Direction¹) a school nurse might hold a certain number of EpiPens®, not individually named, and could use these to administer emergency medication (e.g.: antihistamine/adrenaline) to a patient who has not previously had this prescribed, but who is demonstrating the clinical features of a significant allergic reaction. This would cover those rare cases

¹ A patient group direction (PGD) is a written direction relating to supply and administration, or administration of a Prescription Only Medicine (POM), to persons generally, (subject to specified exclusions) and is signed by a doctor or dentist, and by a pharmacist.

where a pupil presents with a first reaction in school. Teenagers with nut allergy are a particularly vulnerable group in this respect, a recognised factor in fatal reactions is failure to carry their own medication. Therefore a backup system in schools, governed by a Patient Group Direction would be a beneficial safety net.

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

Important issues specific to anaphylaxis to be covered include:

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

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

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

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

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

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

The Anaphylaxis Campaign website contains Guidance for schools, which discusses anaphylaxis, treatment, setting up a protocol, and support for pupils and staff. It also includes a sample protocol. The Anaphylaxis Campaign Helpline is 01252 542029. The Anaphylaxis Campaign has also published the Allergy in Schools website which has specific advice for pre-schools, schools, school caterers, parents, students and nurses.

More information:

Anaphylaxis Campaign www.anaphylaxis.org.uk/schools/help-for-schools
Department of Health, Social Services and public safety www.dhsspsni.gov.uk

Asthma Information

This school aims to provide a caring supportive environment where all learners can achieve their potential. We will achieve high standards in all areas, through a creative, exciting, challenging curriculum and opportunities, which meet the needs of all.

Through engagement with local, national and worldwide communities and issues, our pupils will embrace responsible 21st century citizenship. We will take pride in all that we do and celebrate both success and effort.

School Aims

- We will provide a wide range of exciting and challenging experiences for all to enable our pupils to become effective learners and reach their potential.
- We will promote responsible citizenship, built on respect for ourselves and others, through active links with the local and wider community.
- We will promote high standards of physical, emotional and mental health and well-being among our school community.

We will aim to:

- Promote equality of opportunity between disabled person and other person.
- Eliminate discrimination that is unlawful under the Act.
- Eliminate harassment of disabled pupils that is related to their disabilities.
- Promote positive attitudes towards disabled people.
- Encourage participation by disabled persons in public life.
- Take steps to account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons.

This school recognises that asthma is a widespread, serious but controllable condition affecting many pupils at the school. The school positively welcomes all pupils with asthma. We encourage pupils with asthma to achieve their potential in all aspects of school life by having a clear policy that is understood by school staff, their employers (the Local Education Authority) and pupils. Supply Teachers and new staff are also made aware of the policy. All staff who come into contact with pupils with asthma will be provided with training on asthma from the school nurse who has had asthma training. Training will be updated once a year.

Asthma medicines

- Immediate access to reliever medicines is essential. Pupils with asthma in Years 1 – 6 keep their inhalers in the classroom in their drawer where they are easily accessible. The reliever inhalers of Foundation Stage children are kept in the classroom in a box.
- Parents / carers are asked to ensure that the school is provided with a labelled spare reliever inhaler. The class teacher will hold this separately in case the pupil's own inhaler runs out, or is lost or forgotten. All inhalers must be labelled with the child's name by the parent / carer.
- School staff are not required to administer asthma medicines to pupils (except in an emergency), however many of the school staff are happy to do this. School staff who agree to administer medicines are insured by the local education authority when acting in agreement with this policy. All school staff will let pupils take their own medicines when they need to.

Record Keeping

- At the beginning of each school year or when a child joins the school, parents / carers are asked if their child has any medical conditions including asthma on their enrolment form.
- All parents / carers of children with asthma are consequently sent an Asthma UK School Asthma Card to give to their child's doctor or asthma nurse to complete. Parents / carers are asked to return them to school. From this information the school keeps its asthma register, which is available to all school staff. School Asthma Cards are then sent to parents / carers of children with asthma on an annual basis to update. Parents / carers are also asked to update or exchange the card for a new one if their child's medicines, or how much they take, changes during the year.

Exercise and activity – PE and games

- Taking part in sports, games and activities is an essential part of school life for all pupils. All teachers know which children in their class have asthma and all teachers at the school are aware of which pupils have asthma from the school's asthma register.
- Pupils with asthma are encouraged to participate fully in all PE lessons. Teachers will remind pupils whose asthma is triggered by exercise to take their reliever inhaler before the lesson, and to thoroughly warm up and down before and after the lesson. If a pupil needs to use their inhaler during a lesson they will be encouraged to do so.
- Classroom teachers follow the same principles as described above for games and activities involving physical activity.

Out-of-hours sport

- There has been a large emphasis in recent years on increasing the number of children and young people involved in exercise and sport in and outside of school. The health benefits of exercise are well documented and this is also true for children and young people with asthma. It is therefore important that the school involve pupils with asthma as much as possible in after school clubs.
- Teachers, support staff and out-of-hours school sport coaches are aware of the potential triggers for pupils with asthma when exercising, tips to minimise these triggers and what to do in the event of an asthma attack.
- Information about asthma will be provided on the Asthma UK Out There & Active Poster, to be displayed in several locations around the school. The poster helps to encourage pupils with asthma to be active and get more involved in PE and exercise and has tips to help them do this.

School Environment

The school does all that it can to ensure the school environment is favourable to pupils with asthma. The school has a definitive no-smoking policy. As far as possible the school does not use chemicals in science and art lessons that are potential triggers for pupils with asthma. Pupils with asthma are encouraged to leave the room and go and sit in the school office if particular fumes trigger their asthma.

Making the school asthma-friendly

The school ensures that all pupils understand asthma. Asthma can be included in the National Curriculum Key Stages 1 and 2 in science, design and technology, geography, history and PE.

When a pupil is falling behind in lessons

If a pupil is missing a lot of time at school or is always tired because their asthma is disturbing their sleep at night, the class teacher will initially talk to the parents / carers to work out how to prevent their child from falling behind. If appropriate, the teacher will then talk to the school nurse and special education needs coordinator about the pupil's needs.

The school recognises that it is possible for pupils with asthma to have special education needs due to their asthma.

Asthma attacks

All staff coming into contact with pupils who have asthma should know what to do in the event of an asthma attack.

The signs of an asthma attack include:

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

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

An ambulance should be called if:

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

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

In the event of an asthma attack the school follows the procedure outlined by Asthma UK in its School Asthma Pack. This procedure should be displayed in the staffroom and every classroom.

Further support and information:

Asthma UK <http://www.asthma.org.uk/>

www.netdoctor.co.uk/diseases/facts/asthma.htm

NHS UK www.nhs.uk/conditions/Asthma/Pages/Introduction.aspx

Diabetes Information for Parents & Schools

Parents of children with diabetes should make their condition known and their treatment plan available to the school. All staff in the school should be made aware of what to do if the pupil shows signs of becoming unwell.

General Information

There are two types of diabetes:

- Type 1 diabetes - due to the lack of insulin
- Type 2 diabetes - there is insufficient insulin for the child's needs or the insulin is not working properly

The majority of children with diabetes have Type 1 diabetes. They normally require daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. People with Type 2 diabetes are usually treated by diet and exercise alone.

Each child may experience different symptoms and this should be discussed when drawing up the health care plan. A greater need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control, and staff should draw any such signs to the parents' attention. All Pupil Care plans should include the roles and responsibilities of the following:

- Parents' responsibility
- Early years/school responsibility
- Child's responsibility when deemed competent
- Paediatric diabetes specialist nurse
- School nurse

Medicine and Control for children

Diabetes for the majority of children is controlled by injections of insulin each day. Younger children may be on a twice daily insulin regime of a longer acting insulin which means it is unlikely these will need to be given during school hours, although for those who do require injection it may be necessary for an adult to administer it. Older children may require multiple injections and others may be controlled by an insulin pump. Most children will manage their own injections, but if doses are required school supervision may be required. A suitable, private place to carry out the injections should be made available.

Increasingly, older children are taught to count their carbohydrate intake and adjust their insulin accordingly. This means they have a daily dose of longacting 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 in order to decide how much insulin to give. Diabetic specialists would only implement this type of regime once they were confident the child was competent. The child is then responsible for the injections and their regime would be detailed in the individual health care plan.

Children with diabetes need to ensure their blood glucose levels remain stable which may require checking their levels by taking a small sample of blood and using a 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. Older children should 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 their blood glucose test results.

When staff agree to supervise blood glucose tests or administer insulin injections, they must be trained by an appropriate health professional. Administering injections is a matter for personal preference and no member of staff will be expected to carry out this task without full training and their consent.

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

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

- Hunger
- Sweating
- Drowsiness
- Lethargy
- Pallor
- Glazed eyes
- Shaking or trembling
- Lack of concentration
- Irritability
- Headache
- Mood changes, especially angry or aggressive behaviour

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

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 on their breath, this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

Any illness, even a cough or a cold can affect a child's diabetes control and extra attention should be paid to a child with diabetes if they are unwell.

Information and photographs of children with diabetes should be placed on staff information boards throughout the school.

Important Additional Information

If a child has a hypo, it is very important that the child is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel, or a sugary drink is brought to the child and given immediately. Slower acting starchy food, such as a sandwich or

two biscuits and a glass of milk, should be given once the child has recovered, some 10-15 minutes later.

An ambulance should be called if:

Recovery takes longer than 10-15 minutes **or** if the person becomes unconscious

Additional advice for Schools:

- The needs of children and young people with diabetes are paramount
- Treatment regimens should be led by clinical need, rather than the level of support available in schools and early years settings
- Children and young people with diabetes should have equitable access to all curricular and extracurricular activities
- Where support is required, training should be provided to identified personnel by appropriately trained health care professionals†
- A child or young person with diabetes should have sufficient support to ensure optimal glycaemic control within the school environment, enabling them to meet their full academic capability.

Useful websites and sources of further information

Diabetes UK: www.diabetes.org.uk Care line: 0845 120 2960

<http://www.netdoctor.co.uk/diseases/facts/diabeteschildren.htm>

Department for Education: www.education.gov.uk Tel: 0370 000 2288

Disability Rights Commission merged into the newly created Equality and Human Rights Commission in 2007: www.equalityhumanrights.com

Medical Conditions at School: www.medicalconditionsatschool.org.uk

A partnership of organisations – including Diabetes UK – working collaboratively to support schools to provide a safe environment for children and young people with medical conditions. A policy resource pack is available.

Juvenile Diabetes Research Foundation: www.jdrf.org.uk Tel: 020 7713 2030

National Institute for Health and Clinical Excellence (NICE): www.nice.org.uk

Information provided by: Royal College of Nursing <http://www.rcn.org.uk>

Epilepsy Information for schools

How common is epilepsy?

Epilepsy is the most common serious neurological condition. It affects about one in 279 children under 16. This means that there are about 42,000 children with epilepsy in UK schools. To put it another way, an average sized secondary school will have three to four children with the condition, while an average sized primary school will have one or two children with epilepsy. Over 10 per cent of calls to the Epilepsy Helpline in each year are about issues relating to epilepsy in children.

What is epilepsy?

Epilepsy is defined as having a tendency to have seizures. A seizure happens when the nerve cells in the brain stop working in harmony. When this happens the brain's messages become temporarily halted or mixed up. A child with epilepsy has recurrent seizures, unless the seizures are controlled by medicine.

Some children have epilepsy as a result of damage to the brain. This may have been due to injury before, during or after birth, and is known as symptomatic epilepsy. For other children, there is no known or identifiable cause. They have an inherited tendency to have epilepsy.

This is known as idiopathic epilepsy, and is thought to be related to a low seizure threshold.

Everyone has a seizure threshold; having a low seizure threshold means that a child is more likely to have seizures than children in general.

Seizures

A seizure can either affect part of the brain or the whole brain. There are around 40 different types of seizure, some of which are more common in children. Depending on whether a seizure affects the whole or part of the brain it is called either generalised or partial. Generalised seizures affect the whole, or a large part, of the brain and result in a loss of consciousness, which may be very brief, or may last several minutes. Partial seizures only affect part of the brain and only partly affect consciousness.

The most common types of seizures

Tonic-clonic seizures

Children who have tonic-clonic seizures (previously known as grand-mal) lose consciousness and fall to the ground. Their body goes stiff and their limbs jerk. When their seizure is over, their consciousness returns, but they may be very confused and tired. It's important that you stay with them at this point, to make sure they are alright. First aid advice for tonic-clonic seizures can be found on page 11, together with a sample of an epilepsy policy for schools.

Absence seizures

During an absence seizure (previously known as petit-mal) the child will briefly lose consciousness, but will not lose muscle tone or collapse. They will appear to be daydreaming or distracted for a few seconds. While these episodes may seem unimportant, they can happen hundreds of times a day. This can cause the child to become confused about what is happening around them.

Absence seizures are most common in children between the ages of six and 12 years old.

As the child will lose consciousness during seizures, they are at risk of missing out on vital learning. If a child is having absence seizures during the day, the child's parents

may not be aware that their child has epilepsy. Spotting these seizures can help doctors make a diagnosis. There is no first aid needed for absence seizures, but they must not be mistaken for daydreaming or inattentiveness.

Complex partial seizures

This type of seizure can be difficult to recognise. The child's consciousness level will be affected to some extent, and they will not be fully in touch with what is happening around them. During the seizure they may do things repeatedly, such as swallowing, scratching or looking for something. Complex partial seizures can be misinterpreted as bad behaviour.

In fact the child will not know what has happened and will not remember what they were doing before the seizure started.

Although there is no real first aid needed for complex partial seizures, it's important not to restrain the young person unless they are in immediate danger. This is because they may not recognise you and become frightened. However, if the child is walking towards a busy road, you should try to guide them to safety. When the seizure ends the child is likely to be confused, so it is vital to stay with them and reassure them.

(For more information about complex partial seizures visit www.epilepsy.org.uk or call the Epilepsy Helpline, freephone 0808 800 5050, text 07797 805 390 or email helpline@epilepsy.org.uk)

Myoclonic seizures

When a child has a myoclonic seizure the muscles of any part of their body jerks. These jerks are common in one or both arms and can be a single movement or the jerking may continue for a period of time. Myoclonic seizures happen most often in the morning, and teachers need to bear in mind that a child may be tired or lack concentration if they start school after having one of these. There is no first aid needed for myoclonic seizures unless the child has been injured, when usual first aid procedures are used. If the child is distressed by the seizure, they may need comforting and generally reassuring.

Atonic seizures

Atonic seizures cause a child to lose muscle tone. When this happens the child falls to the ground without warning. This can result in injuries to the face and head. Children who have regular atonic seizures may need to wear protective headgear to avoid injuries. There is no first aid needed for atonic seizures, unless the child is injured during the fall.

General seizure advice

Tonic-clonic seizures are the most widely recognised type of epileptic seizure. It's important to note that most children need a rest following this kind of seizure. Depending on how they are feeling, they may be able to return to lessons. However, if they take many hours to recover, they may need to be taken home.

In different seizures, such as absences, there are other issues. For example, symptoms may not be recognised by staff as being seizures. It is extremely important that staff understand and can recognise the lesser known seizures, so that they can provide students with the right support.

Triggers

A trigger is anything that causes a seizure to occur, in someone who already has a predisposition. There are many different triggers, but some are more relevant to school settings than others. This can include the following situations.

- When a child first starts school, or changes class, they may be excited or anxious. Both of these emotions can trigger seizures.
- When a child or young person is preparing for exams, they may become stressed or not sleep properly. Stress and lack of sleep can be triggers for seizures.
- It's often thought that all people with epilepsy have seizures triggered by flickering light (known as photosensitive epilepsy). This is not the case, as fewer than one in 20 people with epilepsy have photosensitive epilepsy.

Some children with epilepsy may be entitled to extra time or support in exams because their epilepsy affects their ability to function at the same level as their classmates. If a teacher thinks this may be the case, they should speak to the child's parents and, if possible, to a health or psychology service professional. Schools need to apply to the relevant examining body to ask for extra provision. They need to do this as soon as possible.

Guidelines on applying for special adjustments in exams are available from the Joint Council for Qualifications' website: www.jcq.org.uk

During a seizure

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

An ambulance should be called during a convulsive seizure if:

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

Medicines

The majority of children with epilepsy take anti-epileptic drugs (AEDs) to control their seizures. These drugs are usually taken twice a day, outside of school hours. This means there should be no issues about storing or administering medicines in school time.

Certain types of medicines taken for epilepsy can have an effect on a child's learning or behaviour. It is important staff are aware of this. If a teacher notices a change in the child's learning or behaviour, then this should be discussed with their parents.

The only time medicine may be urgently needed by a child with epilepsy is when their seizures fail to stop after the usual time or the child goes into status epilepticus. Status epilepticus is defined as a prolonged seizure or a series of seizures without regaining consciousness in between. This is a medical emergency and is potentially life threatening. If this happens, emergency medication needs to be administered by a trained member of staff. If this isn't possible an ambulance should be called.

Emergency medicines

If a child with epilepsy is likely to need emergency medicine to stop a seizure, it is vital that the parents and school staff work together to decide how this should happen. Although it is not a legal requirement for school staff to administer medicines under the Disability Discrimination Act, the school should ensure that a sufficient number of staff are trained to administer emergency medicines. Alternatively other arrangements could be in place such as the school nurse, a paramedic or the child's parents could be contactable to administer the medicine if it is needed. Training can be arranged by the School Health Service, the local authority or through an independent training provider.

The two main forms of emergency medicines are rectal diazepam and buccal midazolam.

Rectal diazepam has been used for many years. Buccal midazolam is currently unlicensed for treating epilepsy in children. However, many consultants and some epilepsy specialist nurses prescribe this drug, as it is easier to use and less invasive than rectal diazepam. The government's own advice on the use of buccal midazolam states that if the medicine is used in schools then 'instructions for use must come from the prescribing doctor'. These instructions should be written into an individual care plan for each child who may need medication in school time.

Useful contacts and information

www.netdoctor.co.uk/diseases/facts/epilepsy.htm

Epilepsy Action www.epilepsy.org.uk

New Anstey House, Gate Way Drive, Yeadon. Leeds. LS19 7XY

Tel: 0113 210 8800

Helpline: 0808 800 5050

Email: epilepsy@epilepsy.org.uk

Department for Education www.education.gov.uk

Castle View House, East Lane, Runcorn. Cheshire. WA7 2GJ

Tel: 0370 000 2288

Information taken from: Epilepsy Action (working name of British Epilepsy Association)

Why schools need an epilepsy policy

It is essential for schools to have an epilepsy policy. Epilepsy Action believes that all children with epilepsy should be given the same opportunities to achieve their full potential. They should be able to enjoy the same level of participation in school life as their friends and classmates.

The Disability Discrimination Act (DDA) requires schools and education settings to ensure that all children with disabilities (which include epilepsy) are not treated 'less favourably' than their classmates.

To help achieve this, and fulfil legal requirements, every school or education setting should have a school epilepsy policy. Schools can use an epilepsy policy on its own or as part of another policy, for example the school's health and safety policy, its first aid policy or as part of its accessible schools plan.

Some children with epilepsy are prevented from attending school due to prolonged or recurrent absence as a result of their epilepsy. Schools should be prepared to incorporate provision for this in their epilepsy policy. Statutory guidance for educating children with health needs: 'Ensuring a good education for children who cannot attend school because of health needs' January 2013 is available from www.education.gov.uk

School Policy Requirements

Schools should use the information below to develop an epilepsy policy. Each school's policy will be different, but every policy should incorporate the following principles.

1. This school recognises that epilepsy is a common condition affecting many children and young people, and welcomes all students with epilepsy.
2. This school believes that every child with epilepsy has a right to participate fully in the curriculum and life of the school, including all outdoor activities and residential trips.
3. This school keeps a record of all the medical details of children with epilepsy and keeps parents updated with any issues it feels may affect the child.
4. This school ensures that all children and staff in the school understand epilepsy and do not discriminate against any children with the condition.
5. This school ensures that all staff fully understands epilepsy and seizure first aid, and that there is at least one member of staff trained to administer emergency medicines in school at all times.
6. This school will work together with children, parents, staff, governors, educational psychologists and health professionals to ensure this policy is successfully implemented and maintained.

Epilepsy policy for schools Implementation

An epilepsy policy should include all of the above points and explain how they are to be implemented. The following is a typical sample policy for a school. The sample forms should help to gather information to implement this policy.

Example Policy

St Egbert's Primary School, Egton, Hatchington

This policy has been written in line with information provided by Epilepsy Action, the Department for Education and Skills (now the Department for Children, Families and Schools), the local authority, the school health service, the governing body, students and parents.

St Egbert's recognises that epilepsy is a common condition affecting children and welcomes all children with epilepsy to the school.

St Egbert's supports children with epilepsy in all aspects of school life and encourages them to achieve their full potential. This will be done by having a policy in place that is developed in conjunction with the local authority and understood by all school staff. This policy ensures all relevant staff receives training about epilepsy and administering emergency medicines. All new staff and supply staff will also receive appropriate training.

What to do when a child with epilepsy joins St Egbert's

When a child with epilepsy joins St Egbert's, or a current pupil is diagnosed with the condition, the head teacher arranges a meeting with the pupil and the parents to establish how the pupil's epilepsy may affect their school life. This should include the implications for learning, playing and social development, and out of school activities. They will also discuss any special arrangements the pupil may require, for example extra time in exams. With the pupil's and parent's permission, epilepsy will be addressed as a whole-school issue through assemblies and in the teaching of PSHE or citizenship lessons. Children in the same class as the pupil will be introduced to epilepsy in a way that they will understand. This will ensure the child's classmates are not frightened if the child has a seizure in class.

The school nurse or an epilepsy specialist nurse may also attend the meeting to talk through any concerns the family or head teacher may have, such as whether the pupil requires emergency medicine. The following points in particular will be addressed.

Record keeping

During the meeting the head teacher will agree and complete a record of the pupil's epilepsy and learning and health needs. This document may include issues such as agreeing to administer medicines and any staff training needs. This record will be agreed by the parents, and the health professional, if present, and signed by the parents and head teacher. This form will be kept safe and updated when necessary. Staff will be notified of any changes in the pupil's condition through regular staff briefings. This will make staff aware of any special requirements, such as seating the pupil facing the class teacher to help monitor if the student is having absence seizures and missing part of the lesson.

Medicines

Following the meeting, an individual healthcare plan (IHP) will be drawn up. It will contain the information highlighted above and identify any medicines or first aid issues of which staff needs to be aware. In particular it will state whether the pupil requires emergency medicine, and whether this medicine is rectal diazepam or buccal midazolam. It will also contain the names of staff trained to administer the medicine and how to contact these members of staff. If the pupil requires emergency

medicine then the school's policy will also contain details of the correct storage procedures in line with the DfES guidance found in *Managing Medicines in Schools and Early Year Settings*².

First aid

First aid for the pupil's seizure type will be included on their IHP and all staff (including support staff) will receive basic training on administering first aid. The following procedure giving basic first aid for tonic-clonic seizures will be prominently displayed in all classrooms.

Stay calm.

If the child is convulsing then put something soft under their head.

Protect the child from injury (remove harmful objects from nearby).

NEVER try and put anything in their mouth or between their teeth.

Try and time how long the seizure lasts – if it lasts longer than usual for that child or continues for more than five minutes then call medical assistance.

When the child finishes their seizure stay with them and reassure them.

Do not try and move the child unless they are in danger.

Do not try and restrain the child.

Do not give them food or drink until they have fully recovered from the seizure.

Aid breathing by gently placing the child in the recovery position once the seizure has finished.

Sometimes a child may become incontinent during their seizure. If this happens, try and put a blanket around them when their seizure is finished to avoid potential embarrassment. First aid procedure for different seizure types can be obtained from the school nurse, the pupil's epilepsy specialist nurse or Epilepsy Action.

Learning and behaviour

St Egbert's recognises that children with epilepsy can have special educational needs because of their condition (*Special Educational Needs Code of Practice*³). Following the initial meeting, staff will be asked to ensure the pupil is not falling behind in lessons. If this starts to happen the teacher will initially discuss the situation with the parents. If there is no improvement, then discussions should be held with the school's special educational needs co-ordinator (SENCO) and school nurse. If necessary, an Individual Educational Plan will be created and if the SENCO thinks it appropriate, the child may undergo an assessment by an educational or neuropsychologist to decide what further action may be necessary.

School environment

St Egbert's recognises the importance of having a school environment that supports the needs of children with epilepsy. A medical room is kept available and equipped with a bed in case a pupil needs supervised rest following a seizure.

The above epilepsy policy applies equally within the school and at any outdoor activities organised by the school. This includes activities taking place on the school premises, and residential stays. Any concerns held by the pupil, parent or member of staff will be addressed at a meeting prior to the activity or stay taking place.

² DfES *Managing Medicines in Schools and Early Year Settings* Nottingham, 2005

³ DfES *Special Educational Needs Code of Practice* Nottingham, 2005

Legal requirements and responsibilities

The following information is taken from the DfES document *Managing Medicines in Schools and Early Year Settings 2005*. It aims to highlight the importance of having a clear school epilepsy policy and help staff understand their responsibility in ensuring the safety of a child with epilepsy in their school.

The general guidance for ensuring the health and safety of children in schools states that it is the employer's responsibility (under the Health and Safety at Work Act 1974) to make sure schools have a health and safety policy which includes procedures for supporting children with medical needs. It is also the employer's responsibility to make sure that they have taken out Employer's Liability Insurance and that this insurance provides full cover for school staff acting within full scope of their employment i.e. 'duty of care'. In community and voluntary controlled schools the employer is usually the local authority, while in foundation and voluntary-aided schools, staff are employed by the governing body.

In the day-to-day management of children's medical needs, parents should give schools information about their child's condition, including any relevant details from the child's GP, consultant or epilepsy specialist nurse. Parents are also responsible for supplying any information about the medicine their child needs and providing details of any change to the child's prescription or support required.

There is no legal duty requiring school staff to administer medicine. However, schools should consider this issue as part of their accessibility planning duties. Staff are usually happy to volunteer for training to administer emergency medicines. Some proactive schools require support staff to be trained in administering emergency medicines as part of their role (full roles and responsibilities are detailed in the government document *Managing Medicines in Schools and Early Year Settings*).”
Epilepsy Action 2009

Form A: Parental questionnaire

For students with epilepsy

This questionnaire should be completed by the child's parents, Headteacher and, wherever possible, the child

Name:

Date of birth:

Class/form teacher:

What type of seizure/s does your child have? (if you know what they are called)

How long do they last?

What first aid is appropriate?

How long will your child need to rest following a seizure?

Are there any factors that you have noted might trigger a seizure?

Does your child have any warning before a seizure occurs?

What is the name of your child's medicine and how much is each dosage?

How many times a day does your child take medicine?

Are there any activities that you feel may require particular precautions?

Does your child have any other medical conditions?

Is there any other relevant information you feel the school should be aware of?

Form B: Parental agreement

School or setting to administer medicine

The school will not give your child medicine unless this form is completed and the school has a policy for staff to administer medicine.

Name of school:

Child's name:

Date:

Class/form:

Medical condition or illness:

Name and strength of medicine:

Expiry date:

When to be given:

Dosage and method of administration:

Any side effects school needs to know about:

Procedure to take in an emergency:

Number of tablets/quantity to be given to school:

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

Daytime phone number of parent or adult contact:

Name and phone number of GP:

Agreed review date to be initiated by [staff name]:

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

Parent's signature:

Print name:

Date:

Form C: Staff training record

Administration of medicines

Name of school:

Name of staff:

Profession and title:

Type of training received:

Date of training completed:

Training provided by:

I confirm that [staff name] has received the training detailed above and agrees to carry out any necessary treatment.

I recommend that the training is updated [state how often]

Trainer's signature:

Date:

I can confirm I have received the training detailed above:

Staff signature:

Date:

Suggested review date:

Form D: Individual Healthcare Plan

Name:

Date of birth:

School:

Headteacher:

Parental contact no.:

Type of seizure/s experienced:

Symptoms:

Possible triggers:

Usual procedure following seizure:

Prescribed anti-epileptic medication:

Where medication is stored:

Member of staff responsible for replenishment of medication:

Staff trained to give medication:

i)

ii)

iii)

Member of staff responsible for Home/School liaison:

Emergency procedure if seizure lasts for more than _____ minutes.

1. Member of staff to stay with _____ to ensure safety.
2. Quietly clear the classroom/area of students if you think this is necessary.
3. Trained member of staff (see above) to give rectal diazepam/buccal midazolam with witness of same sex present (if possible).
4. If needed, telephone 999, ask for Ambulance Service, give name of student, address and phone number of school.
5. Telephone parents.
6. Inform Headteacher
7. Stay with _____ until ambulance arrives.
8. If parents have not arrived by this time a member of staff will accompany _____ to the hospital in the ambulance.
9. Fill in seizure record form for the student file and send copy to parents/GP.

Name:

Date of birth:

School:

Headteacher:

Parental contact no.:

Useful addresses and telephone numbers of professionals involved with:

Service	Name	Address & Tel No.
Emergency contact		
Epilepsy		
consultant/specialist		
Family GP		
Epilepsy/paediatric/ community support nurse		
Other		

Parental Consent Form

I give consent for _____ to be given rectal diazepam or Buccal Midazolam by trained staff in the circumstances described in this document. I will undertake to inform the school of any changes in the nature of his/her seizures or medication.

Signed:

Date:

Please print name:

Head Lice Information for Parents

If your child has head lice it should be treated immediately and again a week later to ensure they are all gone. If lice or eggs are still found, this process will need repeating if your child has head lice you may take them out of school to treat them. This will take no longer than two hours, once treated they must return to school. If you keep your child off school due to them having head lice the absence will not be authorised. If your child has long hair you may be advised to tie their hair back to help prevent infestation.

Facts

Head lice are small, six-legged wingless insects, pin-head size when they hatch, less than match-head size when fully grown and grey/brown in colour. They are difficult to detect in dry hair even when the head is closely inspected. They very often cause itching, but this is not always the case, particularly when recently arrived on the head.

Head lice cannot fly, jump or swim, but spread by clambering from head to head. Anyone with hair can catch them, but children who have head to head contact, either at school or during play, are most commonly affected.

Head lice feed by biting and sucking blood through the scalp of their host. The female louse lays eggs in sacs (nits) which are very small, dull in colour, and well camouflaged. These are securely glued to hairs where the warmth of the scalp will hatch them out in 7-10 days. Empty egg sacs are white and shiny and may be found further along the hair shaft as the hair grows out. Lice take 6-14 days to become fully grown, after which they are capable of reproduction.

Head lice are not fussy about hair length or condition. Clean hair is therefore no protection, although regular (e.g.: weekly) hair washing and combing sessions offer a good opportunity to detect head lice, and arrange treatment if discovered.

There is no need to wash or fumigate clothing or bedding that comes into contact with head lice.

Detection

Head lice are well camouflaged and hide when disturbed by combing. They do not always cause itching, particularly when recently arrived on the head. They may also be few in number and a quick inspection is unlikely to detect them. The following method of detection is effective:

Wet combing removes lice without using chemicals.

It involves wetting the hair, applying conditioner, then combing it with a fine-toothed comb for at least 30 minutes every third or fourth day over a two-week period.

The aim is to remove any live lice and eggs until none are left.

A 2005 study found wet combing more effective than insecticides at curing head lice infestations. The Bug Busting kit used in the study is available on prescription.

This can be undertaken on a regular basis – e.g.: at routine hair washing sessions - to detect the presence of lice before they can spread. Check all family members at the same time and arrange treatment when lice are found.

If you find lice, then there are two options. Whichever option you choose it is important to recognise that neither will protect against re-infection if head to head contact is made with someone with head lice at a later date. You may therefore wish to undertake occasional checks during hair washing sessions.

Treatment

Do not use lotions unless you find a living moving louse. Check all close family/friends by the "wet combing" method, as described, and treat anyone who is found to have lice at the same time, to prevent re-infection.

Ensure you have enough lotion to treat all those affected and follow the instructions on the packet carefully, e.g.: as to how long the treatment must remain on the hair to be effective, how often you may apply the product etc.

The product may be capable of killing eggs, as well as lice, but there is no certainty of this. Check for baby lice hatching out from eggs 3-5 days after you use it, and again at 10-12 days.

If the lice appear to be unaffected by the product (some lice may have developed resistance to a particular insecticide) or if the problem persists then you should take advice from your local school nurse, health visitor, pharmacist or GP, who will be able to advise you on alternative treatments and explain how to use these to best effect. You should seek advice where whoever is being treated is either under 1 year of age, suffers from asthma or allergies, or is pregnant or breast feeding.

Preventing Re-infestation

Here are some simple ways to get rid of the lice and their eggs, and help prevent a lice re-infestation:

Wash all bed linens and clothing that's been recently worn by anyone in your home who's infested in very hot water (130° F [54.4° C]), then put them in the hot cycle of the dryer for at least 20 minutes.

Have bed linens, clothing, and stuffed animals and plush toys that can't be washed dry-cleaned. Or, put them in airtight bags for 2 weeks.

Vacuum carpets and any upholstered furniture (in your home or car).

Soak hair-care items like combs, barrettes, hair ties or bands, headbands, and brushes in rubbing alcohol or medicated shampoo for 1 hour. You can also wash them in hot water or just throw them away.

Because lice are easily passed from person to person in the same house, bedmates and infested family members will also need treatment to prevent the lice from coming back

Further Information

If you are at all worried about head lice or feel you need more advice on how to cope, then you should consult your school nurse, health visitor, pharmacist or family doctor.

Read more: www.netdoctor.co.uk/diseases/facts/lice.htm

Information provided by: Department of Health

Suggested school letter and Parent Information Sheet

Dear Parent/Carer

We have had reports of live head lice infestations at school. We are therefore asking you to check your child's hair.

It is vital that every child's head is checked to determine whether or not there are lice present. The method we are advising is wet combing (detailed below).

Procedure:

- Wash the hair in the normal way with your regular shampoo.
- Check the water for any lice.
- While the hair is still wet, comb through with conditioner and a fine toothed comb. Start at the roots of the hair and continue through to the ends of the strands. At the end of every stroke check the comb for evidence of lice.
- The conditioner ensures that it is difficult for the lice to hang onto the hair and therefore they are easy to remove with the comb.
- If any lice are found this routine should be continued every four days for a period of two weeks.
- It is advisable to use this routine on a regular basis so that any lice present can be detected early.
- If you find live lice please notify your child's class teacher and also check all members of the family using the wet comb method.
- It is helpful if you also inform anyone with whom your child has had close contact with e.g. Cub's, Brownies, friends, extended family etc.

If you require any further advice or help about the problem of head lice please do not hesitate to contact your school nurse, pharmacist or family doctor.

Head Lice

A head louse is a tiny, wingless insect that can attach to a person's hair, where it feeds on extremely small amounts of blood drawn from the scalp. Lice aren't dangerous and they don't spread disease. Lice eggs (nits) are seen more commonly than lice in children.



Signs and Symptoms

- Severe itching of the scalp.
- Nits (tiny oval specks of grey or yellow-white on the hair shaft).
- Lice (reddish brown tiny insects on the hair shaft).
- Small, red bumps in the scalp.
- A rash on the scalp, with crusting and oozing (if severe).
- Swollen lymph glands in the neck.



What to Do

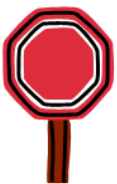
A Pharmacist or doctor will recommend a medicated rinse or lotion to kill the lice. It's important to **follow the directions for these products** exactly because applying them too much or too frequently can be harmful.

Here are some simple ways to get rid of lice and their eggs around the house:

- Check everyone in the house for lice and seek treatment if necessary.
- Wash all bed linens and clothing in very hot water, then put them in the hot cycle of the dryer for at least 20 minutes.
- Dry clean any clothing, bed linens, and stuffed animals that aren't machine washable.
- Vacuum carpets and any cloth-covered furniture in your home or car.
- Discard hair-care items or soak them in rubbing alcohol for one hour, then wash them in hot soapy water.

Seek Medical Care if the Child:

- Shows any signs of having lice.
- Is constantly scratching or complains of itches that don't go away.
- Has scratched the scalp to the point of redness, swelling, or visible pus.



Think Prevention!

You can help prevent head lice by telling kids:

- To try to avoid head-to-head contact with other children.
- Not to share combs, brushes, hair ties, hats, etc.
- Not to lie on bedding, pillows, and carpets recently used by someone with lice.

Impetigo Information

What is impetigo?

Impetigo is a contagious skin infection usually caused by either Staphylococcus or Streptococcus bacteria. It is most commonly found in children although it may also occur in adults.

Impetigo may affect skin anywhere on the body but commonly occurs in the area around the nose and mouth. It first appears as a small itchy, inflamed area of skin which blisters. The blisters rupture, release a yellow fluid and develop honey-coloured crusts and form scabs. New blisters develop in the same area or in different parts of the body and may ooze fluid which is highly contagious.

Impetigo is easily diagnosed by the doctor. Occasionally a skin swab may be taken to identify the bacteria responsible for the infection.

How is impetigo spread?

Impetigo is extremely contagious. It can be spread from one person to another through touch or shared items such as clothes and towels. However, a person can also spread it to another part of their own body through scratching or picking at the blisters and scabs.

Who is most at risk of developing impetigo?

Children are most at risk of developing impetigo. Children and adolescents may be more likely to develop impetigo if the skin has already been irritated or injured by other skin problems such as eczema, insect bites, skin allergy or recent cuts or abrasions.

How long does it take until symptoms start?

The incubation period will vary depending on the particular bacteria.

It is usually 1–3 days for streptococcal and 4–10 days for staphylococcal infections.

How is impetigo treated?

- Impetigo is most often treated with antibiotics, either orally or with bactericidal ointment. It is important to follow the recommended treatment and complete the course of antibiotics.
- Treatment involves washing the sores and crusts every 12 hours or as directed with the prescribed soap or lotion. After each wash pat dry.
- Healing should begin within 3 days and the infection eliminated in 7–10 days.
- If the sores spread and get worse despite treatment or the child becomes unwell with fever, see your doctor.
- Cover the sores with an airtight dressing if the child is returning to school in order to reduce the risk of spreading the infection.
- The child's clothes, towels and bedclothes should be changed at least once a day.
- Always remember to wash your hands after touching scabs or sores or handling infected clothing.

How long does impetigo remain infectious?

If untreated, oozing sores remain infectious for as long as they persist.

When can children return to school or child care?

Children can return to school or child care after treatment has started and the sores are completely covered with a watertight dressing.

How can impetigo be prevented?

- Encourage children to wash their hands regularly and always use their own towel and facecloth.
- Cut your child's nails short and encourage them not to scratch scabs or pick their nose.
- Keep injured areas of skin clean and covered to minimise the chance of any bacterial infection, including impetigo.
- Always wash your hands after touching sores or scabs and use gloves if possible when treating infected children.
- Keep children with impetigo away from other children for the period of exclusion. This is until antibiotic treatment has commenced and the sores are covered with a watertight dressing.

Further Information

If you are at all worried about head lice or feel you need more advice on how to cope, then you should consult your school nurse, health visitor, pharmacist or GP.

Read more: www.netdoctor.co.uk/diseases/facts/impetigo.htm

Slapped Cheek Disease Information

What is slapped cheek disease?

Slapped cheek disease is an infectious disease that mainly affects children between the ages of six and ten years old. It is also called Fifth Disease because it used to be the fifth most common childhood infection.

Slapped cheek disease is caused by a virus and often occurs in outbreaks at nursery and school. It is spread by droplets, which are released into the air by coughing and sneezing.

The incubation period between catching the virus and showing any symptoms is one to two weeks. Slapped cheek disease often occurs in outbreaks because children can be infectious for up to two weeks before any signs appear. It is no longer infectious once the rash has appeared. Once your child has had slapped cheek disease, he or she will not catch it again.

What are the symptoms of slapped cheek disease?

Your child may have a runny nose, rash, aches and pains and a high temperature. To begin with, the rash appears on the cheeks making them look red - which is why it is called slapped cheek disease. A few days later, the rash will appear on your child's chest, arms and legs. The rash may fade a bit and then come back if your child gets hot after a bath, is in direct sunlight or runs about.

Some people can have slapped cheek disease and not have any symptoms, but they will still be able to pass the virus on to other people.

If your child has a chronic illness, particularly affecting his or her blood, you should see your GP if symptoms occur.

How is it treated?

In most children, slapped cheek disease is a mild illness, which gets better in a few days without any treatment. As a virus causes slapped cheek disease, antibiotics won't help to treat it.

If your child has aches and pains, you can give him or her paracetamol according to the instructions on the bottle. Do not give aspirin, or medications containing aspirin, to children under sixteen years old. You should encourage your child to drink plenty of fluids to reduce the chance of dehydration due to the high temperature.

The spread of slapped cheek disease can be reduced by frequent hand washing, putting your hand over your mouth when coughing and sneezing into a handkerchief or tissue.

What is the outlook for children with slapped cheek disease?

The vast majority of children recover completely within a few days, with no lasting effects.

If a pregnant woman comes into contact with or develops slapped cheek disease, she should see her GP as the disease can cause miscarriage.

Information for Teachers: Children who wet and soil

This information is to support schools with providing care for children who wet and/or soils whilst at school. This is not a policy but suggestions for good practice as schools will need to agree individual care plans for each child.

The first few years of school are the years when the child is making friends, and when peer pressure begins to be felt. Faecal soiling at this age can be detrimental to the child's self-esteem, confidence and progress at school.

Faecal soiling at school is clearly a most embarrassing and socially unacceptable problem. For the children concerned it can create isolation, low self-esteem and a situation where they are the 'butt of jokes'. With careful planning and a "circle" of support (parents, child, teacher, and other staff) school can be a successful and happy time. The most important thing is to be prepared, establish good strategies, enlist support and work together.

What can you suggest to parents?

- Be kept informed about the child's condition and how often he or she soils. Find out the routine and method of management at home, and continue this as closely as possible. As a teacher you need to understand whether the child's faecal soiling is a disability or behaviour problems, both require patience and understanding. Maintain regular contact with the parent to check the child's progress.
- Ask parents to send spare clothes and "clean-up" equipment such as wet wipes, a plastic bag or airtight container for soiled underwear, soap and a hand towel. The school will need to provide a lidded bin or pad disposal unit if pads are used.
- Parents whose children are under the care of a stomal therapy nurse may want to discuss the possibility of a suppository or small enema before school as this may clear out the child's rectum enough to prevent accidents during the day.
- Encourage parents to remain patient, understanding and hopeful. Children spend most of their time in school; creating a warm, friendly and easy environment encourages a better quality of life for the child and their academic performance.

What can you do as a teacher?

- Get to know the family. Discuss with them the particular needs of the child - what equipment or appliances are needed? Such as, spare clothes, flushable wipes, plastic bags for disposal, a lidded bin, soap and a hand towel. How frequently do they soil? What are the parent's fears or apprehensions about their child starting school?
- Talk with the child as early as possible – the year before starting in your class is ideal but not always possible. It is vital to establish a good rapport with the child so that they have developed a level of trust in you before classes begin. Strategies and special arrangements can be decided so they are ready to be implemented when the year begins.

- It is also valuable if you can have time to discuss strategies etc with the current or previous teacher of the child. This is particularly helpful if the child or parents speak highly of that teacher.
- Remain in contact frequently. A notebook or communication diary is worthwhile.
- Discuss with the parents the advisability of having a nurse or specialist person talk to the class and staff about the child's disability. This should not be the only disability discussed. There will be other children in the class with asthma, diabetes, sight or hearing loss and many more. The child should not be singled out.
- Provide security and consistency in the approach to the child and the problem. The teacher needs to set up a 'no fuss' signal to let the child know that they need to go to the toilet. The child may not be able to avoid suddenly becoming smelly, but must not be allowed to remain so. It is rare for the child to be able to smell its own faeces. A child who is frequently soiled cannot tell when their pants or pad are dirty, even if there is full skin sensation, they have become unaware of the area, just as adults we become unaware of the feeling of rings, watches, earrings and other things.
- Rethink some classroom strategies such as insisting that students sit cross-legged on the floor, how to ask to leave the room, "toilet times" (some teachers are reluctant to allow students to leave the classroom soon after breaktime or lunchtime) – this may need to be re-assessed.
- Provide a toilet that is private, where other children can't look over or under the partitions to see what they are doing. Sometimes it's easiest to choose a staff toilet, a disabled toilet (provided that the wheelchair sign is removed) or simply close in one of the main toilets. Make sure that you discuss these arrangements with the child and parents before making a decision. It is really important to understand that what you may think is a great solution may not work for the child. There is no way to determine this from an adult's perspective – give the child the final decision!
- All young children will require some supervision in the toilet. This is often just to ensure that the task is actually carried out. Children will often go to the toilet, sit there for a while, then return to the classroom and still be able to say quite honestly that they 'have been to the toilet'. Check on the child if they have been absent for a longer than "normal" time.
- Provide the 'perfect teacher': One who never shows impatience, can take the smell of faeces in closed, warm classrooms, can see through the back of his/her head to know when the child has left/returned to the classroom, has a discrete, private signal to tell the child that they have soiled, even though they think they haven't, then to remember what part of the lesson they have missed and have the time to go over it with the child later.

Information adapted from:

Vicki Ratcliff, Eunice Gribbin, Helen Athanasakos www.bgk.org.au (School link)

Policy Example

1. Intimate and Invasive Care

1.1 Staff who work with young children realise that the issue of intimate care is a difficult one and will require staff to be respectful of children's needs.

1.2 Intimate care can be defined as care tasks of an intimate nature, associated with bodily functions, body products and personal hygiene which demand direct or indirect contact with or exposure of the genitals. Examples include care associated with continence management as well as more ordinary tasks such as help with washing.

1.3 Staff that provide intimate care to pupils have a high awareness of child protection issues. Staff behaviour is open to scrutiny and staff at Woodlands work in partnership with parents to provide continuity of care to pupils wherever possible.

1.4 Staff deliver a personal safety curriculum, as part of Personal, Social and Health Education, to all pupils as appropriate to their developmental level and degree of understanding. This work is shared with parents who are encouraged to reinforce the personal safety messages within the home.

1.5 Woodlands is committed to ensuring that all staff responsible for the intimate care of pupils will undertake their duties in a professional manner at all times. Woodlands recognises that there is a need to treat all pupils with respect when intimate care is given. No pupil should be attended to in a way that causes distress or pain.

2. Basic Components of good practice

2.1 All pupils who require intimate care are treated respectfully at all times; the child's welfare and dignity is of paramount importance.

2.2 As a basic principle pupils will be supported to achieve the highest level of autonomy that is possible given their age and abilities. Staff will encourage each pupil to do as much for themselves as they can.

2.3 In most cases one pupil will be cared for by one adult unless there is a sound reason for having two adults present. If this is the case, the reasons should be clearly documented.

3. The protection of children

3.1 Child Protection Procedures and Multi-Agency Child Protection procedures will be accessible to staff and adhered to.

3.2 Where appropriate, all students will be taught personal safety skills carefully matched to their level of development and understanding.

3.3 If a member of staff has any concerns about physical changes in a student's presentation, e.g. marks, bruises, soreness etc. s/he will immediately report concerns to the appropriate manager/ designated person for child protection. A clear record of the concern will be completed and referred to social services and/or the Police if necessary. Parents will be asked for their consent or informed that a referral is necessary prior to it being made unless doing so is likely to place the child at greater risk of harm.

3.4 If a pupil becomes distressed or unhappy about being cared for by a particular member of staff, the matter will be looked into, outcomes recorded, and the results of any investigation shared with the child and the parent / carers.

Parents will be contacted at the earliest opportunity as part of this process in order to reach a resolution. Staffing schedules will be altered until the issue(s) are resolved so that the pupil's needs remain paramount. Further advice will be taken from outside agencies if necessary.

3.5 If a child makes an allegation against a member of staff, all necessary procedures will be followed and the Head Teacher must be informed. If the allegation is about the Head Teacher, then the Chair of Governors should be informed instead.

Practice Guidelines

Intimate Care Policy

Children have a right to be safe and to be treated with dignity and respect. Intimate care includes washing, and toileting and changing nappies.

Intimate care of children and young people with disabilities

- Children with disabilities can be very vulnerable. They often need adult help with their personal care, including intimate care, long after non-disabled children of similar age have developed the skills to do such tasks for themselves.
- Having to depend on someone else to do these things for you may feel embarrassing or humiliating. Anyone involved with a person's intimate care needs to be sensitive to the child's needs and also aware that some care tasks could be open to possible misinterpretation.

Definition of intimate care

Intimate care may mean different things to different people but is usually used to describe any or all of the following activities:

- Washing any part of the body
- Dressing/undressing
- Changing nappy
- Assisting to use the toilet

1. Treat every child as an individual

Don't make assumptions about how things are done with a child. Families all have their own way of doing things, their own names for body parts etc. Cultural, ethnic and religious differences may affect what is or is not appropriate. Ask the child and/or parents and respect their wishes

2. Involve the children as far as possible in their own intimate care

Try to avoid doing things for a child that she/he can do alone and if the child is able to help, ensure that they are given the chance to do so. Support the child in doing all they can for themselves. If a child is fully dependant on you, talk with them about what you are doing and give them choices wherever possible.

3. Be responsive to a child's reactions and make sure that intimate care is as consistent as possible

You will have had opportunities to talk with parents and learn from them how they undertake intimate care tasks. However, you should also whenever possible, check things out by asking the child, e.g.:

"Is it OK to do it this way?"

"Can you wash there?"

"How does Mummy do this?"

"Does that feel comfortable?"

The following are some basic guidelines to help safeguard both staff and children.

- Be familiar with any special names the child uses for body parts.
- Supply staff are not permitted to carry out any personal care for the child, unless the supply staff member has worked sufficient hours in the building to have built up a relationship with the child.
- Supply staff should whenever possible give the pupil a choice of who they would like to help them with their intimate care.
- When changing a child's nappy or soiled clothing, the member of staff must always wear protective gloves. Parent must provide a change of clothes.
- For the safety of both staff and child it is considered totally inadvisable for a male member of staff to be involved in the intimate physical care of a girl of any age. The same limitations may not apply to female staff and boys.

Date of policy:

Date of review:

Agreed by governing body:

Female Staff & Pupils – Pregnancy

If a pregnant woman develops a rash or is in direct contact with someone with a potentially infectious rash, this should be investigated by a doctor. The greatest risk to pregnant women from such infections comes from their own child/children, rather than the workplace.

- **Chickenpox** can affect the pregnancy if a woman has not already had the infection. Report of exposure needs to be made to the midwife and GP at any stage of exposure. The GP and antenatal carer will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.

- **German measles** (rubella). If a pregnant woman comes into contact with german measles she should inform her GP and antenatal carer immediately to ensure investigation. The infection may affect the developing baby if the woman is not immune and is exposed in early pregnancy.

- **Slapped cheek disease** (parvovirus B19) can occasionally affect an unborn child. If exposed early in pregnancy (before 20 weeks), inform whoever is giving antenatal care as this must be investigated promptly requesting a blood test to clarify her immunity against the disease. Should she be immune, she must seek advice from the medical person whether it would be suitable for her to return to work/school.

- **Measles** during pregnancy can result in early delivery or even loss of the baby. If a pregnant woman is exposed she should immediately inform whoever is giving antenatal care to ensure investigation.

- All female staff under the age of 25 working with young children should have evidence of two doses of MMR vaccine.

In all these cases the school must arrange cover whilst the pregnant woman is off work

In all these cases the school must arrange cover (if staff member)/education (if pupil) should the pregnant woman require to be absent at any time until it is safe for them to return.

If it is a pupil, the school must ensure their educational needs are being met either through attendance at a neighbouring school (providing transport if required) or work being sent home.

Staff immunisations.

All staff should undergo a full occupational health check prior to employment; this includes ensuring they are up to date with immunisations. All females aged 16–25 should be advised to check they have had two doses of MMR. Ref.: www.hpa.org.uk

A notice should be placed on all school entrances informing visitors of the infection present at the school and the proposed risk to pregnant women.

For further information visit: <http://www.dh.gov.uk/health>

Information provided by: Health Protection Agency 2010

Childhood conditions

Basic guide to help recognise some of the most common childhood conditions.



Allergic contact dermatitis

Contact dermatitis occurs when the skin comes into contact with a substance to which they have an allergy. This causes the skin to become inflamed, red, blistered, dry, thickened or cracked. It may take many hours or several days for symptoms to appear after coming into contact with the allergen.



Atopic eczema

Most commonly, eczema develops in the creases of the skin, such as in the crook of the elbow, behind the knees, at the front of the ankles, round the neck or around the eyes.

During a flare-up, atopic eczema can cause the skin to become extremely itchy, red, hot, dry and scaly. It may also be weeping and swollen.



Chickenpox

Before developing a rash, there may be some mild flu-like symptoms. The rash normally appears behind the ears, on the face, scalp, under arms, on chest and stomach, and arms and legs.

The rash starts as small, itchy, red spots. After approximately 12 to 14 hours, these spots develop into fluid-filled blisters, which are intensely itchy.



Hand, foot & mouth disease

Spots and blisters may appear on the hands, feet (more commonly seen on the upper surfaces and often between the fingers and toes) and in the mouth (on the tongue and inner surface of the cheeks) that could cause blisters. They could also have a temperature which can be treated with paracetamol. However, children affected by this condition aren't usually particularly ill with it.



Hives

Swollen, pale red bump appear suddenly due to an adverse reaction to certain allergens. Hives usually cause itching, but may also burn or sting. They can appear anywhere on the body and vary in size, joining together to form larger areas known as plaques. They can last for hours, or up to one day before fading.



Head Lice

Head lice are tiny (pin-head sized) grey-brown, wingless insects that live by sucking blood from the scalp. Their eggs, which look like tiny white specks, are known as nits.

The presence of head lice is indicated by repeated itching of the scalp, or by detecting them in your hair. This can be done using a special fine-toothed comb, available from pharmacies.



Measles

Measles symptoms are cold-like, such as runny nose, red eyes, swollen eyelids, sneezing, and a mild to severe temperature.

The rash is a red-brown spotty rash that appears three to four days after first symptoms, and lasts for up to eight days. It starts behind the ears, spreads around the head and neck, and after two to three days to the legs and the rest of the body.



Mouth ulcer

A mouth ulcer will be round or oval, and inflamed around the edge. It will be white, yellow or grey. Most mouth ulcers appear inside the lips or the cheeks, on the floor of the mouth, or the underside of the tongue.

An ulcer can cause pain and discomfort, particularly when eating, drinking or brushing your teeth. Most mouth ulcers last between 10 and 14 days.



Mumps

In mumps, one or both of the salivary glands swell up and become painful. This creates the characteristic 'hamster' appearance of a swollen face, particularly just below and in front of the ear.

Other symptoms include: sore throat, fever, feeling tired, loss of appetite, tummy pain, dry mouth and headache.



Impetigo

The symptoms begin with the appearance of red sores, usually on the area around the nose and mouth. The sores quickly burst, leaving thick, yellow-brown golden crusts.

Sores are not painful, but they may be itchy. Other symptoms of infection, such as fever and swollen glands, are rare but may occur in more severe cases.



Prickly Heat

Prickly heat causes a rash made up of tiny spots, or bumps, surrounded by a patch of red skin. Sometimes, the spots look like tiny blisters. This rash may cause mild swelling, itching, stinging or a prickling sensation.

It can affect any part of your body, but most commonly appears on the back, abdomen, neck, upper chest; groin, armpits, hands or feet.



Ringworm

Ringworm is a fungal infection that causes ring-like, red lesions on the skin. The skin appears red and inflamed around the rim yet healthy inside the rim.

The rings may multiply and grow, and rings can also merge together. The rings will feel slightly raised to the touch, and the skin under the rash may feel itchy.



Scabies

Scabies causes the skin to feel intensely itchy. The scabies mites will also leave small red blotches and lines on the skin, which are the marks caused by them burrowing into the skin.

Burrow marks can be found anywhere including folds of skin, wrists, armpits, around the waist, inside the elbow, buttocks, soles of feet, knees, shoulder blades and trunk.



Scarlet fever

Often starts with a sore throat or skin infection and fever. The rash appears 12-48 hours after the fever. At first it is red blotches, but turns into a pinkish-red rash that feels like sandpaper.

The rash spreads to other areas, commonly ears, neck, chest, elbows, thighs and groin. The rash will turn white if you press a glass on it.



Slapped cheek syndrome

A distinctive blotchy red rash may begin to appear on the face which gives the appearance of 'slapped cheeks'.

The rash may become itchy and spread to the body and limbs and can take between one-three weeks to clear. It may also recur some time later after increased exposure to sunlight or heat.



Tonsillitis

The main symptom of tonsillitis is a sore throat with red swollen tonsils.

Other common symptoms include white pus-filled spots on your tonsils, pain on swallowing, fever, coughing, headache, tiredness, pain in your ears or neck and swollen lymph nodes.



Verruca

Verrucas (plantar warts) are warts on the soles of the feet, heels and toes. Verrucas do not stick up from the surface of the skin. Verrucas often have a black dot in the centre, surrounded by a hard, white area.

The weight of the body pushing down on them makes them grow back into the skin, which can be painful.



Warts

Common warts (verruca vulgaris) are firm and raised, with a rough surface that can look a bit like a cauliflower.

They can occur anywhere, but are most common on knuckles, fingers, elbows and knees. The size of a wart can range from 1mm to more than 1cm.



Conjunctivitis

Conjunctivitis is redness and inflammation of the thin layer of tissue that covers the front of the eye (conjunctiva). It is very common.

People often refer to conjunctivitis as red eye.

Other symptoms of conjunctivitis include itchiness and watering of the eyes, and sometimes a sticky coating on the eyelashes (if it's caused by an allergy).

Information provided by: NHS Choices 2012
<http://www.nhs.uk/Tools/Pages/Childhoodillness.aspx>

For advice and procedures for reporting cases or suspected cases of infectious disease in schools and other educational establishments contact Public Health England: <https://www.gov.uk/government/organisations/public-health-england>
Telephone: 01904 687100

Useful websites & Documents

Useful websites:

Department for Education www.education.gov.uk

Castle View House, East Lane, Runcorn. Cheshire. WA7 2GJ

Tel: 0370 000 2288

Equality and Human Rights Commission (Disability Rights Commission):

www.equalityhumanrights.com

NHS Choices is the online 'front door' to the NHS. It is the country's biggest health website and gives valid up to date information: www.nhs.uk

NetDoctor Medical information about the prevention, treatment and management of diseases and conditions: <http://www.netdoctor.co.uk/>

National Institute for Health and Clinical Excellence (NICE): www.nice.org.uk

Useful documents:

Managing Chronic Health Conditions at School

<http://www.into.ie/ROI/ManagingChronicHealthConditionsatSchool/ManagingChronicHealthConditionsatSchoolResourcePack.pdf>

Managing Medicines in Schools and Early Years Settings: DfE guidance 2005

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/196479/Managing_Medicines.pdf

Ensuring a good education for children who cannot attend school because of health needs Statutory guidance for local authorities January 2013

<http://media.education.gov.uk/assets/files/pdf/s/health%20needs%20guidance%2020-%20revised%20may%202013%20final.pdf>

Safeguarding Children in whom illness is fabricated or induced. A publication outlining what is known about and the ways in which it can be caused and addressed

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190235/DCSF-00277-2008.pdf

Statutory Guidance on Promoting the Health and Well-being of Looked After Children <http://media.education.gov.uk/assets/files/pdf/s/promotinghealth.pdf>

School Attendance November 2013

<http://media.education.gov.uk/assets/files/pdf/s/advice%20on%20school%20attendance%20nov%202013.pdf>