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Introduction

This publication offers guidance to schools and others who are involved with matters that can affect the health of children at school. It draws upon information from the DfES, the Department of Health and practice that has evolved in Hampshire schools over many years.

The subject is wide ranging. Advice is available on a number of matters, from absence periods for ailments to administration of medication to save life. It is not possible to cover all eventualities but further guidance can always be sought from health authorities and the Children's Services Department. This document does not seek to cover health issues for staff apart from where children's illnesses impact on the well-being of staff.

The issues are important for families, schools and health professionals. I hope you will find this a supportive and helpful publication.

John Coughlan
Director of Children's Services

This guidance has been produced in consultation with headteacher and staff representatives and with help from medical and legal advisers.

Guidance is also available on the Internet. A good starting point is 'Wired for Health' www.wiredforhealth.gov.uk and Hantsnet which provides many links to other websites.

School health services

The school health service varies across the districts within Hampshire. Programmes of preventive health measures, and advice on management of children with special educational needs or illness affecting school, are commissioned locally.

For details about your local service please contact the relevant department:

Hampshire Primary Care Trust

School Health Department
G Floor, North Hampshire Hospital
Aldermaston Road
Basingstoke RG24 9NA
Tel: 01256 313086

Frimley Children's Centre
Church Road
Frimley, Camberley
Surrey GU16 7AD
Tel: 01483 782925

Highcroft
Romsey Road
Winchester SO22 5DH
Tel: 01962 863511

Portsmouth City Primary Care Trust

Dunsbury Way Clinic
Dunsbury Way
Leigh Park
Havant PO9 5BG
Tel: 023 9248 2154

Southampton City Primary Care Trust

Central Health Clinic
East Park Terrace
Southampton SO14 0YL
Tel: 023 8090 2500

Health protection offices

Central contact number: 0845 0552022

Southampton office covers:

Southampton City Council, New Forest District Council, Eastleigh Borough Council and Test Valley Borough Council (south)

Portsmouth office covers:

Portsmouth City Council, Fareham Borough Council, Gosport Borough Council and East Hampshire District Council (south)

Basingstoke office covers:

Basingstoke and Deane Borough Council, Hart District Council, Rushmoor Borough Council and East Hampshire District Council (north)

Health Protection Agency out of hours: 023 8077 7222

Legal framework

Children's Services, schools and governing bodies have a responsibility for the health and safety of pupils in their care. Health authorities and primary care trusts have responsibility for the health of people (see page 5) who reside in their area. Precisely where these responsibilities begin and end is not always clear cut but the advice in this publication represents our understanding of the current position.

See also off-site activities regulations and child protection guidelines

Teachers and other school staff in charge of pupils act '*in loco parentis*'. Hence they take the same care as any reasonably prudent parent would to see children are safe and healthy. The duty of care extends to activities that take place off site. The law protects those discharging this duty. For example, the Children Act 2004 provides scope for teachers to do what is reasonable for the purpose of safeguarding or promoting children's welfare.

Despite the protection available under statute, actions can be brought under civil law for alleged negligence. It is very rare for individual members of staff to be sued for negligence and instead the action generally lies between the parent and the employer. The County Council indemnifies its staff against claims for negligence arising out of their duties. This means that the Council, and not the employee, will meet the cost of damages should a claim for negligence be successful. Staff can be reassured about the protection their employer offers and this applies whether they apply routine first aid (or not) or are engaged in invasive administration of medication, such as rectal diazepam. The Council expects staff to act professionally and take all reasonable steps to prevent claims of negligence.

See also Medicines in school page 43

It is important to note that there is no legal or contractual duty, on teachers in particular and school staff generally, to administer medicine or supervise a pupil taking medication. This is a voluntary role but it does not alter the protection provisions outlined above. Some support staff may have been appointed specifically to carry out these tasks and protection applies in these instances.

The above provisions apply to volunteers or parent helpers acting with the approval of the head of the establishment.

Governors, as the employer in aided and foundation schools, bear the same legal responsibilities (illustrated above) as the County Council.

A-Z on health issues

Acne

This is a common condition in the adolescent age group, with a varied degree of severity. However, even relatively mild acne can cause great anxiety, so a degree of sympathy is helpful. Acne is caused when there is over-production of the skin's natural secretions and particularly when the glands that produce the secretion become colonised by bacteria. Spots should not be squeezed. Application of mild cleansers may help, used according to their instructions. Young people with more severe cases should see their GPs, with the most severe needing advice from a dermatologist.

Alcohol – (see Substance misuse page 70)

Allergy

Allergy is a cover-all term for a range of conditions where the body recognises a substance as foreign and over-reacts, producing unpleasant or even dangerous symptoms.

Anaphylaxis

See also Medicines in school page 43

This is a severe medical condition where an allergy to a certain substance (commonly nuts, sometimes eggs) leads to a sufferer going into shock and unable to breathe.

If a school has a child with potential anaphylaxis they should consult the parents and relevant health care professionals with a view to drawing up an adequate plan to cover emergencies. The school doctor or nurse may be able to help. Anaphylaxis is serious and life-threatening if untreated, but good immediate care is exceptionally effective and the condition need not bar a child from full participation in school life as long as an emergency plan is in place.

Animal handling

See also HCC guidelines: Safety in Science, Off-site activities and educational visits

The decision to keep animals in schools so that pupils can study and care for them must only be taken after careful consideration of the following points:

- what are the likely educational benefits?
- is there a potential risk to pupils, teachers and others?
- can the welfare of the animal be properly safeguarded?

- what are the legal requirements?

To minimise health risks to children and staff:

- animal living quarters should be kept away from food areas and be regularly cleaned using protective gloves
- waste should be disposed of regularly and carefully
- litter boxes should not be accessible to children
- animal handling by children should be supervised
- staff and children should wash their hands thoroughly after handling animals; gloves must be worn when handling carnivorous species
- staff and children should wash their hands thoroughly after handling cages or contents.

Reptiles can carry salmonella, so must be handled as carefully as other animals.

Dead or injured mammals or birds must not be brought into schools but treated with respect where they are found. Dead animals should be handled with gloves, placed in a plastic bag which is then sealed, wrapped in newspaper and placed in a skip or incinerator. The RSPCA should be contacted about injured animals.

Farm visits: Please refer to HCC Off-site activities guidance.

Anorexia Nervosa

Anorexia Nervosa is a complex eating disorder, related to poor self-esteem, distorted body image and sometimes unreasonably high expectations by the young person or by their family or close friends. The reluctance to eat, abuse of laxatives and self-induced vomiting that are the most well-known characteristics of the illness, are usually the external signs of the young person's psychological difficulties.

Early stages of the disease are very like those of any teenage girl on a diet - an avoidance of food, weight loss and perhaps increased exercise. It becomes a significant problem if it turns into an obsession and the young person, usually a girl, begins to be devious in avoiding food. Girls who lose more than 10% of their body weight have health problems, often including amenorrhoea (loss of periods). In the most severe cases, young people have died.

The problem needs professional help and so should be brought to the attention of the parents, keeping in mind that in some cases family relationships could be part of the problem. The school

nurse or doctor will be able to offer support and guidance in seeking further help available.

Anxiety

See also HCC guidelines: bullying in school and child protection procedures

A certain amount of anxiety is normal in children and young people when faced with new or difficult situations. They may appear worried or agitated. The anxiety can usually be related to a specific incident or event and almost always responds to explanation at their own level and reassurance. Once the incident has passed, children may take a little while to return to their normal selves, but almost inevitably will do so.

Children who are subjected to a series of incidents, or to a very serious incident or who have a marked tendency to anxiety, will have more severe problems. In general, if a child appears anxious unrelated to a specific event, or if anxiety continues between events then staff should share their concerns with both senior colleagues and the child's parents. It may help to look at what is happening in the classroom and to see if there are any simple measures to assist. Some children may be helped by calm interludes, as long as their minds are not allowed to dwell on their worries too much at these times. As with all the emotional and behavioural difficulties, an ethos that promotes self-esteem is extremely valuable. There may be a need to seek specialist help if together the family and school cannot resolve the problem.

Anxiety may manifest as aches and pains in the younger child, who may not be able to explain why he/she is worried. As children get older these may change to more specific pains, for example in the legs or abdomen. Older infants, juniors and young people at secondary school may get headaches. Some children feel sick when they are anxious. Staff should be aware that the symptoms are real to the child, who may not have consciously connected his anxiety with his physical symptoms. Occasionally, anxiety may be expressed as a specific phobia.

Staff should be alert to the possibility of bullying when a child appears particularly anxious and should follow the school's guidelines if bullying is suspected. Staff should also remain alert to the possibility of abuse and again follow the appropriate guidelines available.

Asperger's Syndrome – (see Pervasive developmental disorder (PDD) page 63)

Asthma

Asthma is a condition where the small airways in the lungs tighten and prevent easy air flow. It may be triggered by a chemical, smoke or fumes, exercise, stress, excitement or a cold. The main symptom is a feeling of tightness in the chest and wheezing. Some children have a persistent night-time cough. Eventually, they may find it difficult to breathe. School health teams should be able to advise school staff on recognising symptoms of an acute attack and managing it appropriately.

If the school and parent feel that the child is capable and responsible, the child should look after and carry his/her own inhaler marked with his/her name.

Cases should be considered individually in consultation with parents, the school doctor or nurse as necessary. The medical profession has confirmed that inhalers are very safe and it is unlikely that a child using another child's inhaler will come to any harm.

See also Medicines in school page 43

Most children have a 'puffer' treatment. The type and quantity of medication depends on the condition of the individual, but is of two main types - preventive medication and palliative medication. Preventive medication must be taken regularly to be useful. Palliative medication is usually the one carried to ease symptoms at school. Children should be encouraged to take responsibility for their own treatment as soon as they can. Some children, whose main problem is exercise related, will be helped by timing palliative medication to be effective during the exercise. Children who are having severe symptoms need to be reassured and supported while professional help is called. They will be helped by sitting upright, leaning forward and supporting themselves with their arms on the desk. They should not be left alone.

Athlete's foot

Athlete's foot is a fungal disease of the feet. The most common symptom is itching between the toes. This may be accompanied by redness or peeling skin. The condition is less likely if feet are kept clean and dry and if sweating is minimised by wearing cotton socks and airing the feet. Parents should be advised to seek advice and treatment for the young person or child. The young person or child should not be excluded from school or any activities within school, including swimming and bare-foot activities. Towels should not be shared.

Attention Deficit (Hyperactivity) Disorder (AD(H)D)

Attention deficit (hyperactivity) disorder (AD(H)D) is a condition that renders a child very easily distracted. He, most commonly, or she, may be impulsive, have poor concentration and be forever fidgeting or moving around. The features may delay academic progress or cause a child to be constantly in trouble for not attending to the task, distracting other children or shouting out.

See also HCC guidelines: Attention deficit (hyperactivity) disorder

The County Council document on AD(H)D is a useful guide to identifying and managing the disorder. Schools should consult this document and manage the child according to the guidelines. Classroom management may be all that is needed and, at this stage, the management guideline can be used to introduce greater structure to the child's environment without the label of AD(H)D being applied.

More persistent problems may require further assistance. A common approach is being developed across the whole county. The County Council guidelines recommend that the school involve the educational psychologist. In extreme cases children may be referred to the GP or school doctor who in turn may consult a specialist.

It is well known that some children respond to drugs such as 'Ritalin'. Some parents seek medication to change their child's behaviour, but there is growing concern about over-prescription. Medication is not recommended for all children with over-activity. If medication is prescribed, schools will be required to keep a diary of symptoms before and after the drug is administered. The use of medication does not lessen the importance of appropriate classroom and home management.

Hampshire County Council has produced a supporting publication for parents, to complement the school document - Managing Over-activity at Home.

Autism - (see Pervasive developmental disorder (PDD) page 63)

Blood, body fluids and biting

Body fluids are blood, urine, faeces, vomit, eye discharge, nasal discharge and saliva, semen and vaginal fluids. When dealing with body fluids:

- use disposable non-powdered vinyl gloves and disposable plastic apron. Goggles should be available for use if there is a risk of splashing to the face
- clear up spills of body fluids immediately and appropriately, using paper towels
- take care not to splash or otherwise transfer body fluids to the mouth, eyes and nose or on any skin cuts or sores (which should be covered with a waterproof dressing)
- clean and then disinfect surfaces. A suitable disinfectant is a chlorine releasing agent e.g. Presept tablets
- discard material contaminated by the fluid, along with gloves and apron in two yellow plastic bags, one inside the other; secure the bags and dispose of safely
- mops and other equipment used in the clearing up should be washed and disinfected in an equipment sink or washing machine, NOT in a kitchen sink, and dried
- contaminated clothing should be machine washed on a hot (65°) programme for 10 minutes (or the hottest wash the fabric will tolerate). When handling soiled clothing wear gloves and a plastic apron. Never rinse clothes by hand
- blood and body fluids may contain blood-born viruses, although these infections are rare in children – see hepatitis and HIV (see 37). Incidents may occur whereby the blood/body fluids of one person enter the body of another person. This can occur through a sharp implement, such as a needle contaminated with blood, pricking another person. This can occur if children find discarded needles and inadvertently injure themselves. It is also possible for a child to stab several other children with the same drawing pin or textile needle which also results in one person's blood being transferred to another person. Biting injuries permit the transfer of body fluids between people. Exceptionally, blood/body fluids could splash into the eyes, nose or mouth of another person or onto broken skin. Broken skin can occur following cuts or if there is a skin condition such as eczema or dermatitis
- all these types of incidents involving the potential transfer of blood/body fluid to another person require medical advice to be sought the same day. In addition to the individuals concerned seeking medical advice, advice on the incident should also be sought from the school health service or health protection team.

Normal quantities can be discharged with the normal refuse; if there are large quantities, special arrangements for collection must be made. See also Medicines in school page 43

Bulimia Nervosa

Like anorexia, bulimia is more than just an eating disorder. It is also a sign of unhappiness, poor self-esteem and psychological problems. Classically, bulimia is thought of as a disease of altered eating habit, particularly binge eating and then exercise, vomiting or purgatives to ease the physical and mental discomfort of the over-eating. Weight may be stable or may fluctuate a little but there is not the significant loss that is seen in anorexia. Again, all eating disorders must be considered as potentially serious and the family should seek professional help.

Chickenpox and shingles

Chickenpox is a viral illness which is at its most infectious from just before the rash appears to five days after the first appearance. The rash consists of small blister-like lesions which can occur anywhere but are more likely on the trunk. Children may have very few other symptoms and the disease tends to be more severe in adults. Children should be kept away from school for five days following the last crop of blisters/spots. It is not necessary to wait until spots have healed or crusted.

Pregnant women should inform the professional responsible for their ante-natal care (GP, midwife or obstetrician) if they are in contact with chickenpox or shingles within the first 20 weeks of pregnancy or during the last three weeks before birth and have not previously had the disease. Parents of children with reduced immunity should be advised to contact their clinician for medical advice immediately if their children come into contact with chickenpox or shingles.

Shingles is spread by very close contact and touch. Shingles is a reactivation of the chickenpox virus in those who have already had chickenpox. It is not possible to 'catch' shingles from chickenpox. However, it is possible, though uncommon, to catch chickenpox from shingles.

Particularly vulnerable children or staff (see page 73) need to seek medical advice promptly if they are in contact with chickenpox.

Chronic fatigue

Chronic fatigue syndrome is characterised by prolonged debilitating fatigue. It is common for it to come on after an infectious disease perhaps flu, glandular fever or a bacterial sore throat, but may often occur for no apparent reason. Instead of gradually recovering over the next few days, the person remains extremely tired, often with poor appetite. Other symptoms include

nausea, headaches, sensitivity to light, noise and touch, joint pain and muscle ache, generalised weakness and sleep disturbance. Regular lifestyle activity levels are affected for prolonged periods of time (which in extreme cases may last for several years). This may affect a successful return to full-time education and schooling. Although there are many physical signs to consider, it is also important to investigate underlying psychological factors which may need to be addressed.

There are many strands to the illness and the attitude of family, friends and school staff will play a part in recovery. Generally, a planned and gradual increase in activity is the best route to recovery. This will include a gradual phased return to school at the appropriate time which should be planned in collaboration with the multi-professional team working with the child and the family. The plan may need to be developed with medical and therapy professionals. Schools need to be flexible in the short term in order to promote a long-term return to normal health. Each young person will have his or her own particular problems to be taken into account. Where appropriate, in line with the management plan, young people should be encouraged to maintain contact with their peer group. As with many other problems in adolescence, the promotion of the young person's self-esteem is crucial.

Cold sores

Cold sores are caused by the herpes simplex virus. Children need not be absent from school. Avoid kissing and contact with sores. Cold sores are generally a mild self-limiting disease.

Conjunctivitis

Conjunctivitis causes red, sore or itchy eyes. It may be caused by viruses or bacteria but bacterial causes are much less common. Some children may need treatment. No child need be absent from school. However, if the disease does appear to be spreading from child to child, the local consultant in health protection should be informed.

Contraception information

**See also DfES
guidelines: sex and
relationship
education guidance**

**See also
DfES/0913/2004
Teenage
pregnancy**

Contraception should be part of a school's provision for sex education and is generally best dealt with as part of the PSE curriculum. Young people often need personal advice as they grow up. It is important to distinguish between the school's function of providing education generally about sexual matters on the basis described above and counselling and advice to individual pupils on these issues, particularly if this relates to their own sexual behaviour. Good teachers have always taken a pastoral interest in the welfare and well-being of pupils. But this function should never

trespass on the proper exercise of parental rights and responsibilities.

See also HCC guidelines: Managing the support and reintegration of pregnant pupils

Particular care must be exercised in relation to contraception advice to pupils under 16, for whom sexual intercourse is unlawful. The general rule must be that giving an individual pupil advice on such matters without parental knowledge or consent would be an inappropriate exercise of a teacher's professional responsibilities. Teachers are not health professionals and the legal position of a teacher giving advice in such circumstances has never been tested in the courts. However, pupils may be given information about where they can obtain professional advice (see page 64).

Health professionals and other visitors who contribute to the school's sex education programme must work within the school policy.

Dental disease

Children with rotten teeth can be teased and may get bad breath and toothache. Dental disease is preventable by diet and good tooth care. Schools can help by promoting tooth care, bringing problems to parents' attention and looking at the school's policies on snacks and what might be available at school events (e.g. limits on sweet-buying on trips, low-sugar squashes etc.). Good advice is available from local health promotion departments.

Depression

Depression is commonly considered to be an adult problem but is increasingly being recognised in children. It is important to distinguish between the child who is sad and the child who is depressed.

Sadness is usually related to an event that has upset the child. The most frequent causes of sadness in children are simple, such as a disagreement with friends or family. They may be sad because a pet has died, or there may be illness or a death in the family or amongst their friends. Children also react to illness and death of other adults they are close to, such as school staff or club leaders. As children get older they may also be exposed to sad stories in the media. These reactions are normal and respond well to support, usually improving within a few days, a week or two, or perhaps a few months for close bereavement.

Depression is more difficult to support and is more persistent. In depression, the child has turned the sadness on him or herself. They are likely to feel very hopeless and will often blame themselves for their poor self-esteem. Depression can show in a

number of ways. Children may withdraw from contact with other people and give up social activities or sports. They may lose interest in looking after themselves and be unkempt, or have poor hygiene. They may find it difficult to concentrate and work may deteriorate. They may be tearful, lose appetite and have disturbed sleep.

Depression becomes more common as children get older and there are links with other conditions, such as anxiety, eating disorders and self-harm. Staff who are concerned that a child or young person is depressed should encourage them to seek professional help, with the parents where possible, and should remember that it may be difficult for a depressed person to take action for themselves. Measures that promote self-esteem are useful, but may not be effective in a person who is feeling too low to acknowledge them.

Staff should be alert to specific situations that may contribute to depression, such as bullying, abuse, pressure from school, peers or family, and substance abuse.

Disorder Attention and Motor Perception (DAMP) – (see Developmental Co-ordination Disorder (DCD) below)

Developmental Co-ordination Disorder (DCD)

Developmental co-ordination disorder is increasingly recognised as a condition that inhibits progress at school. It is more common in boys. It may manifest as problems with fine motor co-ordination. The child may have difficulties colouring, drawing or writing. He or she may find building bricks difficult, as well as sewing and other movements that require co-ordinated movements of the hands and fingers. Some aspects of PE may also be affected, particularly throwing, catching and hitting targets.

Some children have problems with their gross motor co-ordination. This may be called dyspraxia. These children may appear clumsy. They have poor balance and no sense of direction. They may trip over their own feet or other people's, crash into things and have particular problems with, for example, dance movements.

Perceptual problems are the third main group. These children have particular difficulties connecting external stimuli with their own movement responses. They can have poor hand-eye co-ordination, poor sequencing skills (both auditory and visual) and may not yet have connected both sides of their body, that is, when they move

on one side they cannot make the corresponding movement on the other side.

It is also possible for children to have a mix of conditions in varying degrees. Children with a continuation of some co-ordination disorders plus poor attention may be said to have DAMP (Disorder Attention and Motor Perception).

All three main groups of problems are linked. A child may have all parts equally severely, or may have more problems in one area than in the others. A few only have problems in one area. There is also a spectrum of severity, from mild and barely noticeable to severe enough to be disabling.

It may help to take the children back to an earlier stage of development in the skill where the problem is noticed. For example, the child who cannot grasp writing may need to go back to the scribbling stage and work up through colouring to shape copying. Many children may benefit from occupational therapy intervention. The school nurse may have details of services and how to access them. However, there are not many occupational therapists trained in this particular work and in some areas the work is not considered a high health priority.

It is also important to note that these conditions are still subject to research and development and are also inclined to attract unproven therapies.

Diabetes

Diabetes is a disease in which the body does not produce enough of the hormone, insulin. This results in the body not being able to control its blood sugar levels, which tend to increase. A very high blood sugar level can eventually lead to death. A child developing diabetes is lethargic and unwell. He or she may lose weight. In addition, he or she may be drinking large quantities of fluid and going to the toilet much more frequently than usual. There are other reasons for drinking a lot, including habit, but the impending diabetic usually has other symptoms or signs as well. (See Medicines in school pages 43 to 59).

Diabetes in childhood almost always needs to be controlled by insulin. Once diagnosed, a school should talk to the parents to learn about the condition related to that particular child. Schools need to have procedures for general care and for emergencies. A specialist nurse or your school nurse may be able to help. The most urgent emergency for a diabetic is low blood sugar (hypoglycaemia) which may occur if a child with diabetes has an insulin injection but not enough food, or if he or she exercises

without enough food. The school should recognise early signs of hypoglycaemia and take supportive action. Children with diabetes should be encouraged to exercise and eat a healthy diet. The timing of meals is often crucial.

Diarrhoea and vomiting illnesses (gastro-enteritis)

Diarrhoea and vomiting (gastro-enteritis) illnesses are common and there are many causes. Brief bouts might not be investigated and so no particular cause may be identifiable. Sufferers should not return to school until the symptoms of diarrhoea and/or vomiting have been settled for 48 hours. In addition, if diarrhoea is due to the cryptosporidia germ, swimming should be avoided until two weeks after the last episode of diarrhoea. Some children and adults may feel weak after diarrhoea has stopped and may need further days away from school. Small children and older children unable to practice good hygiene (e.g. learning disabilities) may need special consideration before they return to school depending on the term involved. Advice may be obtained from the health protection team.

Outbreaks of diarrhoeal disease should be notified to school health and the local consultant in the health protection team.

E. coli 0157 and haemolytic uraemic syndrome

E. coli 0157 is a cause of diarrhoea which can lead to serious consequences such as kidney failure in some children. It can spread within nurseries and younger children in schools. Specific advice will be given by the health protection team. It may be necessary to exclude well younger children from school until they have been tested if there is a case in the family. Good hygiene is very important.

Giardiasis

Giardiasis is a diarrhoeal illness requiring antibiotic treatment. Treatment should be commenced and the diarrhoea settled for 48 hours before the child returns to school.

Salmonella

Salmonella is a well-known diarrhoeal illness. There are many types of salmonella. Children under five, and those with personal hygiene difficulties, need very particular hygiene advice, e.g. supervised hand-washing. Seek advice from health protection. If

personal hygiene is reasonable, return to school is allowed 48 hours after diarrhoea/vomiting have settled.

Shigella

Shigella is a less-common cause of gastro-enteritis but the advice is as for salmonella. For some less-common types of shigella, the health protection team will advise.

Typhoid and Paratyphoid (Enteric Fever)

The length of time the child will be away from school will depend on the age of the child and whether they are the person with the disease or it is within the family. Specific advice will be given by the health protection team.

Diphtheria

Diphtheria is preventable by routine vaccination. Always contact the health protection team for advice if a case is suspected.

Diets

See Nutrition on page 63

If a child requires a special diet, needs will be very individual and the parents should be consulted, with additional advice from a dietician, school nurse or doctor, GP or consultant if there are any queries. A child may need a special diet for cultural as well as medical reasons and this should be treated with the same sensitivity and care.

Drug misuse - (see Substance misuse page 70)

Dyspraxia – (see Developmental Co-ordination Disorder (DCD) page 17)

Eczema

Eczema is a relatively common skin condition which is usually a mild, itchy, red rash. When severe it can impair a child's concentration. Each child will have his or her own individual treatment and needs. Eczema may look unpleasant but it is not contagious. However, other children may not know that and children with severe eczema are at risk of being isolated by their school friends.

Epilepsy

**See also HCC
guidelines: Safety
in Physical
Education**

Epilepsy is a general term for a group of conditions where the electrical activity in the brain is dysfunctional. Classification of epilepsy is constantly being revised and is complex, but classical seizures (fits) are only a problem in certain forms. Children with epilepsy have a range of needs, though very few will have a significant disability and almost all will benefit from being included in all activities. They will need to have additional supervision for activities where a brief loss of consciousness poses a risk, for example, climbing and water activities.

Staff should be aware of symptoms in pupils with epilepsy so that they can recognise a seizure (fit) and act consistently and appropriately.

Schools may find it helpful to have prominently displayed guidance on dealing with a fit and if a child is at particular risk, should consider arranging for key staff to have training in appropriate management.

This may require a joint plan of health care.

Exercise

Exercise has been proven to be very good for all children and there are very few reasons to exclude children from exercise. Children with asthma, diabetes, epilepsy and almost all other long-term conditions will benefit from the exercise itself and from joining in with their peers. The school doctor should be able to help with any questions about the suitability of particular forms of exercise for children with medical conditions and may be able to help with suggestions for adapting exercise for children unable to participate fully. The Advisory Teacher for Physical Disability is also a useful source of information on this topic.

Children who have physical disabilities may be under the care of the local physiotherapy and or occupational therapy team. Staff should approach the therapists for advice on activity and exercise for individual children and young people.

Teenagers, girls in particular, are most at risk of opting out of exercise. Schools may wish to develop strategies for encouraging this group of young people.

First-aid provision in schools

Introduction

The Health and Safety (First Aid) Regulations, 1981 require that adequate provision be made for employees who are injured or become ill at work. There is no requirement under these Regulations to provide for children and visitors but because they are owed common-law duty of care, this guidance takes account of them.

Minimum first-aid provision

- suitably stocked first-aid container (see page 24)
- an appointed person to take charge of first-aid arrangements (see below)
- information about provision.

Level of first-aid personnel

There are no hard and fast rules on exact numbers. An assessment needs to be made based on local circumstances. The assessment should be recorded. Factors influencing the level of provision will include:

- number on roll and number of staff
- site layout and extent of facilities where there is increased risk, e.g. gymnasia, laboratories and workshops
- distance from external medical services
- pupils or staff with special health needs
- nature and extent of community use
- accident statistics.

The minimum provision is an 'appointed person' to take charge when someone is injured or becomes ill. This person does not have to be formally trained but will need appropriate information and instruction. However, parents will expect trained staff to administer first aid so it is recommended that each school has a sufficient number of suitably trained staff available.

First-aid personnel

First aider: A person who holds a current first-aid certificate issued on completion of a training course approved by the Health and Safety Executive. Courses normally extend over four days or the equivalent. Certificates are valid for three years. To retain

first-aider status, refresher training and re-testing of competence must be undertaken before certificate expires. Refresher training normally lasts two days.

Appointed person: A person designated to take charge of the situation (e.g. call an ambulance) if a serious injury/illness occurs in the absence of a first aider. Ideally appointed persons should receive training in emergency first aid. Courses normally last four hours and can be school based.

Nurse: Registered nurses may administer first aid providing they have up-to-date knowledge and skills in that area.

Duties of first aiders and appointed persons

- take charge when someone is injured or becomes ill
- render first aid within the limitations of training received and as appropriate in the circumstances
- arrange to call an ambulance or other professional medical help if necessary
- if appropriate, arrange for next of kin to be contacted and, if contact cannot be made, arrange for somebody to accompany injured children to hospital
- maintain simple records of all first aid provided
- ensure first-aid boxes and travelling first-aid kits are kept stocked with sufficient quantities of suitable materials and nothing else (see page 24).

See Child Protection Procedures for advice on contact with children

Duties of headteachers

Headteachers need to set up appropriate arrangements so that:

- first-aid equipment is provided
- as far as reasonably practicable, the level of first aiders/appointed persons is maintained
- notices are displayed prominently giving the locations of first-aid facilities, and the names and locations of first aiders/appointed persons
- staff are informed - through induction training and whenever changes are made - of first-aid facilities and the names and locations of first aiders/appointed persons
- a record is kept of dates on which first aiders/appointed persons were trained
- refresher courses are arranged
- first aiders and appointed persons are aware of their duties

- a telephone is always available to call an ambulance, that emergency access to buildings is maintained, and the local ambulance service is kept informed of arrangements for access to the site
- accidents are reported and recorded in accordance with statutory requirements and the Local Authority's procedures.

Contents of first-aid containers

There is no mandatory list of items to be kept in first-aid containers but contents of boxes and kits should be checked frequently to ensure contents are sufficient and items with expiry dates on packets are removed. The following is a guide to quantities. Equivalent or additional items are acceptable but tablets and medications should not be stored in first-aid boxes.

	First-aid boxes	Travelling first-aid kits
Guidance card	1	1
Individually wrapped sterile adhesive dressing (assorted sizes)	20	6
Sterile eye pad, with attachment	2	-
Individually wrapped triangular bandage	4	2
Safety pin	6	2
Medium individually wrapped sterile unmedicated wound dressing (approx. 12cm x 12cm)	6	-
Large sterile individually wrapped unmedicated wound dressing (approx. 18cm x 18cm)	2	1
Individually wrapped moist cleaning wipes (where soap and water is not available)	6	6
Pair of disposable gloves*	1	1

*Additional disposable gloves should be kept nearby first-aid facilities.

Where tap water is not available for eye irrigation, sterile water or sterile normal saline in sealed disposable containers should be provided. Each container should hold at least 300ml and should not be re-used once the sterile seal is broken.

Soap and water and disposable drying materials should be provided for first-aid purposes. Where soap and water are not available, individually wrapped moist cleaning wipes, which are not impregnated with alcohol, may be used. The use of antiseptics is not necessary for the first-aid treatment of wounds.

First-aid accommodation

The Education (School Premises) Regulations 1999 require every school to have a suitable room that can be used for medical or dental purposes and for the care of pupils during school hours. The area, which must contain a washbasin and be reasonably near a toilet, need not be used solely for medical purposes but should be readily available when needed. Adequate space and facilities should be maintained so that health care staff can undertake their work in a professional and dignified manner.

Training

First-aid training can be accessed via Hampshire Learning Centre on 01962 826037. Details of courses available can be found on their website www.hants.gov.uk/learningcentre

Indemnity

Hampshire County Council fully indemnifies its staff against claims for alleged negligence providing they are acting within the scope of their employment. In the context of first aid, such indemnity will apply to trained personnel and other staff who act in good faith in an emergency. In practice, indemnity means the Council and not the employee will meet the costs of damages should a claim for alleged negligence be successful. It is very rare for school staff to be sued for negligence and instead the action will usually be between the parent and employer.

Honorarium payment

The County Council has agreed that employees acting as the designated first aider for their workplace as a voluntary extension to normal duty should receive an annual honorarium. The honorarium is to be met from the school budget. The honorarium does not apply to:

- appointed persons
- staff specifically appointed to care for the well-being of others, like a school appointed matron, nurse or welfare assistant.

To generate payment, schools need to advise the County Treasurer's payroll section of the name and payroll reference

number of the designated first aider and the date payment should begin. This will normally be the first day of the month following completion of the training course. The honorarium payment, currently £120, is subject to normal tax/national insurance deductions.

Food allergy

See DfES guidance: **Managing Medicine in Schools and Early Years, and Medicines in school** page 43

Allergy to cows' milk, eggs and other foods is more common in pre-school children than in school children. However, occasionally a child may be allergic to food colourings or preservatives, or a food like chocolate, cheese, wheat or nuts. The allergy can manifest as a rash, itching, eczema, headaches, abdominal pain or diarrhoea. A very severe allergy can lead to anaphylaxis (see page 8). There are many other illnesses, both physical and psychological, which can produce the same symptoms. All diagnosis of food allergies should be made by a doctor. In particular, it is dangerous for special diets to be imposed on children. In many cases, these diets have led to severe malnutrition in children. If school staff are concerned about symptoms, they should be discussed with the parents in the first instance. Parents may then wish to talk to their GPs or to the school nurse or doctor.

Many children do not like certain foods and may feel sick if they eat them. This is not a food allergy. Children also get food intolerances. For example, a temporary intolerance to milk and milk products after an attack of gastro-enteritis may give prolonged diarrhoea. These are not food allergies either.

Foot care

See also HCC guidelines: **Safety in Physical Education**

Most schools have a footwear guide as part of their uniform policy. Schools may make suggestions about the suitability of shoes, as well as the footwear to be worn for games and PE. Schools should also seek advice if they wish to adopt an unusual guideline, for example asking children to wear soft-soled shoes or slippers all day to protect floors.

Policies need to be flexible in order to allow certain children with specific footwear requirements to participate in activities.

German measles

German measles is also called *rubella*. Children may have a red rash, mild fever and slightly swollen glands, especially at the back of the neck. Occasionally they may have joint pain. Children should be kept away from school for five days after the onset of the rash, if they are well enough. It is generally a very mild viral disease and is becoming less common now that rubella is included in the childhood immunisation programme. Pregnant women who

come into contact with the disease should inform the person responsible for their ante-natal care promptly whatever their stage of pregnancy. However, most women are immune to rubella, either from natural infection in childhood or from immunisation. It is important to provide information about risk associated with pregnancy in the school's programme of health education. MMR immunisation is available for adults who may discuss immunisation with their GP if they are concerned that they may not have immunity.

Parents should be advised to see their doctor as the disease is notifiable

Glandular fever (infectious mononucleosis)

Glandular fever (infectious mononucleosis) is a viral illness which may lead to fever, sore throat, swollen glands and, sometimes, a rash. There is no particular treatment and sufferers may remain lethargic with a poor appetite for some time. Children may return to school as soon as well enough.

Growth impairment

Most short children are normal. However, if there is concern it should be mentioned to the parents in the first instance. In some areas the school nurse may be able to offer a height measurement service, otherwise the parents may be advised to take the child to his or her GP.

Hand, foot and mouth disease

Hand, foot and mouth disease is a mild illness that may give blisters on the palms, soles and in the mouth. As transmission to others tends to take place before symptoms appear, it does not justify time off school as long as the child is well enough to attend. Schools may need to review their hand-washing procedures during an outbreak. There is no evidence to suggest that bare-foot activities need be restricted. If a large number of children are affected, contact the health protection team for advice.

Hay fever

Hay fever is an allergy to pollens and plant material. It occurs most often in spring and usually shows as a blocked or runny nose and itchy eyes, which may water and become red. It is generally not serious, though it can be unpleasant. If a child has been prescribed preventative treatment it is worth checking it is effectively used as this will help during outdoor activities and at crucial times, such as exams.

Hygiene and hand-washing

Effective hand-washing is an important method for controlling the spread of infection, especially illnesses associated with diarrhoea and vomiting and respiratory disease. The following good practice applies to all environments but active promotion will vary. Infant hand-washing is likely to be supervised whereas at secondary level 'wash hands' notices in toilets could help promote the message. Some good guidelines are:

- always wash hands after using the toilet and before eating, or handling food and after handling animals. Use warm running water and a mild, liquid soap
- the hands should be rubbed together vigorously until a soapy lather appears and continue for 15 to 20 seconds
- rinse hands under warm, running water and dry hands with preferably a paper towel or a hot-air dryer
- discard paper towels in a bin. Bins with a pedal-operated lid are preferable
- encourage use of disposable paper tissues when coughing and sneezing. Hands should be washed after use of disposable tissues
- if a food handler has diarrhoea or vomiting then immediate exclusion from work is required. Advice may be sought from an environmental health officer or the local consultant in health protection team
- toilets must be kept clean
- where possible, encourage finger nails to be kept short and clean.

Head lice

This guidance has been drawn up by a working group including representatives of health authorities, NHS trusts, headteachers and Hampshire County Council Children's Services Department, drawing upon information from the Department of Health.

Part 1 – Introductory information

What are head lice?

- Head lice are small insects.
- They are usually grey or brown in colour and can be difficult to see.
- They do not necessarily cause itching.
- Head lice cannot fly, jump or swim, they spread by crawling from head to head.

- Head lice need warmth and cannot survive for very long away from the skin.
- They are not fussy about hair length or condition.
- They feed by sucking blood from the scalp of their host.
- The female lays eggs in small sacks glued to the base of the hair (nits).
- The eggs take seven to 10 days to hatch.

Who can get head lice?

Anyone with hair can catch head lice, and this can happen repeatedly. Infection occurs in schools, particularly amongst young children, because of close personal contact. However, most infection will come from within the family but too many parents put the blame on schools. It is very difficult to break down this 'blame' culture.

Can the problem be eliminated?

Realistically and regrettably there is no likelihood of head lice being eliminated from society in the foreseeable future. The aim must therefore be to develop prevention strategies and back these up with effective infection control measures when outbreaks occur.

Part 2 – Preventative strategies and support

School strategies

Examples of ideas and successful strategies from Hampshire County Council schools are included on page 34.

Curriculum initiatives

The personal social education (PSE) team have prepared materials for use across the curriculum and these are being trialled.

Communicating with parents

Apart from the need to write to parents when there is an outbreak, regular communication is important.

For example:

- the school nurse might be asked to talk to groups of new entrants

- a letter at the end of the summer term could serve as a useful reminder that outbreaks can arise in the forthcoming holiday period.

A sample letter is provided on page 35.

Campaigns

Resources are available from local health promotion units and the School Health Service to support ‘bug-busting’ campaigns. Schools could also share good ideas in their clusters and possibly purchase materials for joint use.

Involvement of others

School nurse

Every school has a named school nurse who should be able to provide:

- up-to-date information regarding head lice.
- support and advice for parents whose children appear to have persistent problems
- support and advice for teachers in the planning and delivery of health education both in the classroom and at parent sessions
- liaison with other health professionals and agencies.

Health protection teams

Health protection teams can advise on the most recent information and guidelines to the community health services, GPs, community pharmacists and other interested health personnel.

Education welfare officers (EWOs)

EWOs will respond to referrals from school staff resulting from poor or non-attendance because of head lice infestation or fear of infestation. Such advice from EWOs will match that provided by health staff.

Part 3 – Treatment

The advice below reflects a local Hampshire-wide consensus on the treatment of head lice.

We recommend that either the wet-combing method (as described in Department of Health guidance reproduced below) or chemical treatments be used to treat identified cases of head lice infection.

With all methods of treatment, it is important to ensure that the method is being used correctly and that any other cases in family members or close friends are identified and treated.

The chemical treatments that are recommended are the pyrethroid products (Full Marks or Lyclear) and Malathion products (Derbac M). A new silicone based treatment is available called Hedrin. A mosaic policy is advised, with a different first choice of chemical treatments being used with individual cases followed by another choice if this fails. Lotions or liquids should always be used in preference to shampoos.

School nurses and health visitors will provide support to families where there is evidence of repeated infection or where the situation is causing particular disruption to the pupil/class. Headteachers should liaise directly with the school nurse in this situation to discuss the best approach. There is no case for the return of the 'nit nurse'.

It is important for headteachers to send 'alert' letters to the parents of children in the same class as a child with head lice recommending that parents check their children's hair. It may be useful to send a head lice leaflet with the letter giving information on how to check the hair for lice. The parents of pupils who have been identified as having head lice should be asked to treat the child, after which they can return to school (if using the wet-combing method, a child can be assumed not to be infectious after the first session of combing). It is acceptable for headteachers to ask whether wet-combing will continue for the recommended two-week period. As mentioned above, if there are particularly difficult situations concerning parental refusal to treat a child with head lice, the headteacher should discuss the situation with the school nurse to try to resolve the problem.

The 'wet-combing' method

Head lice can be cleared over a two-week period by following these steps:

- wash the hair in the normal way with an ordinary shampoo
- use lots of hair conditioner and, while the hair is very wet, comb through the hair from the roots with a fine tooth-comb. Make sure the teeth of the comb slot into the hair at the roots with every stroke, and do this over a pale surface, such as a paper towel or the bath
- clear the comb of lice between each stroke.

Wet lice find it difficult to escape, and hair which is slippery from conditioner makes it hard for them to keep a grip – so removal with the comb is easier.

If you find any lice, then repeat this routine every three to four days for two weeks, so that any lice emerging from the eggs are removed before they can spread.

Children can return to school after the first session of combing.

Chemical treatments

These should only be used if live lice are detected on the head. Close contacts should be checked and treated if live lice are found. Your named school nurse will recommend lotions which are specifically made to kill lice and their eggs quickly.

The manufacturer's instructions should always be followed. The following points are also important:

- use lotions not shampoos
- sufficient lotion must be used
- the scalp, rather than the hair, should be saturated
- leave the lotion on the hair for the recommended time
- hair dryers should not be used to dry the hair following application of the lotion
- if the person has been swimming in a chlorinated pool in the past 24 hours, the hair should be washed and dried prior to treatment
- treatment should be repeated after seven days.

Alternative treatments

It is acknowledged that some families may prefer alternative methods of treatment. Families using these methods should ensure they seek professional advice.

Part 4 – Management issues

Can staff inspect children's heads?

School staff should not, normally, examine children for head lice (though a cursory glance would probably **not** constitute an 'examination'). Apart from the legal difficulties that might arise, there are practical considerations which suggest that schools should not conduct examinations. Firstly, the examination will only identify the worst cases and will only be as good as the day on

which it is done. Secondly, it might build up an expectation from parents that this is a task which schools should carry out routinely.

If, for some reason, a school felt that the circumstances were so exceptional that it wished to carry out an examination, parental consent should be obtained first.

Can schools exclude children with head lice?

Disciplinary exclusion (not to be confused with the ‘exclusion’ measure available to the health service) may **not** be used in head lice cases.

Can schools send children home or refuse to admit?

We recognise that situations will arise where tensions are high. However, it is not possible to require a child to go home, or to refuse to admit a child, where head lice are concerned. If a child appears to be uncomfortable or distressed, it is reasonable to contact the parent and ask whether he or she would prefer to have the child at home for the remainder of the day in question.

How is absence recorded?

It follows from the above that, with the limited exception of a child whose parents agree that he or she should go home on the day on which the condition is identified, there is no justification for recording a child’s head lice-related absence as other than “unauthorised”.

What legal measures exist?

There are legal measures but these should be regarded as a last resort and only used in the most exceptional circumstances. Headteachers are advised to contact their EWO or the Chief Executive’s Department. Using the law would be unlikely to be effective in practical terms.

Should children be isolated from classmates?

Isolating children with head lice is another sensitive issue. Schools will want to avoid ‘singling out’ children by withdrawing them from class, but parents of apparently non-infected children may contend that this is an appropriate course of action. You may need to reach a compromise. If head lice are suspected, the child could, for example, be given work within the classroom which would avoid close head-to-head contact with other children.

Headteachers' suggestions

There are Bug Busting Days three times a year. If schools wish to find out more information regarding these days they can click onto the link below. Stickers, head lice combs, videos, teaching materials and an information pack can be bought. The belief is that lice can be effectively and safely dealt with without the use of chemical treatments. Efficient combing is enough. Even five year olds can be taught to use the combs. Further information can be found from:

Community Hygiene Concern – www.nits.net/bugbusting

Community Hygiene Concern
Manor Gardens Centre
6-9 Manor Gardens
London N7 6LA
Bug Buster Helpline: 020 7686 4321

I found it quite useful when I sent a letter home asking parents to return the tear-off slip saying that they had checked their child's hair that night. It made the stressed out parents feel that action had been taken and we haven't had any cases since (three weeks!).

Having been driven to distraction by parental complaints, we decided to subscribe to Community Hygiene Concern's Bug Busting campaign. We now hold an event annually although we don't push the Bug Busting packs as these are quite expensive. We recommend parents buy a dust comb and teach the children that to "wash, rinse, condition and comb, will leave the bugs without a home". This action, taken three years ago, has resulted in a dramatic drop in the number of cases and everyone feels that they are doing something positive about the situation. We can thoroughly recommend.

We have found putting 'Nit Alert' on the newsletter has been quite effective. It has reduced the stigma and increased awareness. We send out leaflets from time to time but each time there is an alert we give brief instructions and advice.

Have you heard of the 'electronic' comb. Turn it on and comb through hair. It makes a buzzing noise which stops on contact with lice. Clean the comb and continue through the hair. It is quite expensive but all options should be publicised!

Whenever we need to remind parents about head lice, we always enlarge diagrams of the little beasts and put them round the edge of the letter which makes it quite eye-catching! It also ensures it is read.

Sample letter to parents

Dear Parent

Head lice

Some cases of head lice have been reported recently. Please could we all take extra care with checking children's hair. Although lice can be seen in dry hair, the best way to check is by the combing of wet hair with a fine toothed 'detector' comb.

Treatment, if necessary, can be done by either:

Wet-combing method:

- wash the hair in the normal way with an ordinary shampoo
- use lots of hair conditioner and while the hair is very wet, comb through the hair from the roots with a wide-tooth comb to remove tangles, then use a fine-tooth comb. Make sure the teeth of the comb slot into the hair at the roots with every stroke, and do this over a pale surface, such as a paper towel or the bath
- wet lice find it difficult to escape, and hair which is slippery from conditioner makes it hard for them to keep a grip – so removal with the comb is easier
- clear the comb of lice between each stroke
- if you find any lice then repeat this routine every three to four days for two weeks, so that any lice emerging from the eggs are removed before they can spread.

Using lotions

These are available from the chemist over the counter or on prescription for children. The chemist will advise on which lotion to use. It is important to follow the instructions on the packet.

If lice are found, it is most important to check and, if necessary, treat the rest of the household. Regular wet-combing as part of routine hair washing is the best way to prevent the problem recurring.

The school nurse is available to offer advice and can supply further information and leaflets.

Let's stop making life too easy for the louse!

Yours sincerely

(This letter can be adapted for local use depending on circumstances.)

Health precautions

There are a number of simple actions a school can take to minimise health risks and promote healthy living for staff and pupils. More detailed information on healthy living is available from your school nurse, local health promotion service (the school nurse will have contact details), PSE advisers and the Health Education Authority.

Hearing impairment

In some health districts there are still hearing screening tests for children just before or after school entry. A child who has a normal screen result is very unlikely to have a significant hearing loss later, unless it is due to an intervening illness (such as meningitis) or an injury to the ear or brain. A child who is inattentive, has poor communication or is failing to progress, may have poor hearing. In a few cases, poor hearing can also lead to disruptive behaviour. In most areas the school nurse is the first line of assistance to exclude a hearing loss, but parents may also be asked to see their GP. It is good practice to mention to the parents that you are suggesting a hearing test, before referring to the school nurse. Children with significant hearing impairment will have a number of professionals involved. These are likely to include the Advisory Teacher for the Hearing Impaired and an ENT (ear, nose and throat) surgeon. These children may have hearing or other communication aids.

Hepatitis A

Hepatitis A is a viral infection that affects the liver and commonly results in jaundice (yellowing) of the skin and the whites of the eyes. Usually a person is non-infectious a week after jaundice has started. The virus is present in faeces and spread within schools is possible but can be minimised with good hygiene.

Hepatitis B and C

Hepatitis B and C are rare in children and carriers of the disease are often unaware that they have it. All schools, therefore, need to follow strict body fluids procedures (see page 13). Exclusion from school is unnecessary. Hepatitis B and C are not infectious through casual contact and have only rarely spread within a school setting.

A higher prevalence of Hepatitis B carriage has been found among certain groups of those with learning disabilities in residential accommodation, compared with the general population. Close daily living contact and the possibility of behavioural problems may lead to increased risk of infection.

Similar consideration may apply to special schools for those with severe learning disability. Decisions on immunisation for staff can be complex and advice should be sought from the local consultant in health protection.

HIV and AIDS

HIV and AIDS do not spread through casual contact. All schools should have procedures for dealing with body fluids (see page 13) and these should be used for all body fluid incidents. They should also have procedures for disposing of sharp objects, including discarded syringes. Children and adults with HIV infection do not pose a threat to others in schools providing these procedures are followed (see page 69).

The main routes of transmission of HIV infection are:

- by intimate sexual contact with an infected person
- by blood-to-blood contact (e.g. contaminated needles and syringes)
- from infected mother to her baby, either during pregnancy or childbirth.

Although the virus has been found in many different body fluids, only blood, semen and vaginal secretions appear to be significant in the transfer of HIV infection.

See also DfES: sex and relationship education guidance

Secondary schools are required (by law) to include education about HIV and AIDS in their sex education programme.

Immunisation

The immunisation programme in the UK saves thousands of children each year from death and serious disability, as well as protecting them from prolonged time off school and unpleasant symptoms.

Some areas of Hampshire have an immunisation service in school at secondary age for diphtheria, tetanus and polio boosters. The uptake for these immunisations is generally better in a school-based programme compared with requesting young people to attend their GPs.

The health staff are aware that the school-based immunisation sessions do cause some disruption and will try to minimise it. Schools can also help minimise problems by offering reasonable

space for the sessions and by not allowing for last-minute changes to dates and times.

The school health service is very grateful for schools' support, particularly as a case of infectious disease in a school can be very disruptive for the staff and pupils.

Routine childhood immunisation programme (children who present certain risk factors may require additional immunisations).

When to immunise	What vaccine is given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Hib Pneumococcal injection
Three months old	Diphtheria, tetanus, pertussis, polio, Hib, meningitis C
Four months old	Diphtheria, tetanus, pertussis, polio, Hib, meningitis C Pneumococcal injection
Twelve months old	Hib, meningitis
Around 13 months old	Measles, mumps and rubella (MMR) Pneumococcal injection
Three years four months to five years	Diphtheria, tetanus, pertussis and polio Measles, mumps and rubella (MMR)
Thirteen to 18 years old	Tetanus, diphtheria and polio

Routine BCG is no longer offered to all school children. It is recommended for children with a parent or grandparent who was born in a country where TB is more common, and to infants under 12 months of age born or living in areas where the incidence of TB is 40/100,000 of the population or greater. Up-to-date immunisation advice can be found at: www.immunisation.nhs.uk

Immunisation is very safe and effective. It is one of the best researched and monitored health interventions that exists and there are extremely few children who, for medical reasons, should not have all the immunisations. Whilst it cannot be said that no child ever has a side effect from the injection, such effects are uncommon and almost always mild. The effects of the illnesses are more common and more serious. In particular, the risks of the diseases prevented by the MMR vaccination are more significant than any problem that might be associated with the injection, and,

to date, there is no evidence that the injection causes either autism or bowel problems.

No child should be denied the benefits of immunisation without very good reason. Parents who have questions can talk to their health visitors, GPs, or local immunisation co-ordinators, and should be encouraged to do so before making any decisions not to have their child immunised.

An additional useful immunisation is Hepatitis B. In some countries this is part of the childhood programme, but in the UK it is given to people considered at higher risk. Those at higher risk include:

- travellers to high risk areas
- babies of mothers who carry Hepatitis B
- drug misusers
- individuals who change sexual partners frequently
- close family contacts of cases
- people with certain medical conditions
- health care workers
- staff and children at establishments for people with severe learning disabilities may fall into this category, depending upon risk assessment of the individual circumstances.

The latter two may apply to schools. If your school has children who need additional physical care, you can get advice from your local consultant in health protection or immunisation co-ordinator, who will also help you write a protocol for staff and child protection if you need one.

Staff immunisation

Staff required to complete a medical questionnaire prior to employment will have their immunisation status checked by the Occupational Health Unit. All staff aged 16-25 years should be advised to check they have had two doses of MMR. Older staff who may be concerned that they are not immune to measles, mumps or rubella can discuss immunisation with their GP.

Impetigo

Impetigo is caused by a bacterial infection of broken skin, usually on the face and commonly around the mouth. The child should not attend if the lesions are weeping but may return as soon as the lesions are crusted. Antibiotic treatment by mouth may speed

healing and reduce the infectious period. Children may need a further brief period off school for any recurrence until treatment is re-established. Parents should be advised to seek medical advice as antibiotics may be prescribed in some cases.

Infection and infestation

See also DfES document - Supporting Medical Needs in Schools and Medicines in school pages 43

Children with an infectious disease who are unwell should not be at school. Children with viral illnesses, generally coughs and colds, may return when they are well enough. No specific advice is needed for these conditions. There are, however, some illnesses for which time off school and/or other action is recommended. These are outlined in alphabetical order under the following headings:

- Rashes and skin diseases – on page 66
- Diarrhoea and vomiting – on page 19
- Respiratory conditions – on pages 72 & 73
- Other infections and infestations
 - 1 Conjunctivitis - on page 15
 - 2 Glandular fever - on page 27
 - 3 Head lice - on page 28
 - 4 Hepatitis A, B & C - on page 36
 - 5 HIV and AIDS – on page 37
 - 6 Meningitis - on page 60
 - 7 Mumps - on page 63
 - 8 Threadworms - on page 71
 - 9 Tonsillitis - on page 72

The Health Protection Agency frequently has useful information relating to infections in schools.

http://www.hpa.org.uk/infections/topics_az/schools/default.htm

Influenza

Influenza is a viral illness. The common symptoms are fever, headache, joint and muscle pains and loss of appetite. Children and staff with medical conditions which put them at increased risk of complications from flu, should have an annual flu immunisation as advised by their doctor. Children may return to school as soon as well enough.

Life-threatening illness

See also HCC guidelines: Critical Incidents - guidance for schools

Life-threatening illness includes acute conditions, such as anaphylaxis (see page 8), longer-term disability like muscular dystrophy, and conditions, such as leukaemia or other cancers. The aim is for children to lead as normal lives as possible, but what that means for each child will differ. It is important to have good communication with the parents and with the health care professionals involved. One-off or regular multi-disciplinary (or multi-agency) meetings according to need will facilitate communication and help ensure that the child is given as many opportunities as possible. A planning meeting is essential if the child has a fatal illness as classmates and staff may need help to come to terms with their grief. Staff and pupils may need counselling, support and help from local bereavement counsellors or play teams may help them come to terms with their grief.

See also Wessex guidelines [www](#).

For specific life-threatening diseases where prompt action could save the child, schools should have a procedure for recognition of symptoms and a plan of action. This procedure should be drawn up with the agreement and co-operation of the parents, school staff and an appropriate health practitioner, along with the child, if they are mature enough to contribute. The written procedure should be easily identifiable and displayed where it is usefully and easily found. The procedure should identify the child by name and date of birth as a minimum and should also have the contact phone numbers as well as the practical procedure to identify and manage the life-threatening episode. A photograph of the child is helpful. The school office or staff room walls are likely to offer the best combination of confidentiality for the child and ease of access for the staff.

Children differ but, where competent to do so, they should be encouraged to participate in discussions about themselves and their views should be respected.

Measles

Measles is preventable by routine vaccination. Cases occur in children who have recently come to the UK and in unimmunised children. Measles is an unpleasant disease that can leave children with severe disabilities or be fatal. The red rash may first appear behind the ears and on the face and then spreads in blotches. It is usually accompanied by a fever. The child may become listless and sick, with red eyes and a runny nose. The child should remain at home until five days after the start of the rash, returning to school after that only if well enough. The parent should be advised to seek medical advice as the disease is notifiable. Prompt action may prevent serious disease being passed to vulnerable contacts.

Particularly vulnerable children/staff and pregnant women need to seek medical advice promptly if they are in contact with measles (see page 73).

Medicines in school

Overall considerations

Children with medical needs have the same rights of admission to a school as other children. Most children will at some time have short-term medical needs, for example, finishing a course of antibiotics. Some children have longer-term medical needs and may require medicines on a long-term basis to keep them well.

Some children with medical needs are protected from discrimination under the Disability Discrimination Act (DDA) 1995. The DDA defines a person as having a disability if he has a physical or mental impairment which has a substantial and long-term adverse effect on his abilities to carry out normal day-to-day activities.

There will be many cases where the administration of medicines is routine and straightforward and where the responsibility for administering the medicine should rest with the child. There may be instances, however, where either the parent requests the school to exercise a degree of supervision over the child or the administration is more complicated. In such cases, headteachers are advised to consult their staff where they are considering taking responsibility for administration of medicines. It is essential that the practical and organisational implications are addressed before any decision is taken bearing in mind that there is no legal duty requiring school staff to administer medicines.

General principles

The administration of medicine is the responsibility of parents. Whilst there is no requirement on school staff generally to administer medicines, many volunteer to do so. The job descriptions of certain categories of support staff provide for the administration of medicines. Staff who are concerned about their position should be advised to contact their professional association or trade union.

Children suffering from short-term ailments who are clearly unwell should not be in school and headteachers are within their rights to ask parents to keep them at home. Some parents may seek to send children to school with non-prescribed medicines (e.g. cough mixtures) and as a general rule schools should discourage this practice.

To help children with chronic illness or disability to lead as normal and happy a life at school as possible, it may be necessary for them to take prescribed medicines during school hours.

Nowadays, most health advisers encourage children, even the very young, to take responsibility for their own medical care. This could cover self-administration of medicines, using an inhaler or giving their own injection. Schools are recommended to support this practice, where appropriate (see guidance on good practice).

There will be instances, particularly with young children and those with special needs, where adult support will be needed. Although responsibility for the medical care of children rests with parents and the medical profession, it may not be feasible for parents to come to schools to administer medicines. Also, such attendances could slow down the personal development of a child.

The headteacher needs to agree with parents exactly what support can be provided. Where parents' expectations appear unreasonable, the headteacher should seek advice from the school nurse or doctor, the child's GP or other medical advisers and, if appropriate, the Children's Services Department.

The teaching profession has a general duty of care towards children in schools. Whilst, in law, this duty cannot require teachers to administer medicines, it does expect them to react promptly and reasonably if a child is suddenly taken ill. In these cases clear procedures must be followed, particularly in potentially life-threatening situations (see page 46).

Policy and procedures

Where medicines are administered in school – with or without involvement of staff – it is most important that robust procedures are in place. A clear school policy understood and accepted by staff, parents and children provides a sound basis for ensuring that children with medical needs receive proper care and support. Keeping accurate records, use of consent forms and, in some cases, preparing a health care plan, will minimise the chance of something untoward happening. The following model forms are appended to this guidance. They can be modified to meet local or particular circumstances. Some health authorities will offer schools forms they have designed – these will be equally acceptable.

Form 1 – Administration of medicines/treatment consent form

Form 2 – Health care plan

Form 3 – Record of prescribed medicines given to a child in a school:

Form 4 – Staff training record

Form 5 – Contacting emergency services

Health care plan

The main purpose of an individual health care plan for a child with medical needs is to identify the level of support required. Not all children who have medical needs will require an individual plan. A consent form from parents may be all that is necessary, such as Form 1 (see page 54).

An individual health care plan clarifies for staff, parents and the child the help that can be provided. It is important for staff to be guided by medical or health care professionals. Staff should agree with parents how often they should jointly review the health care plan. It is sensible to do this at least once a year, but much depends on the nature of the child's particular needs; some would need reviewing more frequently. Staff should judge each child's needs individually as children and young people vary in their ability to cope with poor health or a particular medical condition.

Developing a health care plan should not be onerous, although each plan will contain different levels of detail according to the need of the individual child. In addition to the input from the school health service, the child's GP or other health care professionals (depending on the level of support the child needs), those who may need to contribute to a health care plan include:

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

Confidentiality

The headteacher and staff should always treat medical information confidentially. The headteacher should agree with the child, where appropriate, or otherwise the parent, who else should have access to records and other information about a child. For example, some parents might be concerned about displaying in medical or staff rooms, information about children with a particular medical condition.

Training

It is most important that training and guidance is sought via the School Health Service for non-routine administrations. A record of training should be made. Form 4 (page 58) (or similar) can be used for this purpose.

Routine administration of medicines

Sometimes it may be helpful for schools to seek clarification of timing of administrations. Taking medicine “*three times a day*” could mean **before school, after school and at night** thus relieving the school of responsibility. Schools must not make their own interpretations and must confirm with parents the doctor’s advice in respect of timing. When making enquiries of this nature it should be explained that the professional judgement of the doctor is not being questioned and the enquiry is related to practicalities from the school’s point of view. In cases of difficulty, the school doctor should be asked to act as an intermediary between the school and the child’s general practitioner/consultant.

A standard practice should be followed when administering medicines:

- refer to the written instructions received by the school
- check the prescribed dose and frequency
- check the expiry date
- measure out the prescribed dose and check the child’s name again (for liquid medicines parents should provide measuring spoons)
- complete and sign a record card when the child has taken/been given the medicine (an example of a record card can be found on page 57, which can be photocopied)
- if uncertain, do not give the medicine and check with the child’s parent or doctor.

Non-routine administration

Unusual administrations

Some children require types of treatment which school staff may feel reluctant, for professional or other reasons, to provide. For example, these might be injections, administration of rectal diazepam, assistance with catheters or use of equipment for children with tracheotomies.

Specially appointed staff may be available to carry out these tasks. Where they are not available, other staff may volunteer to undertake the tasks. In all cases, professional training and guidance via the School Health Service or appropriate medical team must be obtained before a school accepts the commitment.

Conditions requiring emergency action

As a matter of routine, all schools must have a clear procedure for summoning an ambulance in an emergency (see Form 5 page 59) . However, some life-threatening conditions may require immediate treatment. Some staff may volunteer to stand by to administer the medicine prescribed and if they do so they must receive professional training and guidance via the School Health Service.

Medicines for these purposes should only be held where a health care plan for the child concerned has been written up for the school by a medical professional. Examples of these conditions follow but will be more fully explained during training and in the health care plan. The full indemnity provisions referred to later apply in these emergency situations.

Acute allergy to bee stings or nuts

A very small number of people are particularly sensitive to bee stings or nuts and require an immediate injection of adrenaline or an immediate inhalation of adrenaline to save life (depending on individual medical prescription).

Major fits

Some children require rectal diazepam if a fit does not stop spontaneously. Wherever possible, a second member of staff (of the same gender as the child) should be present during such administrations to minimise the potential for accusations of abuse.

Diabetic Hypoglycaemia

Blood sugar level in diabetics may drop to a very low level causing confusion and even unconsciousness. If the child does not respond to the dextrose or Lucozade tablets they may carry or to biscuits or other food/drink containing sugar, Hypostop or an injection of Glucagon may be required.

Another form of emergency can arise if the normal routine for administering treatment of an unusual nature breaks down, e.g. the trained member of staff is absent. Immediate contact with the parent needs to be made to agree alternative arrangements

Refusal to take medicine

If a child refuses to take medicine, staff should not force them to do so, but note this in the records and follow agreed procedures. The procedures may either be set out in the school policy or in an individual child's health care plan (see Form 2 page 55). Parents should be informed of the refusal on the same day. If a refusal to take medicines results in an emergency, the school's emergency procedures must be followed.

Disposal of medicines

Staff should not dispose of medicines. Parents are responsible for ensuring that date-expired medicines are returned to a pharmacy for safe disposal. They should also collect medicines held at the end of each term. If parents do not collect all medicines, they should be taken to a local pharmacy for safe disposal. Sharps boxes should always be used for the disposal of needles. Sharps boxes can be obtained by parents on prescription from the child's GP or paediatrician. Collection and disposal of the boxes should be arranged with the district council's environmental services.

Storage

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

Children should know where their own medicines are stored and who holds the key. All emergency medicines, such as asthma inhalers and adrenaline pens, should be readily available to children and should not be locked away. Many schools allow children to carry their own inhalers. Other non-emergency medicines should generally be kept in a secure place not accessible to children. A few medicines need to be refrigerated. They can be kept in a refrigerator containing food but should be in an airtight container and clearly labelled. There should be restricted access to a refrigerator holding medicines. Local pharmacists can give advice about storing medicines.

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

The supply, possession and administration of some medicines are controlled by the Misuse of Drugs Act. Some controlled drugs may be prescribed as medication for children. A member of staff may administer a controlled drug to the child for whom it has been prescribed. Staff administering medicine should do so in accordance with the prescriber's instructions. A child who has been prescribed a controlled drug may legally have it in their possession. It is permissible for schools to look after a controlled drug where it will be administered to the child for whom it has been prescribed. Schools should keep controlled drugs in a locked non-portable container and only named staff should have access. A record should be kept for audit and safety purposes. A controlled drug, as with all medicines, should be returned to the parent when no longer required to arrange for safe disposal (by returning the unwanted supply to the local pharmacy). If this is not possible, it should be returned to the dispensing pharmacist (details should be on the label). Misuse of a controlled drug, such as passing it to another child for use, is an offence. Schools should have a policy in place for dealing with drug misuse.

General issues

Medical accommodation

The Education (School Premises) Regulations 1999 require every school to have a suitable room that can be used for medical or dental purposes and for the care of pupils during school hours. The area, which must contain a washbasin and be reasonably near a toilet, need not be solely used for medical purposes but should be readily available when needed. Adequate space and facilities should be maintained so that health care staff can undertake their work in a professional and dignified manner.

Medi-alerts

Some children wear bracelets or necklaces which alert others to their medical condition in an emergency. As with jewellery, these items are a potential source of injury in games or certain practical activities. In appropriate circumstances they should be covered with sweatbands or removed temporarily.

Anapens and Epi Pens

To avoid possible breakage it is advisable for anapens and epipens to be kept in a stout container, e.g. old spectacles case.

Impaired mobility

Providing the approval of the GP or consultant has been given, there is no reason why children wearing plaster casts or using crutches should not attend school. Restrictions will be necessary on games or practical work to protect the child or others. Similarly, some relaxation of normal routine in relation to times of attendance or movement around the school may need to be made in the interests of safety.

Sporting activities

Most children with medical conditions can participate in physical activities and extra-curricular sport. Flexibility will allow all children to participate in ways appropriate to their own abilities. For many, physical activity can benefit their overall social, mental and physical health and well-being. Any restrictions on a child's ability to participate in PE should be recorded in their individual health care plan. All adults should be aware of issues of privacy and dignity for children with particular needs. Some children may need to take precautionary measures before or during exercise and may also need immediate access to their medicines, such as asthma inhaler. Staff supervising sporting activities should consider whether risk assessments are necessary for some children, be aware of relevant medical conditions and any preventative medicine that may need to be taken and emergency procedures.

Off-site activities and educational visits

Please see HCC guidance on off-site activities and educational visits

A medical condition must not be seen as an automatic barrier to joining an off-site activity or educational visit. The challenge is to make these activities available to all those who want to participate whilst maintaining the safety of all concerned, the integrity of the activity and the ability to manage the visit or venture. Further information is available in 'Off-site activities and educational visits' or direct from the Outdoor Education Unit.

Home to school transport

Most pupils with medical needs do not require supervision on school transport but in some cases trained escorts will be necessary. Guidance should be sought from the child's GP or paediatrician. Drivers and escorts should know what to do in the case of a medical emergency. They should not generally administer medicines but, where it is agreed that a driver or escort

will administer medicines e.g. in an emergency), they must receive training and fully understand what procedures and health care plan to follow. They should be clear about roles and responsibilities. Where pupils have life-threatening conditions, specific health care plans should be carried on vehicles. Schools will be well placed to advise the local authority and its transport contractors of particular issues for individual children. Individual transport health care plans will need input from parents and the medical practitioner for the pupil concerned. The care plans should specify the steps to be taken to support the normal care of the pupil as well as the appropriate responses to emergency situations. Some pupils are at risk of severe allergic reactions. Risks can be minimised by not allowing anyone to eat on vehicles.

Employees' medicines

Employees may need to bring their own medicine into school. They have a clear personal responsibility to ensure their medicines are not accessible to children.

Staff protection

Practical and common sense hygiene precautions will minimise the risk of infection where contact with blood or other body fluids is possible (see page 13). Should cross infection be suspected, medical advice must be immediately sought.

Staff indemnity

Hampshire County Council fully indemnifies its staff against claims for alleged negligence providing they are acting within the scope of their employment. For the purposes of indemnity, the administration (or supervision of self-administration) of medicines falls within this definition and hence staff can be reassured about the protection their employer provides.

The indemnity would cover the consequences that might arise where an incorrect dose is inadvertently given or where the administration is overlooked. In practice, indemnity means the County Council and not the employee will meet the costs of damages should a claim for alleged negligence be successful. It is very rare for school staff to be sued for negligence and instead the action will usually be between the parent and the employer.

Medicines likely to be brought into or used at school

Non-prescribed medicines

Parent supplied

Parents may wish to send children to school with medicines, such as cough mixtures. Generally speaking, schools cannot be expected to take responsibility for medicines of this nature.

School supplied

Age-appropriate doses of paracetamol may be given to secondary-age children as described on the packet. If possible, contact should be made with the parent before administration but, as a minimum requirement, staff should ask the pupil whether he or she has taken any medication that day. If so, paracetamol should not be administered without parental consent. A child under 16 must never be given aspirin or medicines containing Ibuprofen unless prescribed by a doctor. Other medicines should not be purchased by schools except by agreement with the school doctor.

Prescribed medicines

Antibiotics

A child taking antibiotics can recover quickly and be well enough to attend school but it is essential that the course of treatment is completed.

Inhalers

A child with asthma may have an inhaler, which may need to be used regularly or before exercise, or when the child becomes wheezy. If the school and parent feel that the child is capable and responsible, the child should look after and carry his/her own inhaler marked with his/her name.

Cases should be considered individually in consultation with parents, the school doctor or nurse as necessary. The medical profession has confirmed that inhalers are very safe and it is unlikely that a child using another child's inhaler will come to any harm.

Enzyme additives

A child with cystic fibrosis may not be able to digest food without added enzymes. It is important that the child has a pancreatic

supplement (normally Creon) with food. This is not a drug and many children need several capsules at a time. These are entirely safe if taken, accidentally, by another child.

Maintenance drugs

A child may be on medication (e.g. insulin) for a condition that requires a dose during the school day. A health care plan could be helpful in these circumstances see Form 2 (page 55).

Form 1: Administration of medicines/treatment consent form

School name: _____

Child's name: _____

Child's address: _____

Parents' home telephone no: _____

Parents' work telephone no: _____

Parents' mobile telephone no: _____

Name of GP: _____

GP telephone no: _____

Please tick the appropriate box:

My child will be responsible for the self-administration of medicines as directed below

I agree to members of staff administering medicines/providing treatment to my child as directed below or in the case of an emergency, as staff may consider necessary

I recognise that school staff are not medically qualified

Signed (parent/carer): _____

Date: _____

Name of medicine	Dose	Frequency	Completion date of course (if known)	Expiry date of medicine

Special instructions:

Allergies:

Other prescribed medicines:

Form 2: Health care plan

Name of school/setting: _____

Child's name: _____

Group/class/form: _____

Date of birth: _____

Child's address: _____

Medical diagnosis or condition: _____

Date: _____

Review date: _____

Family contact information

Name: _____

Home telephone no: _____

Work telephone no: _____

Mobile phone no: _____

Clinic/hospital contact

Name: _____

Telephone no: _____

GP _____

Name: _____

Telephone: _____

Describe medical needs and give details of child's symptoms

Daily care requirements, e.g. before sport/at lunchtime

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

Follow-up care

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

Form copied to

Form 3: Record of prescribed medicines given to a child in a school

Child's name: _____

Date of birth: _____

	Date	Time	Medicine given	Dose	Signature
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Form 4: Staff training record

Procedure to which training applies

Instructor Signature

(Print Name)

Designation _____

Date _____ Review Date _____

I have received instructions, written and verbal to enable me to carry out the above Procedure.

I understand the procedure and feel confident to carry out the procedure unsupervised.

I understand the actions required in the event of problems occurring during or after the procedure.

Date	Name	Designation	Signature

Form 5: Contacting emergency services

Request for an ambulance:

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

Your telephone number:

Your location as follows (insert school/setting address):

State that the postcode is:

Give exact location in the school/setting (insert brief description):

Your name:

Name of child and a brief description of child's symptoms:

Inform ambulance control of the best entrance and state where the crew will be met

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

Keep a completed copy of this form by the telephone

Meningitis

Meningitis is a disease that frightens parents, carers and all those working with children. There are several forms of the disease, including the ones listed below. School staff should seek urgent medical attention and contact parents if the disease is suspected. It is difficult to differentiate the more serious forms in the early stages so prompt specialist advice is essential. Spotting and treating the disease early is extremely important.

Common signs and symptoms of meningitis and septicaemia

Babies	Children and Adults
Fever - cold hands and feet	Fever – cold hands and feet
Refusing food or vomiting	Vomiting
Fretful or dislike being handled	Headache
Pale blotchy skin	Still neck
Blank, staring expression	Dislike of bright lights
Drowsy, difficult to wake	Joint or muscle pain
Stiff neck, arched back	Drowsy, difficult to wake
High-pitched cry	Confusion

Immunisation against Meningitis C, Haemophilus influenza type B and pneumococcal infection are included in the routine childhood immunisation programme.

Viral meningitis

Viral meningitis is one of the most common forms. Early symptoms and signs of viral meningitis are much the same as other forms. Although it can be an unpleasant disease, viral meningitis almost always gets better with no after effects. There is no particular treatment, so sufferers simply receive support for their symptoms until they get better. There is no preventative treatment either and the infection almost never spreads from person to person. Affected cases can return when clinically well.

Hib (Haemophilus influenza B) meningitis

Hib (Haemophilus influenza B) meningitis is another form of meningitis which is nearly always confined to pre-school children. It has been controlled by the Hib immunisation which all children are offered in infancy. Cases are now extremely rare. The health protection team will give advice on any action needed for

household contacts. There is no reason to exclude siblings and other close contacts of a case from the school setting.

Pneumococcal meningitis

Pneumococcal meningitis is more common in younger children and is caused by one of the bacterial groups that also cause pneumonia. The early symptoms are generally the same as for other forms of meningitis. Urgent medical attention is needed. A routine childhood immunisation against pneumococcal meningitis has been introduced. There is no reason to exclude siblings and other close contacts of a case and further linked cases practically never occur in schools.

Meningococcal meningitis and Meningococcal septicaemia

Meningococcal meningitis, along with the blood poisoning variation Meningococcal septicaemia, are serious diseases that can be fatal. They may begin with the same symptoms as the other forms but there may also be a reddish-purple rash that does not blanch (whiten) if you apply pressure. One way of testing this blanching is to press a clean glass on the rash; if the rash stays reddish/purple through the glass then it is more likely to be a significant rash. Urgent medical attention is needed. (NB: not all cases have a rash. Early warning symptoms can also include cold hands and feet, joint and muscle pains and mottling of the skin.) This form of the disease does not spread easily from person to person but on very rare occasions, instances have been reported.

All cases of meningitis, whatever the cause, must be notified to the local health protection team who will decide what action needs to be taken. For meningococcal infection, increasing awareness of the symptoms is advised so that other cases may be identified early in the unlikely event that linked cases occur. For meningococcal cases it is necessary to treat those who have been in very close household-type contact. The health protection team will advise the school if any action is needed.

Action within a school is likely to be needed if linked cases of meningococcal infection occur. This is when two people who are in contact with each other, both have meningococcal disease. Initially, it may not be known if the two cases have the same or different strains of bacteria. In addition, both patients have to have this infection within a specified period of time. It is only in this uncommon combination of circumstances that mass treatment is required. Treatment consists of antibiotics.

Health services have action plans to deal with contact treatment of mass treatment, should either or both be required.

There is no reason to exclude siblings and other close contacts of a case from the school setting.

Useful public information (leaflets, general helplines)

Meningitis Trust	01453 768000 0800 028 1828 helpline http://www.meningitis-trust.org.uk
Meningitis Research Foundation	01454 281811 0808 800 3344 helpline http://www.meningitis.org
NHS Direct	0845 4647 (public number)

Menstruation

All schools should make clear to girls aged nine and above the arrangements for an unexpected period, for example, which member of staff to go to and how sanitary protection should be disposed of, as it is quite often the practical aspects of periods that upset girls most. It is also helpful to make this information available during off-site and residential activities. More and more girls and young women are happy to use tampons and need not miss PE, swimming or other activities, but this is far from universal and a sympathetic but practical attitude to these activities is needed. Girls may use periods as an excuse to avoid PE, but others may have genuinely heavy or frequent periods. If the girl is missing a lot of PE, then a female member of staff should discuss the difficulty, speaking to the parent if necessary and with the girl's permission. Period pain should also be treated with sympathy, though in most cases over-the-counter analgesics will provide relief (see page 52). If they do not, then the girl should be encouraged to see her GP.

Molluscum contagiosum

Molluscum contagiosum is another mild disease that presents as small, blister-like nodules, often on the trunk. As transmission to others tends to take place before symptoms appear, the child need not be absent from school if otherwise well.

MRSA

No exclusion is necessary. Good hygiene, in particular handwashing and cleaning, will minimise the spread of this infection. The health protection team can give further advice if required.

Mumps

Mumps is preventable through routine childhood immunisation. A child with mumps should be off school for five days from the onset of swollen glands but may then return as soon as well enough.

The disease is notifiable, so parents should be advised to report symptoms to the child's doctor.

Nutrition

The content of school meals is subject to minimum nutritional requirements, but schools should be alert to the standard of meals provided within their establishment and take action if there is any concern. Children should be given adequate time to eat their meal - some children are just naturally very slow. If a child persistently eats very little, the concern should be discussed with the parents. Schools should also help children understand the importance of a healthy diet through the curriculum, for example in PSE and PE.

Periods – (see Menstruation page 62)

Pervasive developmental disorder (PDD)

See also HCC guidelines: The Autistic Spectrum – approaches to facilitate inclusion in mainstream

This broad term is often used to include conditions related to autism. It suggests a significant delay in a range of developmental skills, but always includes a delay in social communication skills. An unqualified diagnosis of autism tends to be used for children with the most severe disorder, although to some extent, its use depends on the doctor or team who assess the child. Other children are described as being on the autistic continuum or as having features compatible with the autistic spectrum. Primarily, these features are poor responses to other people, that is poor communication and poor social development. They may be associated with intellectual impairment and unusual and repetitive behaviour. The condition is usually noticed early in life.

Asperger's syndrome suggests a much lesser degree of intellectual impairment. It is generally noticed and diagnosed later than the other forms of PDD because the child's intellectual ability masks his or her other difficulties. These conditions are more common in boys.

Physical disabilities

See HCC guidelines 'Services for disabled people and their carers'.

Pregnancy

Additional advice obtainable from the Social Exclusion Unit (Cabinet Office)

Generally, there is no medical reason why a girl experiencing a normal pregnancy should not remain at school, including joining in PE and games. This should be the normal expectation. She may need to stop attending towards the end of her pregnancy on the advice of her midwife or GP. Specific medical problems in pregnancy may mean school is inadvisable at an earlier stage.

See also: Managing the support and reintegration of pregnant pupils and school parent HCC 2004

The Government's Teenage Pregnancy Strategy (1999) requires that girls are supported in remaining in school and continuing their education after their baby is born.

Pregnant women may be especially vulnerable to infectious diseases and should be made aware of the guidance relating to chickenpox, German measles and slapped-cheek disease. They may also wish to seek advice from their own practitioner if they are in contact with any other infectious disease.

Principles of consent for treatment

Administering medicines at school

See pages 43 to 59 for information on the administration of medicines at school.

Contraception, termination of pregnancy and substance misuse

Young people who consult either teaching or medical staff on these issues may request that their parents are not informed. Staff need to act in the best interests of the child and within the law. If the guidance below is followed these objectives will be met.

Legal parameters were established by the Law Lords in the Gillick judgement in 1985. The Law Lords said a girl under 16 could consent to contraceptive treatment without obtaining parental approval provided she was sufficiently mature, both emotionally and intellectually, to understand its nature and implications. The concept is also applied to other types of medical care.

The decision about medical care rests with the medical professional and not school staff. The medical professional has to judge whether the child is '*Gillick competent (Frazer competent)*'. The role of school staff is to encourage and help the young person to get professional advice.

In practice this is likely to include:

- providing information about where the advice can be obtained (see below)
- facilitating the contact by making a private telephone available
- checking that the appointment was kept.

Schools should clarify the procedures so that teachers know which senior member of staff they should contact to discuss their concerns about a young person. The decision whether to contact parents should be made by the headteacher, not individual teachers. Current guidance from the DfES states that parents should be informed. However, there may be instances where a headteacher decides that this would not be in the best interest of the young person (Children Act, 2004).

Whilst medical staff will encourage a competent young person to inform parents, they will not involve the parents without the express consent of the young person.

Young people who do not have the capacity to make their own medical decisions may have consent given for them by anyone with parental responsibility or a court. Once this has been obtained, treatment can lawfully be carried out providing it is in the person's best interests. Advice from the Local Authority, initially the education welfare service, should be sought in these cases.

Confidential notes should be made of discussions with young people on these issues.

Professional advice is obtainable from:

- GP
- school health service
- family planning clinic
- sexually transmitted diseases clinic
- drug and alcohol advisory service
- Relateen (general counselling service for young people).

Guidance is also available on the Internet site for the national Healthy Schools Programme for secondary pupils Key Stage 3 www.lifebytes.gov.uk and Key Stage 4 www.mindbodysoul.gov.uk, 'Wired for Health' www.wiredforhealth.gov.uk and Hantsnet.

Emergency medical treatment

When emergency medical treatment is required for injury or illness it is preferable for parents to come to school to reassume responsibility for their child. If it is obvious that hospital treatment is necessary, e.g. broken limb, an ambulance should be called immediately and parents contacted soon afterwards. Children should not be left alone at hospital for any length of time. The best way of ensuring this does not occur is for a member of staff to accompany a child in the ambulance or follow in a car. If neither is feasible, telephone contact with the hospital is most important so that the school can be sure that the parents have arrived. When a child is taken to a hospital or medical centre by car, a second member of staff should accompany the child if he or she is distressed or likely to require support during the journey.

First aid

See First-Aid provision in Schools page 22

Staff administering first aid do so '*in loco parentis*' and prior consent of parents is not required. If children are reassured and told what is happening, their consent will be inferred. However, refusal to accept treatment for minor injuries must be respected and should be recorded.

Staff should ensure, wherever possible, that another adult or other children are present if they have any doubt that necessary physical contact could be misconstrued.

Outbreaks of infection

Certain infections can pass easily between pupils and staff. These include diarrhoea and vomiting, influenza, infections with a rash. If there is a sudden increase of pupils who are ill with similar symptoms over and above what is a usual expected everyday number for the school, or several pupils/staff ill with symptoms who are connected in some way, e.g. same class, same group, same food, you should keep a log of these pupils reported ill with symptoms and dates of onset. Report to school health service, local authority (health and safety) and local health protection team.

Rashes and skin diseases

It is sometimes difficult to identify illnesses by their rashes. Schools should advise parents to seek medical advice if a child is unwell, whether an identifiable rash is present or not.

Reduced immunity

Reduced immunity in adults and children may mean they are especially vulnerable to infectious diseases. Reduced immunity may be caused by cancer and cancer treatment, high doses of steroids (for example oral steroids for severe asthma or some kidney diseases) and certain deficiencies of natural immunity. Schools should be aware of children who fall into these categories.

Ringworm (tinea)

Ringworm (tinea) occurs in different forms on different parts of the body but may be suspected by scaly round lesions. Ringworm of the scalp may cause the child's hair to fall out. The child should be kept away from school until treatment has commenced. Also check and treat pets.

Roseola

Roseola is a mild viral illness. The child may have a high temperature and a red rash. The child should be off school if unwell but need not be excluded to protect others as transmission tends to take place before symptoms appear.

Scabies

Scabies is caused by a mite that burrows under the skin and produces redness and itching. This classically occurs between the fingers but may also affect the wrists, elbows, armpits and back. The child should be off school until after the first treatment. A second treatment is necessary one week later. Treatment usually includes the child's household contacts. Further information can be obtained from the health protection team.

Scarlet fever

Scarlet fever is a complication of an uncommon form of tonsillitis. The child requires antibiotic treatment and should be kept away from school for five days after the start of the antibiotic treatment. Unaffected contacts do not require treatment.

Self-injury

Most staff in secondary schools will be aware of young people who cause themselves deliberate harm. The risk of self-harm is age-related, but increasingly younger children may deliberately hurt themselves as an expression of their distress or depression. Attempted suicide and wrist-slashing are perhaps the best known

forms of deliberate self-harm, but children and young people may injure themselves in a variety of other ways. There is a significant difference between the number of young people who appear to attempt suicide and those who succeed in killing themselves. However, deciding which young people are a significant suicide risk is a complex process and requires an expert professional opinion. Even in those young people who self-harm without really wishing to kill themselves, the problem is rarely straightforward attention-seeking.

Deliberate self-harm may be associated with problems at home, abuse, depression or substance abuse. There may be links with eating disorders. The young person may be aggressive and impulsive and, as with most of the other mental health disorders, they tend to have low self-esteem.

School staff should be alert to such problems, but, as for depression, it is wise to seek the advice of senior staff, via whom the problem can be brought to the attention of parents and relevant professionals. A supportive school environment is an essential addition to any therapy and/or treatment that Child and Adolescent Mental Health Services may provide.

Sensory and developmental problems

Children with developmental difficulties often have complex special needs. Needs are very individual and school staff should note specific details about each child. Parents, the professionals involved, the child's documents and more detailed literature should be consulted. It is essential that staff, who may have limited knowledge about the conditions, talk to parents about concerns without using the specific labels for the conditions. Many of these conditions overlap and may also share some characteristics with other, less common, conditions. For many children, a suggestion that he or she has one of these conditions before a thorough assessment has been carried out, causes great anxiety and difficulties between the carers and other professionals involved. It is also very important not to make assumptions about individual children, based on experience of other children as their needs can be so diverse.

Sexually transmitted infections (STI)

See also DfES guidelines: sex and relationship education guidance

There has been an increase in diagnosis of sexually transmitted diseases in teenagers in the UK. Secondary schools are required to include education about STIs in their sex education programme and discussion may form part of the PSE curriculum.

Symptoms vary according to the cause of the STI and its severity, but in girls may present as discharge, itching, pelvic pain or frequency of urination. Boys may get a discharge or irritation. Sometimes, however, STI can be symptomless and this is particularly true of HIV and Hepatitis B. If the young person is at risk of STI from intercourse without a condom, especially if the partner was at higher risk (homosexual or bisexual man, from sub-Saharan Africa or South East Asia, known carrier, intravenous drug user) then they should attend the genito-urinary medicine (GUM) clinic or GP as soon as possible. Although some diseases cannot be prevented, others can be, and nearly all have a better outcome if diagnosed early and treated.

Health promotion departments and GUM clinics will have up-to-date leaflets on the diseases.

Sharps disposal

Care needs to be taken regarding disposal of sharps where these have to be used in school (e.g. syringes for diabetics). Guidelines are available from the school health service or the local environmental health department. Sharps should be discarded straight into a sharps bin conforming to BS7320 and UN3291 standards. Sharps bins must be kept off the floor (preferably wall-mounted) and out of reach of children.

Shigella (see Diarrhoea page 19)

Slapped-cheek disease (Parvovirus B19)

Slapped-cheek disease is characterised by a fever and bright red cheeks. It is also known as *Fifth disease or erythema infectiosum*. The child may be in school if well enough as transmission tends to take place before the child shows any signs of the disease. No treatment is required. Pregnant women in contact with this disease in the first 20 weeks of pregnancy should inform the professional responsible for their antenatal care promptly, even though risk to the baby is very low.

Smoking

See also
HCC
guidelines:
Smoke-free
Environment
for Schools

The hazards of smoking are now well known but smoking amongst teenagers, and girls in particular, is continuing to rise. The issues may be addressed in PSE. Young people are influenced by example. Health promotion departments have audio-visual resources and written literature on smoking and young people.

Speech and language disorder

Speech and language disorders are increasingly recognised as learning impairments. Speech impairments are recognised most readily. They may consist of mispronunciations, substituting one letter sound with another and lack of speech tone, which makes it difficult to distinguish one word from another. Causes include poor tongue or palate movements, cleft lip or palate and poor hearing. In general, simple speech impairments do not require speech and language therapy. It is more likely to be useful where the child's speech is unintelligible.

See also HCC
guidelines: Drug
Matters -
guidelines for
schools

Language disorder is more difficult to identify. Receptive language disorder means that children cannot understand the language they hear around them although their words may sound normal. In expressive language disorders, the child understands language appropriate for their age but are unable to respond. Some children have both receptive and expressive disorder.

Semantic-pragmatic disorder means that a child can only understand and use the literal meanings of words (though this is a simplified explanation). They will be unable to see hidden meanings in words and phrases, for example, they will be unable to understand sarcasm or jokes. The child will often have difficulties with social communication. Mild problems may go undetected, though the child may find it difficult to make friends. If a child has a severe problem, communication through normal conversation will be close to impossible. Many professionals believe the semantic-pragmatic disorders to be part of the autistic continuum, although this is still debated.

Substance misuse

Substance misuse may be of tobacco, alcohol, illegal drugs, prescribed or over the counter medication or solvents. All schools are required to have a drug education programme as part of their PSE provision and also a policy describing how they will respond to drug-related incidents. This important issue is fully explained in Drug Matters - guidelines for schools (HCC 1995).

If first aid is required and substance misuse is suspected, the health and safety of the pupil is paramount and questions about the circumstances should be left until later. If there is evidence of substance misuse, such as pills, alcohol, suspected illegal drugs, then these should be placed in a secure container and shown to medical staff on arrival at hospital.

Sun-care

A little sunshine is good for both psychological and physical health as it stimulates the production of certain natural chemicals in the body. However, too much sun can lead to premature ageing of the skin and has also been implicated as a major factor in causing skin cancer.

There are some basic rules for safe sun-care:

- check the weather forecast and the predicted sun power, which is given in relation to different types of skin
- judge the sun power for a group of children in relation to the fairest and most vulnerable child in the group
- take particular care between 11am and 3pm
- provide shade during breaks and encourage its use
- encourage children to wear light, long-sleeved, full-length clothes, especially in the absence of shade
- encourage the use of hats or caps, particularly with a neck cover
- make sure children have plenty of opportunities to drink
- see also HCC guidelines: Safety in Physical Education
- encourage use of sun blocking creams at factor 25+. Application should essentially remain a parental responsibility. A good quality sun cream applied before school should give protection through to lunchtime. Parents can check the package for duration of effect. Children who are old enough can apply their own cream and schools may like to facilitate this with a reminder. Schools should be wary about applying cream to large groups of children, as the cream chosen may be unsuitable for some, the process takes a very long time and parents may be concerned about the physical contact if their prior approval is not sought. Exceptional arrangements for children with particular problems, for example, photosensitivity due to medicines or conditions, may be negotiated with the parents.

Threadworms

See Health precautions page 36

Threadworms are small, white, thread-like creatures that may cause itching, discomfort or even pain around the anus, sometimes extending to the vulva in girls. The worms tend to be more active and cause more symptoms at night. Children should see their GP for treatment and advice. Although the risk of transmission is very small, it can be reduced by good personal hygiene. Treatment is recommended for the child and family.

Tonsillitis

Tonsillitis is common, often caused by viruses and rarely needs any treatment (see Scarlet fever, page 67, for an exception). The child may return to school as soon as well enough.

Travel

**See also HCC
guidelines: off-site
activities**

Please see guidance available in the off-site activities regulations and guidance notes. Additionally, if a school party is travelling abroad it is essential to check out the health precautions at the booking stage and to advise pupils and parents to seek advice a minimum of three months before they go. Complicated immunisation schedules cannot be arranged at short notice.

Tuberculosis (TB)

Tuberculosis (TB) is uncommon. Not all cases are infectious to others and those that are need prolonged close contact to pass it on. Adults and children diagnosed with TB are notified to the consultant in health protection who will arrange any further action required.

Upper respiratory tract infection

Such infections, including colds and sore throats, do not necessarily require antibiotics or absence from school.

Visual impairment

Even mild degrees of visual impairment, long or short sightedness, can affect a child's learning. A child who cannot see the shared text in literacy hour suffers a significant disadvantage. In the classroom, the child with poor vision may fidget and try to move closer all the time, or may stop concentrating. Work may be untidy or he or she may crouch down over the paper. The school nurse is likely to be the first line for assessment after the parents. Glasses can correct most of these difficulties.

There are also less common visual difficulties. A squint or turning eye can lead to poor distance vision, as judgement of distance and space depends on two functioning eyes. These children should have specialist assessment.

Children with partial sight, or those who are blind, will have the services of the Advisory Teacher for the Visually Impaired. There are many causes for this, for example, congenital cataract (though

this can often be corrected surgically to some degree), nystagmus (or rapid eye movements), and visual field defects (where children have part of their visual field blanked out). As the causes are very diverse, each child should have an individual plan for managing the impairment.

Vulnerable children and staff

Pregnant women, and adults and children who have reduced immunity, may be especially vulnerable to infectious diseases. Pregnant women should be made aware of the guidance relating to chickenpox, measles, German measles and slapped-cheek disease. Reduced immunity may be caused by cancer and cancer treatment, high doses of steroids (for example oral steroids for severe asthma or some kidney diseases) and certain deficiencies of natural immunity. Schools should be aware of children who fall into these categories.

Warts and Verrucae

These are caused by a virus that enters feet that have minor injuries to the skin. It has a very low incidence of cross infection. Approximately 2% of school children have plantar warts at any particular time. If these warts cause pain the child should be referred to their family practitioner. There is no need to exclude the child from swimming or other bare-foot activities but verrucae should be covered. It is important that all children should learn to swim and children should not be denied access to swimming pools on account of verrucae.

Whooping cough (Pertussis)

Whooping cough (Pertussis) is a severe disease in young children but is prevented by immunisation. When the disease strikes, the child needs to be treated with antibiotics and, if well enough, may return to school five days after antibiotics have begun. The cough may persist for weeks. The health protection team can advise on any action needed for household contacts but usually no action is needed for school contacts.

Acknowledgements

The advice is taken from:

Department of Health (DoH), Department for Education and Skills (DfES), Public Health Laboratory Services (PHLS) *Guidance on infection control in schools and nurseries 1999*, Health Education Authority leaflets.

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