MEDICINES, ILLNESS IN SCHOOL AND FIRST AID

Reviewed October 2020

1 Medicines in School.

We recognise that there may be the need for medicines to be administered to children during the school day at the request of parents.

Medicines should be sent to school in secure containers holding the required measured dose. Each bottle should be clearly labelled with the name of the child and the instructions for usage. All medicines are received by the Office Coordinator or school nurse. Medicines are then stored in the secure medicine cabinet.

Inhalers will be held by class teachers in Early Years and Key Stage One. Students in Key Stage Two and above should be independent in use and storage of such devices. It is imperative that children, who possess inhalers should take them with them when engaged in work off-site (e.g. sports, field trips etc). Parents should inform the school office and class teacher if their child uses an inhaler

2 Children becoming ill in the course of the school day.

It is inevitable that children will develop an illness during the course of the school day from time to time. Sometimes all that is needed is a rest and a sympathetic ear but from time to time it may be necessary to send a student home or to the named emergency contact. The decision to send a student home must be taken by Headteacher/ phase leader or if they are not available the class teacher, in consultation with the school nurse. Teaching staff have the final decision in making the call to parents. If there is any doubt then parents should be called. Emergency contact details should be checked with parents at least annually.

3 First Aid.

The school nurse is the first person to be called to administer first aid. Named first aiders are displayed in the staff room.

Any accident should be recorded in the accident book which is stored in the office. The person who carried out the administration of the first aid should record the incident. The school nurse must inform the class teacher or personal tutor of any incidents. Class teachers/tutors are responsible for ensuring that the record book has been completed. Serious incidents should be reported to the headteacher immediately.

4 Children returning to school after Illness.

It is hoped that parents will recognise that school is a place where children engage in intense and occasionally strenuous activity and will not allow their children to return after illness until fully fit to do so.

Similarly, close contact between children is inevitable and infectious and contagious diseases are quickly passed on. Basic hygiene will be taught and will include use of tissues and the importance of washing hands.

Detailed instructions for the treatment of asthma attacks are attached.
Guidelines for absences related to illnesses is also attached.

APPENDIX A

WHAT TO DO IF A CHILD HAS AN ASTHMA ATTACK

Assess the child's condition using the guidelines below

REGARD THE ATTACK AS MILD TO MODERATE IF:

- The child feels breathless but can speak normally.
- Is coughing and/or wheezing (wheezing may or. may not be present).
- Has a tight feeling in the chest or throat.
- Looks well.

TREATMENT OF MILD TO MODERATE ATTACK.

- Give or allow the child to take two puffs of their own **BLUE RELIEVER INHALER.**
- As soon as the child feels, better they can return to school activities.
- If symptoms reappear within FOUR HOURS.
- Give TWO MORE PUFFS of their own **BLUE RELIEVER INHALER.**
- Call the parents to take them home to see a Doctor.

IF THE BLUE RELIEVER INHALER GIVES NO RELIEF FOLLOW INSTRUCTIONS FOR SEVERE ATTACK REGARD THE ATTACK AS SEVERE IF:

- The child is too breathless to complete sentences.
- Is blue around the lips.
- The child seems confused.
- Is exhausted.
- The **BLUE RELIEVER INHALER** does not work.

TREATMENT OF A SEVERE ATTACK

- Keep calm.
- Keep the child sitting upright, leaning slightly forward. not lying down.
- Allow the child space to breathe, loosen tight clothing around the neck.
- Give two puffs of the child's own **BLUE RELIEVER INHALER,** wait five minutes.
- If no improvement, give two more puffs of Ventolin, using the schools emergency Ventolin and spacer.
- Dial 999 for an ambulance or take the child to hospital, and keep on giving two puffs of Ventolin through the spacer every five minutes till you get to medical help.

- APPENDIX 2
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- **Exclusion from school Guidelines**
- Guidelines for the exclusion from day nursery and school of children and household contacts suffering from an infectious disease

Disease	Usual Incubation Period (days)	Infectious Period (days)	Minimum period of exclusion of patients from school, day nursery, playgroup, etc.	Exclusion of family contacts who attend playgroup, day nursery or school
Campylobacter	3-5	Whilst organism is in stools (<7 weeks) but mainly whilst diarrhoea is present	Until clinically fit with no diarrhoea for 48 hours	None
Chickenpox	13-21	From 1-2 days before, to 5 days after appearance of rash	5 days from onset of rash	None
Shingles	Usually years after chicken pox	Blisters contain Chicken Pox virus (Varicella Zoster)	Discuss with local HPU	None
Colds / Flu	1-3 days	while symptoms persist	while child unwell	None
Conjunctivitis	2-3 days	during active infection (with pus and crusting)	Single cases: if child is well no exclusion necessary	None
Cryptosporidium	3-11	Whilst cysts are present in stools (several weeks) but mainly whilst diarrhoea is present	Until clinically fit with no diarrhoea, for 48 hours	None
Diphtheria	2-5	Whilst the organism is present in nose and throat	Until clinically fit and bacteriological examination is clear	7 days and until bacteriological result is negative

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Ear Infections/Sticky Ears	may be chronic	usually not infectious	None	None
Fifth Disease (Slapped Cheek)	4-20	1 week+ before the rash develops	Until clinically well. Presence of rash does not indicate infectivity	None
Food Poisoning (including salmonellosis and shigella sonnei but not E coli 0157- seek further advice)	varies according to cause	Varies according to cause- usually whilst symptomatic (may need to consult CCDC)	Until clinically fit with no diarrhoea or vomiting for 48 hours.	None
German Measles (Rubella)	14-21	From 7 days before to 5 days after onset of rash	5 days from appearance of rash	None. If pregnant woman is in contact, she should consult GP.
Giardia Lamblia	7-28	Whilst cysts are present in stools but mainly whilst diarrhoea is present	Until clinically fit with no diarrhoea after treatment	None
Glandular Fever	4-6 weeks	Once symptoms have cleared risk is small apart from very close contact e.g. kissing	Until clinical recovery	None
Hand. Foot and Mouth Disease	3-5	Probably from 2-3 days before and up to several weeks after onset of symptoms (virus in stools)	Until clinically well. Presence of rash does not indicate infectivity	None

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Head and Body Lice	eggs hatch in 1 week	as long as live lice or eggs	None: treatment should be started on day head lice found. No need to send child home	None. Others affected in household should be treated at same time
Hepatitis A	2-6 weeks	From 7-14 days before to 7 days after onset of jaundice	7 days from onset of jaundice	Adults in family should discuss prophylaxis with GP
Hepatitis B(see text)	2 weeks to 6 months	not infectious under normal conditions	until the child feels well	None
Herpes Simplex (Cold Sore)	2-12 days	during infection	None	None
HIV infection (see text)	variable	not infectious under normal conditions	None	| None
Impetigo/ Erysipelas	Impetigo: 4-10 days Erysipelas: 1-3 days	as long as lesions are wet and pus is present	until lesions are crusted or healed	None

Measles	7-14 days	From a few days before to 5 days after onset of rash	5 days from onset of rash	None

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