Making a difference where you live

COTHERSTONE PRIMARY SCHOOL

MEDICINES IN SCHOOLS

HANDBOOK AND RESOURCES FILE

CONTENTS

ACKNOWLEDGEMENTS

Members of the Working Party were:-

Durham County Primary Head Teachers Association members

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- Pat Barker
- Anne Firth
- Pat Henderson
- Peter Nelson
- Gill Wray

Durham Local Education Authority member

- John Bowman
- Gail Naylor

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- The Anaphylaxis Campaign, P.O. Box 149, Fleet, Hampshire

Thanks are also due to Mr. Keith Mitchell, Director of Education who gave the project his full support.

INTRODUCTION

This handbook has been produced to advise Head Teachers and Governing Bodies on the development of policies related to supporting pupils in school with special medical needs and to help schools put an effective and safe Medication in School policy into practice.

Medication in School can be a difficult issue and the guidance in this handbook addresses the problems that schools may face in supporting children with both **short-term medical needs** and **special medical needs** such as Asthma, Anaphylaxis, Diabetes and Epilepsy. It is not intended that it should replace handbooks of specific medical advice, such as the Asthma Handbook, which have been issued to schools. Should a school admit a child with a particular medical condition it is expected that Head Teachers will consult such advice.

The guiding principle has been the need to offer ***practical advice*** that is ***medically sound***, *has* ***LEA approval*** and is ***legally 'safe'***.

Head Teachers work under enormous time pressures and though there is merit in creating personalised documents and protocol in relation to school issues there is also a danger that something crucially important may be overlooked. When the issue is a medical one, this could literally mean the difference between life and death. With that in mind this document includes specimens of policy, protocol, forms and letters that fulfil the requirements set out in the above paragraph. It also includes a flow diagram to give Head Teachers a systematic course of action and a check list.

The development of this document has influenced the way in which medication issues are considered at LEA level. Suggested changes to Admission Forms if adopted will make it easier in future to prepare for the admission and help of children with special medical needs. It will make possible the collation of centrally held data and the development of ongoing support for Head Teachers who require it.

We hope, too, that we might more easily put schools in touch with each other to share experience and by so doing improve the guidance available.

Dealing with medication questions will never be easy but if this document helps make the process easier, safer and more effective then it will have succeeded.

KM/GP/SA
0191 383 3115
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the Director

January 2004

Dear Head Teacher

Medicines in Schools : Handbook and Resource File

The administration of medicines in schools can be a straightforward matter, but equally it can present difficulties:

- for staff in schools, because they may be unsure about the nature of the medical condition the pupil is presenting; uncertain about their legal position regarding their administering medicines to pupils and concerned about the general plan for supporting and sustaining the meeting of the pupils' medical needs in school;

- for parents who wish for the pupil to be attending school but are concerned about their having necessary medicines and procedures administered to them;

- for children who have medical needs in school but want them to be met directly, safely and correctly by someone they know and trust.

Promoting Inclusion is a priority of both the Government and the County Council. Legislation including the Disability Discrimination Act and the Special Needs and Disabilities Act require that pupils must not be discriminated against because of disability and that pupils with special educational needs are provided for in mainstream schools where possible. It is inevitable therfore that schools will have on roll some children with learning, behavioural, physical and medical difficulties. Teachers and other school-based staff have a duty to act as any reasonably prudent parent would to ensure the health and safety of pupils in school. This duty can extend to administering medication and/or taking action in an emergency. Section 3(5) of the Children Act 1989 provides scope for school based staff to act reasonably for the purpose of safeguarding or promoting pupils' welfare.

This Medicines in Schools Handbook was originally developed by a group of Head Teachers, in liaison with others, because they felt they needed information, guidance and practical documentation to manage the administration of medicines in their schools and was developed into a Handbook because they believed that what they had learned could be shared with other schools and colleagues. This updated handbook builds upon this good practice, and also includes information contained in sessions arranged by the LEA on how to administer medication in schools. It has been developed therefore from good school practice and tried and tested in a variety of County Durham Schools.

This clearly written, informative and very practical Handbook will help schools manage the administration of medicines legally and safely, provide information about medical conditions in schools and enable schools to develop the best and most appropriate monitoring and recording systems in rleation to pupils with medical needs in schools

Yours sincerely

MEDICINES IN SCHOOLS: HANDBOOK AND RESOURCES FILE - DISCLAIMER

This handbook and resource file is not offered as an authoritative medical text relating to the medical problems young people may experience in school: it is simply presented as a guidance resource, designed to help schools manage and support, in close liaison with parents/carers and medical professionals (as appropriate), the medical health problems which young people may present in school.

All of the information and guidance has been offered in good faith, based on good practice developed in County Durham schools. It should not of course replace specific medical advice/guidance already provided by the LEA or medical professionals, (nor should it be seen as a substitute for the seeking of such), it simply supports such, and provides a practical framework for the management in school of such matters.

Whilst a number of medical professionals were consulted in the process of producing this handbook, it does not represent all of their views. In addition, information relating to these matters published in this handbook may have become or may become out of date. However the Working Party of the Durham County Primary Head Teachers' Association who produced this handbook, in liaison with the LEA will endeavour to provide updates and/or replacement sections for this handbook to ensure that information in the handbook is kept as up to date as possible.

Irrespective of the detailed information contained in the handbook, the important principles of planning; working with parents, medical professionals and other relevant people, and recording information and actions will remain constant.

SECTION ONE

DURHAM COUNTY COUNCIL

EDUCATION AUTHORITY

GUIDELINES ON THE ADMINISTRATION OF MEDICAL TREATMENT IN EDUCATIONAL ESTABLISHMENTS

1. INTRODUCTION

1.1 Increasing concern has and continues to be expressed about the procedures which should be followed in educational establishments in connection with the administration of medications/treatments in particular those prescribed by registered medical practitioners. Whilst there are certain exceptions where it is specifically written into their job descriptions the administration of medication is not a normal occupational duty of staff and this should only be undertaken by special agreement. In some instances appropriate training may be deemed to be necessary before medical treatment is administered. These need to be identified and suitable arrangements put in hand which ensure the staff concerned have been provided with any necessary instruction, including the use of protective clothing and/or equipment.

1.2 Whilst the administration of medical treatment is ultimately a matter for determination by the management of each establishment it is expected that all establishments will benefit from guidance by the Local Education Authority in this matter and these guidelines have been formulated in order to assist Governing Bodies in producing their policies and Head Teachers and those in charge of establishments in implementing them.

1.3 These guidelines refer to the administration of medications/treatments in all of the Authority's educational establishments. They refer to the administration to pupils by school/establishment based staff of medications prescribed by registered medical practitioners and the self-administration of medications by pupils.

1.4 The Local Education Authority is aware that there is potential for conflict between the aspirations of parents of pupils who may require medical treatment on educational premises and the organisational needs of establishments. It is, however, of the firm view that in every case the interests of the pupils are paramount.

2. RESPONSIBILITIES

2.1 Local Education Authority

2.1.1 It is the responsibility of the Local Education Authority to make sure that arrangements are put in hand aimed at ensuring that all reasonable and practical steps are taken by its establishments to safeguard their pupils and employees.

2.2 Governing Bodies

2.2.1 It is the responsibility of Governing Bodies to ensure that all reasonable and practical steps are taken to safeguard the health and safety of pupils when they are authorised to be on school or other educational premises or when they are engaged in authorised activities elsewhere. Governing Bodies are responsible for determining detailed policies for their own establishments and providing appropriate facilities and staff training, where deemed necessary to ensure that their policies are carried out.

2.3 Head Teachers/Heads of Establishments

2.3.1 Head Teachers/Heads of Establishments should:

- ♦ contribute to and support the establishment's policy;
- ♦ ensure that adequate and appropriate procedures are devised in order to safeguard the health and safety of pupils in their establishments;
- ♦ ensure that all members of staff understand and implement the policy and are aware of their responsibilities;
- ♦ assist parents/guardians, pupils and staff in seeking to resolve any problems brought to them in connection with the administration of medications in their establishments; and
- ♦ arrange through the School Health Service for staff training to be provided where this is deemed to be appropriate.

2.4 School/Establishment Staff

2.4.1 All members of staff should ensure that they are fully aware of and act strictly in accordance with the establishment's policy on the administration of medication at all times.

2.4.2 Whilst there are certain exceptions where it is specifically written into their job descriptions the administration of medication is not a normal occupational duty of staff and this should only be undertaken by special agreement. In some instances appropriate training may be deemed to be necessary before medical treatment is administered. These need to be identified and suitable arrangements put in hand which ensure that the staff concerned have been provided with any necessary instruction.

2.4.3 If it is agreed that medication can be administered in the establishment the Head Teacher/Head of Establishment should ensure that all staff involved comply with these guidelines and any School Health Service Guidelines which may be issued from time to time.

2.5 Parents/Guardians

2.5.1 Parents/guardians have the right to be supported in assisting the establishment accommodate their child(ren). Whilst it is preferable for medication to be given at home it is recognised that where medicines are prescribed to be taken three or more times per day it may need to be administered in school or in such other educational establishment. However, wherever possible parents/guardians should assist by asking the prescribing medical practitioner if the administration can occur outside normal school hours.

2.6 **School Health Service**

2.6.1 The School Health Service has an important role in:

- ♦ assisting in the identification of pupils with special medical needs;
- ♦ ensuring that such needs are monitored and reviewed and there is an adequate and accurate flow of information regarding such pupils;
- ♦ ensuring that parents/guardians and schools are kept informed and clearly understand the implications and appropriate responses to identified pupils' health needs; and
- ♦ assisting in the provision of appropriate training and guidance to those staff who work in schools with pupils with special health needs.

3. GENERAL

3.1 The guidelines outlined in Sections 5 to 13 refer to situations where:

(i) it is essential, in the opinion of a registered practitioner, for a pupil to receive medical treatment on school or other educational premises during school hours in order for the pupil to remain at school;

(ii) treatment has been prescribed by a registered medical practitioner;

(iii) the Head Teacher/Head of Establishment or his/her nominated representative has agreed that the administration of such medical treatment can take place; and

(iv) named staff have been identified who have received appropriate guidance, information, instruction and training and where written authorisation has been given by the pupils' parents/guardians.

4. NOTIFICATION TO PARENTS/GUARDIANS

4.1 Head Teachers/Heads of Establishment will need to consider the various methods available to them for communicating their establishment's policy on the administration of prescribed medical treatment together with information having regard to non-prescribed medicines and self-medication by pupils and first-aid provision in the establishment.

A. ADMINISTRATION OF PRESCRIBED MEDICATION

5. AUTHORITY TO ADMINISTER PRESCRIBED MEDICAL TREATMENT

5.1 Written authority must be received from parents/guardians before prescribed medicines are administered. A specimen form to be completed for this purpose by parents/guardians is attached. **Oral messages received via pupils should not be accepted.** Where authorisation is received this should be recorded on the pupil's file and a Medication Record set up and maintained (for details see Section 7).

6. SUPPLIES AND STORAGE OF MEDICINES

6.1 In the interests of safety and security parents/guardians should be requested to ask dispensing chemists to dispense any medicines for administration by school/establishment based staff in specific containers and in such quantities sufficient only for the amount that will be required to be administered during school hours. All such medicines should be brought to the school by the parents/guardians and handed personally to the Head Teacher/Head of Establishment or his/her nominated representative who should check:

- ♦ the security of the container;
- ♦ the labelling to verify the pupil's name, dosage, frequency, duration of course of treatment, date prescribed and expiry date (note - the dosage must comply with the printed label on the packages produced by the pharmacy, if the label of the container is not correct or legible, the container must be returned to the parents/guardians and no administration undertaken);
- ♦ where applicable appropriate measuring devices supplied by the dispensing chemist have been provided.

6.2 Upon receipt of medical supplies from the parents/guardians an appropriate entry should be made in the Medication Record.

6.3 All essential medicines kept at school/other educational establishment should be stored in a suitable clean, cool and lockable storage facility to which only the Head Teacher/Head of Establishment and named staff should have access. This includes inhalers supplied on prescription which may be used for the routine prevention and treatment of asthmatic pupils who are not yet responsible for their own treatment. Where medicines need to be stored at low temperature they could be stored in a plastic container with a lid, in a food refrigerator. The fridge should be in a safe/secure location and the container should have the pupil’s name on the outside.

7. MEDICATION RECORD

7.1 Upon receipt of written authorisation a personal Medication Record should be prepared for each pupil which should identify the following:

Date of authorisation by parents/guardians
Surname
Forename(s)
Date of birth
Class/form
Name of medicine
Formula (e.g. liquid, tablet, ointment, eye drop, etc.)
Dosage
Frequency/time(s)
First date of administration
Projected last date of administration (if known)
Expiry date of medicine (if known)
Medicines returned to parents/guardians/destroyed.

7.2 All doses administered must be recorded. The minimum data requirements should include:

Date of administration
Name of medicine
Time of administration
Dosage
Name of person administering the medicine

8. PRIOR TO ADMINISTRATION OF MEDICATION

8.1 Prior to administering the medication, the named member of staff should check with the pupil his/her name and age against the information contained in the Medical Record and that provided on the container label.

9. ADMINISTRATION OF MEDICATION

9.1 Administration of prescribed medication and treatment to be taken orally in tablet or liquid form.

Specific training is not required and such medication may be administered by a competent named member of staff. It should, however, be administered strictly in accordance with the instructions provided on the container/label as indicated by a registered medical practitioner. Where medicines are to be taken orally individual measuring spoons supplied to the parents/guardians by dispensing chemists should be used.

9.2 Application of Eye and Ear Drops

Few eye and ear drops now come with separate droppers - the plastic bottle acts as its own dropper. If staff are concerned information leaflets can be obtained from local pharmacists..

9.3 **Treatments for Asthmatic Pupils**

The parents/guardians of a pupil who requires such medication and has reached the stage whereby he/she is able to take responsibility for self-administration should:

(a) be encouraged to notify the Head Teacher/Head of Establishment of such a requirement and
(b) supply details of the type of medication, predicted/expected dosage and use.

The administration by staff of treatments for asthmatic pupils who are, for whatever reason, unable to take responsibility for such administration is only authorised by the employing authority if the procedure detailed in 9.4 below is followed.

9.4 **Administration of Prescribed Medicines and Treatments other than those referred to above.**

In each instance before the Head Teacher/Head of Establishment or his/her nominated member of staff accepts responsibility for such administration on behalf of the school reference should be made to the School Doctor or School Nurse. Communication between the three parties should ensure that:

- the need for the administration of such medication is confirmed and fully understood;
- a "Care Plan" is determined for the pupil which is then implemented and monitored; and
- a training programme determined by the School Health Service which meets the needs of the named members of staff is identified and provided.

Note: The School Doctor or School Nurse should be consulted if there is any query or problem with a medication or its administration.

10. AFTER ADMINISTRATION OF MEDICATION

10.1 Before returning to normal duty the named member of staff must ensure that the Medical Record is entered up as appropriate.

11. CHANGES IN COURSE OF TREATMENT

11.1 Where any changes take place to the medication prescribed by the registered medical practitioner written confirmation by the parents/guardians must again be requested. The Medication Record should be amended accordingly by the nominated representative.

12. COMPLETION OF COURSE OF MEDICAL TREATMENT/TERMINATION OF TREATMENT ARRANGEMENT

12.1 Wherever possible any unused medications should be returned personally to the parents/guardians upon completion of the course of medication. The Medication Record should be noted accordingly and returned to the pupil's file. Written confirmation should be sought from the parents/guardians which should be attached to the Medication Record. If, however, Head Teachers are unable to arrange for the parents/guardians to collect any unused medication then it should be returned to any community pharmacy for safe disposal (it does not need to be the pharmacy indicated on the label). A signature should be obtained from the pharmacist who receives the drugs for destruction, in the medication record.

13. END OF TERM

13.1 All agreements/authorisations regarding the administration of medications should expire at the end of each term. If the administration of medication needs to be continued all relevant information must be confirmed in writing at the commencement of the new term or before the new term if continuity of treatment is important.

B. SELF-ADMINISTRATION OF PRESCRIBED MEDICATION BY PUPILS

14. MEDICATION BY PUPILS

14.1 Pupils who are known to carry their own medication and who have received instruction in its application may be responsible for it as and when necessary. However, parents/guardians should be asked to co-operate in ensuring that the establishment is notified of such requirements and that quantities sufficient only for the amount that will be required during school hours are brought onto educational premises.

C. ADMINISTRATION OF NON-PRESCRIBED MEDICINES AND TREATMENTS BY PARENTS/GUARDIANS

14.2 These may range from the taking of a paracetamol tablet or a dose of "cough medicine" to homeopathic tablets for hay fever or the application of a cream/ointment to a wound. Again parents/guardians should be asked to co-operate in ensuring that minimum quantities are brought onto educational premises.

The administration of such medication by staff is not authorised by the employing authority and should not be undertaken.

COTHERSTONE PRIMARY SCHOOL

Dear Head Teacher

Administration of Medication in Educational Establishments

I request that .....……..... (name of child in full) be given the following medication, which has been prescribed by a registered medical practitioner:

..... (Name of medicine)

..... (Dosages)

..... (Methods of administering the medicine)

at the following times during the school day:

.....…….....

.....….....…….....

.....….....…….....

I understand that the medicines must be delivered personally by me to ..... (nominated representative) and that this is a service which is subject to agreement with the school.

Signed .....…..... (Parent/Guardian)

Date ..... 200 .....

Address .....….....

.....….....

.....….....

Notes: (1) Medication will not be administered by the establishment unless this authorisation is completed and signed by the parents/guardians of the pupils.

(2) The Governors and Head Teacher/Head of Establishment reserve the right to withdraw this service.

ISSUES FOR CONSIDERATION BY SCHOOLS

The LEA view on whether or not schools should be involved is absolutely clear and is expressed on page 1 (1.4) of its guidelines:

> *"It is however, of the firm view that in every case the interests of the pupils are paramount".* (Guidelines on the Administration of Medical Treatment in Educational Establishments: Durham LEA - January 1994)

Having taken that 'on board' there are still extremely important issues which need to be considered by the Head, staff and Governors before a decision is reached in respect of the voluntary administration of medicines. Some are listed below:

- Agreeing to administer medicines sets a precedent.
- Qualified support is needed to deal with some medical conditions, particularly chronic ones.
- Teachers should discuss the issue with their professional associations.
- Medical statements, from medical specialists, are required in many cases to establish need.
- There may be difficulties in fulfilling agreements when staff are absent or, for example, on a school visit.
- Members of staff must be indemnified against possible insurance claims.
- Disruption to normal school routine and the education of their children needs to be considered.
- A thorough risk assessment needs to be undertaken in every case/
- Key issues needing particular consideration are:

  (a) Is administration crucial to the welfare of the child?
  (b) How much technical/medical knowledge/expertise is going to be needed?
  (c) Is intimate contact going to be needed?
  (d) Is the treatment invasive?

- No medicines should be administered to children who fall ill during the school day.

COTHERSTONE PRIMARY SCHOOL

POLICY DOCUMENT

MEDICINE IN SCHOOL

Date Revised: 09/03/2021

Date for Review: 09/03/2024

Signed:_____

SUPPORTING PUPILS WITH MEDICAL NEEDS

Definition

Pupil medical need may be broadly summarised as being of two types:

(a) Short-term affecting their participation in school activities which they are on a course of medication.

(b) Long-term potentially limiting their access to education and requiring extra care and support (deemed **special medical needs**).

Rationale

LEAs and schools have a responsibility for the health and safety of pupils in their care. The Health and Safety at Work Act 1974 makes employers responsible for the health and safety of employees and anyone else on the premises. In the case of pupils with special medical needs the responsibility of the employer is to make sure that safety measures cover the needs of all pupils at the school. This may mean making special arrangements for particular pupils who may be more at risk than their classmates. Individual procedures may be required. The employer is responsible for making sure that relevant staff know about and are, if necessary, trained to provide any additional support these pupils may need.

There is **no legal or contractual duty on teachers to administer medicines or supervise pupils taking medicines, nevertheless we would wish to support our pupils where we can. Pupils with special medical needs have the same right of admission to school as other children and cannot be refused admission or excluded from school on medical grounds alone.** However teachers and other school staff in charge of pupils have a common law duty to act in loco parentis and may need to take swift action in an emergency. This duty also extends to teachers leading activities taking place off the school site. This could extend to a need to administer medicine.

The prime responsibility for a child's health lies with the parent who is responsible for the child's medication and should supply the school with information. The school should have a clear policy understood and accepted by staff which should be communicated to parents and staff through the school prospectus, staff handbook. etc. School policies should encourage self-administration of medication when possible.

Aims

The school aims to:

- assist parents in providing medical care for their children;
- educate staff and children in respect of special medical needs;
- adopt and implement the LEA policy of Medication in Schools;
- arrange training for volunteer staff to support individual pupils;

- liaise as necessary with medical services in support of the individual pupil;
- ensure access to full education if possible.
- monitor and keep appropriate records.

Entitlement

The school accepts that pupils with medical needs should be assisted if at all possible and that they have a right to the full education available to other pupils.

The school believes that pupils with medical needs should be enabled to have full attendance and receive necessary proper care and support.

The school accepts all employees have rights in relation to supporting pupils with medical needs as follows:

- choose whether or not they are prepared to be involved;
- receive appropriate training;
- work to clear guidelines;
- have concerns about legal liability;
- bring to the attention of management any concern or matter relating to supporting pupils with medical needs.

Expectations

It is expected that:

- parents will be encouraged to co-operate in training children to self-administer medication if this is practicable and that members of staff will only be asked to be involved if there is no alternative;
- where parents have asked the school to administer the medication for their child they must ask the pharmacist to supply any such medication to be dispensed in a separate container, containing only the quantity required for school use. The prescription and dosage regime should be typed or printed clearly on the outside. The name of the pharmacist should be visible. Any medications not presented properly will not be accepted by school staff.
- that employees will consider carefully their response to requests to assist with the giving of medication or supervision of self-medication and that they will consider each request separately.
- the school will liaise with the School Health Service for advice about a pupil's special medical needs, and will seek support from the relevant practitioners where necessary and in the interests of the pupil.

Policy into Practice

There is a need for proper documentation at all stages when considering the issue of support for pupils with medical needs in school.

We have written this policy with reference to:

Durham LEA Guidelines on Medication in Schools

Medication in Schools Handbook (Durham County Primary Heads Association and Durham LEA)

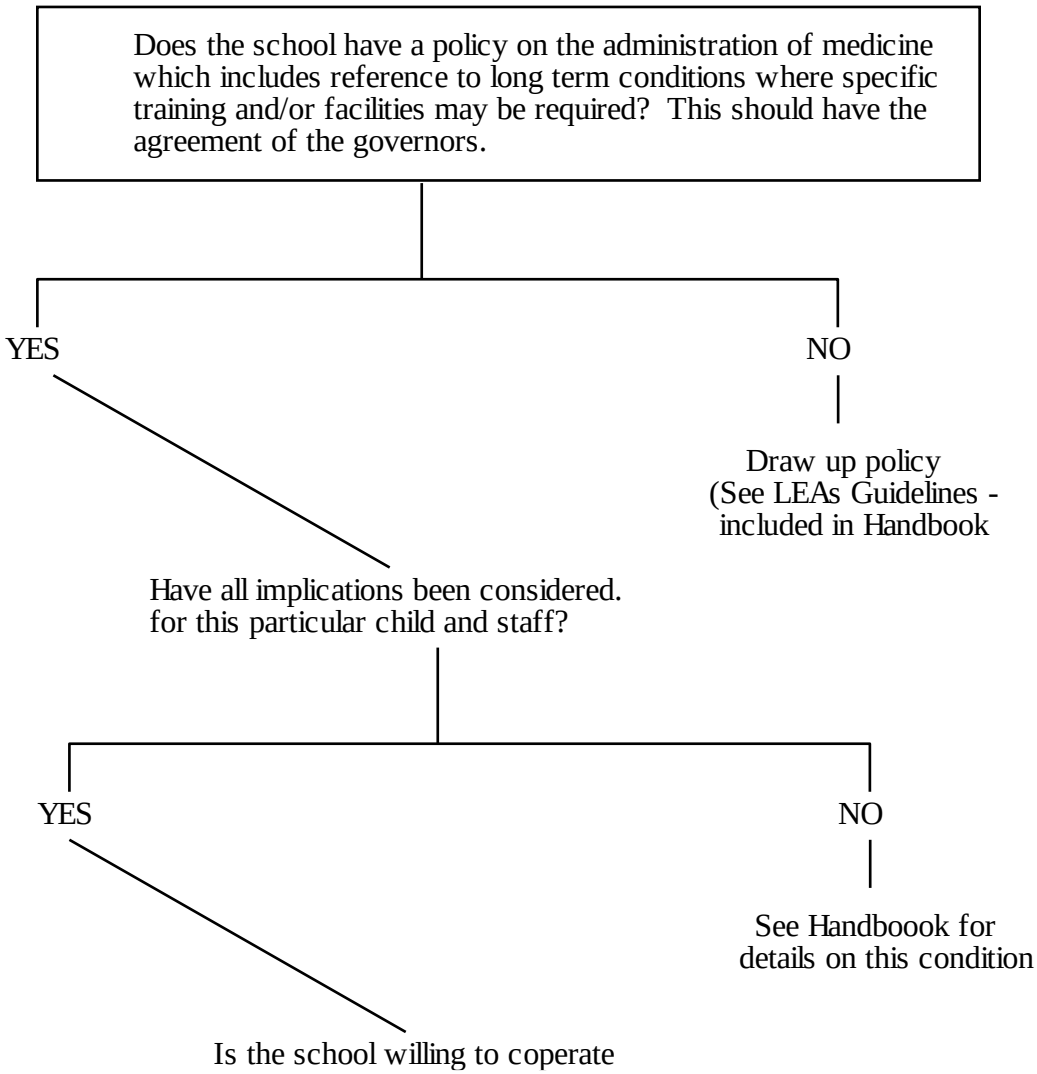
Supporting Pupils With Medical Needs (DfEE/Dept. of Health)

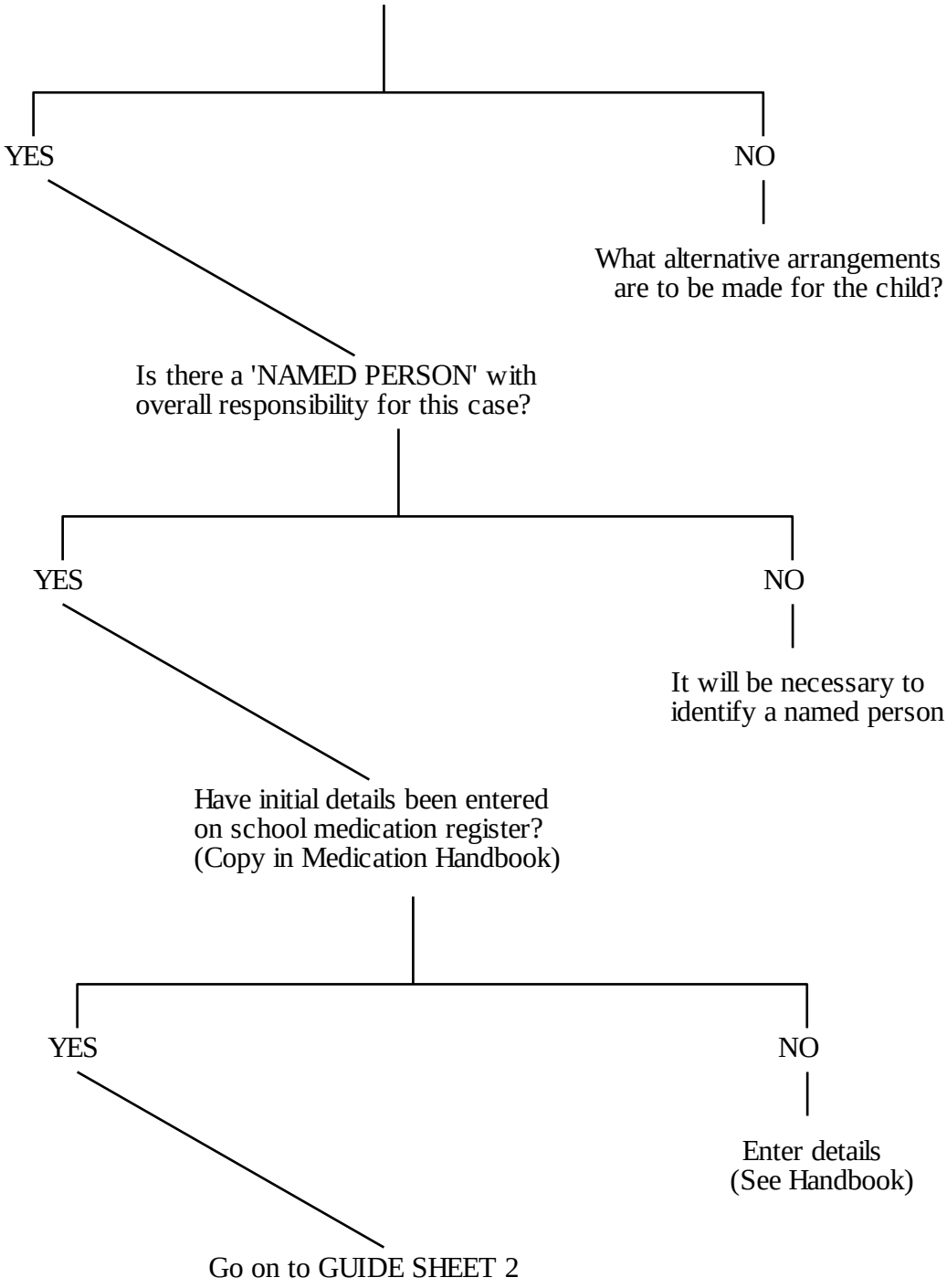
SPECIAL MEDICAL NEEDS FLOW DIAGRAM

Procedures for Dealing with Non-Routine Administration of Prescribed Medications and Treatments (i.e. those where specific training and/or facilities may be required)

GUIDE SHEET 1

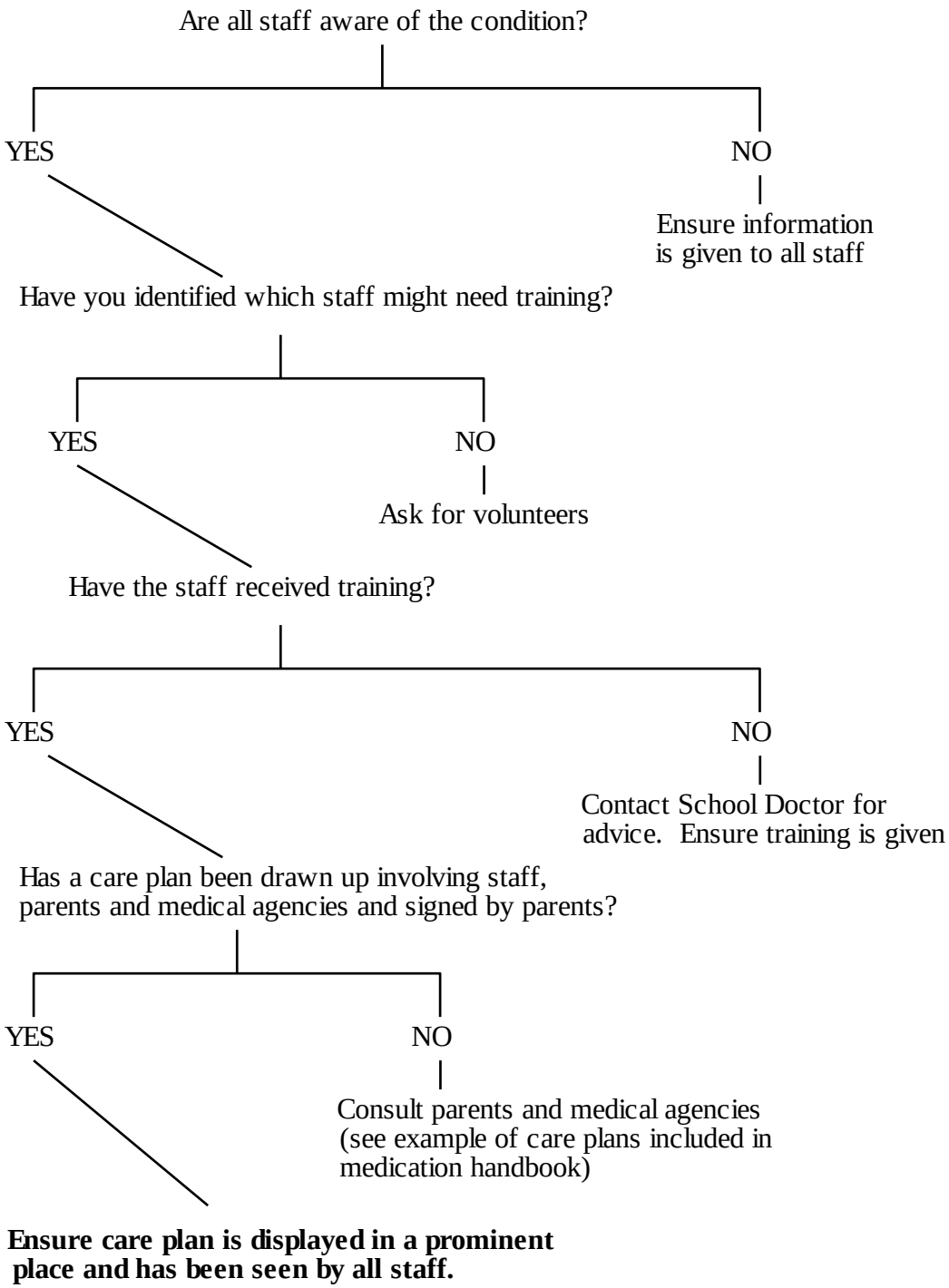
GENERAL ARRANGEMENTS




YES
NO
What alternative arrangements are to be made for the child?
Is there a 'NAMED PERSON' with overall responsibility for this case?
YES
NO
It will be necessary to identify a named person
Have initial details been entered on school medication register? (Copy in Medication Handbook)
YES
NO
Enter details (See Handbook)
Go on to GUIDE SHEET 2

GUIDE SHEET 2

TREATMENT



Ensure care plan is displayed in a prominent place and has been seen by all staff.

COTHERSTONE PRIMARY SCHOOL
SPECIAL MEDICAL NEEDS REGISTER

Name of Child	Special Medical Need	Is Care Plan Available?

COTHERSTONE PRIMARY SCHOOL
SPECIAL MEDICAL NEEDS DATE RECORD

Child's Name: _____ Date of Birth: _____

Name of Child	Special Medical Need
Initial notification Parental request	
Adoption of current School Medication Policy	
Consultation with staff	
Completion of Care Plan	
Parental agreement (signature) to Care Plan	
Implementation of Care Plan	
Memo - Care Plan review date	

Any Other Important Events/Dates

Dear Head Teacher

Administration of Medication in Educational Establishments

I request that .....……..... (name of child in full) be given the following medication, which has been prescribed by a registered medical practitioner:

.....……..... (Name of medicine)

.....……... (Dosages)

.....……..... (Methods of administering the medicine)

at the following times during the school day:

.....…….....

.....…….....

…….....

I understand that the medicines must be delivered personally by me to ..... (nominated representative) and that this is a service which is subject to agreement with the school.

Signed .....…..... (Parent/Guardian)

Date ..... 200 .....

Address .....….....

.....….....

.....….....

Notes: (1) Medication will not be administered by the establishment unless this authorisation is completed and signed by the parents/guardians of the pupils.

(2) The Governors and Head Teacher/Head of Establishment reserve the right to withdraw this service.

COTHERSTONE PRIMARY SCHOOL

Pupil's Name ………………..…………………………………….. Date of Birth ……………..

Address ………………………………………………………………………………………......

…………………………………………………………………………………………………...

Class No ………………….

Date Received	Name of Person who Brought it in	Name of Medication	Amount Supplied	Form Supplied	Dosage Regime

Register of Medication Administered

Date	Medication	Amount Given	Amount Left	Time	Administered By	Comments/Action

COTHERSTONE PRIMARY SCHOOL

PERSONAL MEDICATION RECORD

No. _____

Date of Authorisation by Parents/Guardian ____/____/_____

Surname _____

Forename(s) _____

Date of Birth ____/____/_____

Class _____

Name of Medicine _____

Formula ☐ Liquid ☐ tablet ☐ ointment ☐ eye drops ☐ *please tick*

Enter Other _____

Dosage _____

Frequency _____

First date of Administration ____/____/_____

Projected last date of Administration (if known) ____/____/_____

Expiry date of medicine (if known) ____/____/_____

Medicines returned to parents/guardians or destroyed ____/____/_____

Signature of person completing this form _____ (Position)

N.B. Written authority must be received from parents/guardians before prescribed medicines are administered. **Oral messages received via pupils should not be accepted**.

When authorisation has been received this form should be kept on the pupil's file and a Medication Log set up and maintained.

SECTION TWO

SPECIAL MEDICAL NEEDS

(Included in each: basic information; implications; sample letters; sample care plans; additional detailed information.)

ANAPHYLAXIS

Basic Information

Anaphylaxis is a rare severe allergic response that occurs when a person is exposed to an allergen (an allergy causing substance).. It is brought about when the allergen enters the bloodstream causing the release of chemicals including histamine from cells in the blood. These chemicals then act on the blood vessels causing them to swell and blood pressure to drop. There are a variety of allergens, the most common of which are foods (especially peanuts, nuts, eggs, cow's mil, shellfish), certain drugs such as penicillin and the venom of stinging insects (such as bees, wasps or hornets).

In its most severe form the condition is life threatening.

Anyone can experience an anaphylactic reaction - not just those with known allergies. They are unpredictable and may vary. Allergy testing can help determine what substances an individual may be allergic to, although it does not predict how serious the reaction will be.

Symptoms

Symptoms, which usually occur within minutes of exposure to the causative agent, may include:

- itching, or a strange metallic taste in the mouth;
- swelling of the throat and tongue;
- difficulty in swallowing;
- hives anywhere on the body;
- generalised flushing of the skin;
- abdominal cramps and nausea;
- increased heart rate;
- sudden feeling of weakness or floppiness;
- sense of doom;
- difficulty in breathing - due to severe asthma or throat swelling;
- collapse and unconsciousness.

Not all of these symptoms need be present at the same time.

Implications for School

Where a school has a child at risk of anaphylaxis or where admission for such a child is sought, it is important to ensure that the child is treated normally and the parents' fears allayed by the reassurance that prompt and efficient action will be taken in accordance with medical advice and guidance.

Medication

When a child is at risk of anaphylaxis the treating doctor will prescribe medication for use in the event of an allergic reaction. These may include anti-histamines, an adrenaline inhaler or an adrenaline injection. The adrenaline injections that are most commonly prescribed are "The

Min-i-jet" and the "EpiPen". These devices are preloaded and easy to administer. The school doctor can arrange for staff to receive essential training.

Day to Day Measures

Day to day measures are needed for food management, awareness of the child's needs in relation to the menu, individual meal requirements and snacks in school.

Catering staff should be made fully aware of the child's particular requirements.

Appropriate arrangements for outdoor activities and school trips should be discussed in advance by the parents and the school.

Cookery and science experiments and food may present difficulties for a child at risk of anaphylaxis. Suitable alternatives can usually be agreed.

SAMPLE LETTER

Dear Parents,

You have informed the school that your child may suffer anaphylactic reaction if he/she eats ..... To enable us to draw up a care plan could you please let us have the following information:

- Foods to which ..... is allergic.
- Symptoms that will be shown should ..... inadvertently eat the above food.
- Medication/procedure that the G.P. or consultant has recommended.

When the care plan has been drawn up it should be approved by yourselves and the G.P. Should staff need to be trained to administer medication then your permission will be sought for those members of staff to administer that medication.

Yours sincerely

Head Teacher

SAMPLE CARE PLANS

DURHAM COUNTY EDUCATION AUTHORITY

Name of School:

Head Teacher: _____ Tel: _____

Procedure in the event of extreme allergic emergency
Start Date _____

If _____ complains of being unwell or becomes abnormally flushed, **or** develops:

swollen neck, face, lips or tongue, itchy rash, difficulty in breathing or fainting.

The following procedure **must** be initiated **immediately**

1. a) Call Head or Deputy Head.
   b) Call **Paramedic Ambulance** - (Name of Staff)
2. _____ to administer adrenaline as follows using EpiPen Auto-Injector as follows:
   a) Remove Epi-Pen from carton. Pull of grey safety cap.
   b) Place black tip on thigh at right angle to leg. **Always apply to thigh!**
   c) Press hard into thigh until Auto-Injector clicks. Hold in place for 5 seconds.
   d) The EpiPen should then be removed.
   e) Massage the injection are for 10 seconds.
   f) Repeat procedures a) to e) with a second pen **NOTE TIME**.
3. If symptoms persist after 15 to 20 minutes then **repeat all of Procedure 2**.
4. Remain with _____ until ambulance arrives.

   Give discarded injectors to crew for safe disposal.

   Instruct crew to go straight to (Name of Hospital) where (Doctor) will have been alerted.
5. Following emergency treatment _____ must still go to hospital, even if symptoms subside.
6. Name of person to contact:
   i) 999 Paramedic Ambulance
   ii) Hospital
   then iii) Mother
   or Grandmother or other contacts.

Procedure to be reviewed annually in March with statutory review of statement or in the event of interim changes of circumstances.

PROCEDURE IN THE EVENT OF EXTREME ALLERGIC EMERGENCY

APPEARANCE OF SYMPTOMS

Feeling unwell
Flushed appearance
Swelling in neck, face, lips, tongue
Appearance of rash
Difficulty breathing
Fainting

(Name)
Administer 2 doses
Adrenaline Auto-Injector
IMMEDIATELY
Note time

(Name)
Dial 999
Paramedic Ambulance
Note time

Remain with .....
until Ambulance arrives
If symptoms persist
repeat injections after
15-20 minutes

(Name)
Telephone Hospital

Direct Ambulance Crew
to Ward
(Hospital & Doctor)
Crew dispose of used
injectors

Contact Mother or
Grandmother or other
contacts

EMERGENCY PROCEDURE

Emergency procedure to be followed should _____ suffer an adverse reaction following oral or physical contact with _____ products.

START

Administer Piriton orally and provide CONSTANT adult supervision

Medication

..... should be carrying own medication IF NOT spare medication in office.

Expect a mild reaction

or

Contact:
Tel:

or

Tel:
Home:

If condition worsens

Provide inhaler and ensure it is used under CONSTANT adult supervision

Tel: 999
Request Paramedics

Tel: Casualty Department
Hospital Tel No:
Inform them of situation

Provide Mini Jet-Adrenalin
Supervisory staff to maintain CONSTANT attention

_____ **Primary School**

Date:

Agreed Protocol

Re: Pupil

SAMPLE PROTOCOL ANAPHYLAXIS PATIENT

This protocol has been compiled following advice from: The Anaphylaxis Campaign
P.O. Box 149
Fleet
Hampshire
GU13 9XU

This sample protocol has been compiled based on working documents currently in use for children in schools in Berkshire, Birmingham, Dudley and Hampshire. The schools and Local Education Authorities have kindly shared them with The Anaphylaxis Campaign.

1. Background

1.1 ..... suffers from an anaphylactic reaction if she eats nuts or products containing nuts.

If this occurs she is likely to need medical attention and, in this situation, her condition may be life threatening. However, medical advice is that attention to her diet, in particular the exclusion of nuts, together with the availability of her emergency medication, are all that is necessary. In all other respects, it is recommended by her consultant that her education should carry on 'as normal'.

1.2 ..... also suffers from mild asthmatic condition and procedures exist in school for use of her inhaler.

1.3 The arrangement set out below are intended to assist ....., her parents and the school in achieving the least possible disruption to her education, but also to make appropriate provision for her medical requirements.

2. Details

2.1 The Head Teacher will arrange for the teachers and other staff in the school to be briefed about ..... condition and about other arrangements contained in this document.

2.2 The school staff will take all reasonable steps to ensure that ..... does not eat any food items unless they have been prepared/approved by her parents ..... parents have discussed with the school meals services the contents of the meals viz a viz peanuts.

2.3 ..... parents will remind her regularly of the need to refuse any food items which might be offered to her by other pupils/people. N.B. Pupils at this school do not bring sweets or snacks. All children are given a plain biscuit at morning break, the contents of the biscuit have been cleared by ..... parents.

2.4 If there are any proposals which mean that ..... may leave the school site, prior discussions will be held between the school and ..... parents in order to agree appropriate provision and safe handling of her medication and if necessary the Head Teacher will invite a member of her family to accompany the outing.

2.5 When ever the planned curriculum involves cookery or experimentation with food items, prior discussions will be held between the school and parents to agree measures and suitable alternatives.

2.6 The school will hold, under secure conditions, in the stock cupboard in the Head Teacher's office, appropriate medication, clearly marked for use by designated school staff or qualified personnel and showing an expiry date.

Two EpiPens are to be held in the stock cupboard in the Head Teacher's Office. The parents accept responsibility for maintaining appropriate up-to-date medication.

3. Allergic Reaction

3.1 In the event ..... showing any combination of the following physical symptoms for which there is no obvious alternative explanation, her condition will be immediately reported to the Head Teacher/teacher in charge.

The symptoms are:

- Itchiness
- Mottled rash red and white
- Swollen lips
- Swollen tongue
- Swollen eyes
- Difficulty with breathing
- Panic attack
- Palpitations

These are the symptoms identified by ..... parents.

On receipt of such a report, the person in charge if, agreeing that her condition is a cause for concern will:

Instruct a staff member to contact in direct order of priority:

Ambulance - Emergency Services 999
G.P. (Tel. No.)
Messages to be given -
..... Anaphylactic reaction - Emergency
and then her parents - Tel. No.

3.2 Whilst awaiting medical assistance the Head Teacher and designated staff will assess ..... condition and administer the appropriate medication in line with perceived symptoms and following closely the instructions given by the paediatrician during the staff training session.

3.3 The following procedure will be followed:

..... will be given the EpiPen, Adrenaline Auto-Injection into the outer side of the thigh, midway between knee and hip.

3.4 The administration of this medication is safe for ..... and even if it is given through a misdiagnoses it will do her no harm.

3.5 On the arrival of the qualified medical staff the teacher in charge will appraise them of the medication given to ..... All medication will be handed to the medical person.

3.6 After the incident a debriefing session will take place with all members of staff involved.

3.7 Parents will replace any used medication.

4. Transfer of Medical Skills

4.1 Volunteers from the school staff have undertaken to administer the medication in the unlikely event of ..... having an allergic reaction.

4.2 A training session was attended by four of the school staff. Dr. ....., Clinical Medical Officer, explained in detail ..... condition, the symptoms of the anaphylactic reaction and the stages and procedures for the administration of medication.

4.3 Further advice is available to the school staff at any point in the future where they feel the need for further assistance. The medical training will be repeated at the beginning of the next academic year.

4.4 We await for Durham Local Education Authority's indemnity for any school staff who agree to administer injections to a child in school given the full agreement of parents and school.

Copy for information to all teachers, support staff and parents working in school.

DURHAM COUNTY EDUCATION AUTHORITY

COTHERSTONE PRIMARY SCHOOL

Name of Child:

Date of Birth:

..... is allergic to ..... She/he will have a packed lunch at school and must not eat any food brought into school by another child. In any baking activity involving the above foods ..... will not eat or touch the foods. She/he will, however, observe the activity and take as full part as possible.

PROCEDURE IN THE EVENT OF EXTREME ALLERGIC REACTION

If ..... inadvertently eats the above foods the first signs of reaction are:-

Blisters on her lips
Sore, red eyes
A strange feeling in her throat

It is also possible that her face may become flushed or a rash may develop.

At any sign of one or more of these symptoms ..... requires the ..... tablets enclosed in her EpiPen box in the staffroom. These should be dissolved in a **very** small amount of water.

Should ..... have difficulty with breathing, difficulty with swallowing or lose consciousness the following action should be taken:

1. **Send someone to call an ambulance and note time.**
2. **If unconscious put into the recover position.**
3. **Sent for ..... who have been trained to use the EpiPen (the EpiPen is stored in the staffroom).**

USE OF EPIPEN

1. Remove EpiPen from carton.
2. Pull of grey safety pack.
3. Place black tip on thigh at right angles to let.
4. Press hard into thigh until auto-injector mechanism functions (it will click) and hold in place for 10 seconds.
5. The EpiPen should then be removed - it will be given to the ambulance crew.
6. Massage the injection area for 10 seconds.
7. Note time.
8. Stay with patient.
9. Ensure parents are contacted.

ADDITIONAL DETAILED INFORMATION

GUIDELINES FOR PATIENTS/PARENTS FOR THE ADMINISTRATION OF EPIPEN ADRENALINE

When your child develops an anaphylactic reaction your child will develop two or more of the following reactions:

Facial flushing
Swollen lips or tongue
Urticarial RASH (Nettle rash)
Difficulty in breathing leading to **Loss of Consciousness** (Faint)
Difficulty in swallowing

If this happens the following action should be taken **immediately**:

1. Send someone to call for a Paramedic Ambulance (if possible) and note the time.
2. Turn the patient/child into the recovery position.
3. Remove EpiPen from carton.
4. Pull of grey safety cap.
5. Place black tip on thigh at right angles to leg.
6. Press hard into thigh until Auto-Injector mechanism functions and hold in place for several seconds.
7. The EpiPen should then be removed from thigh and discarded.
8. Massage the Injection area for 10 seconds.
9. Call Paramedic Ambulance (if this has not already been done).
10. Stay with patient.

N.B. Steps 3-8 may be repeated with a second EpiPen if you have been instructed to do so by a Doctor.

Compiled by:

Sister T. Green & Sister T. Askey
Department Immunology
Newcastle General Hospital

DIRECTIONS FOR USING THE EPIPEN ADRENALINE AUTO-INJECTOR

1. Safety Cap

1. Remove EpiPen from carton.
   Pull of grey safety cap (illustration 1)

2. Place black tip on thigh at right angle to leg (illustration 2). **Always apply to thigh!**

3. Press hard into thigh until Auto-Injector mechanism functions.
   Hold in place for 10 seconds.

4. The EpiPen should then be removed and discarded safely.

5. Massage the injection area for 10 seconds.

Sister T. Green & Sister T. Askey
Department Immunology
Newcastle General Hospital
Tel: 0191 2738811 Ext. 23062
Bleep. 1815

ASTHMA

The following is reproduced with permission, from "The County Durham Asthma Handbook for Schools". Please refer to that handbook for additional information.

What is it?

Asthma is defined in the Oxford Dictionary as "a disorder, frequently of allergic origin, characterised by paroxysms of difficult breathing". It is a condition which causes difficulty in the movement of air in and out of the lungs during breathing.

There are two lungs occupying the chest space together with the heart. Each lung is 30cm high and resembles a sponge with a capacity of 1.3 litres. In terms of their structure and function they resemble inverted trees. Air is breathed through the trunk (main windpipe or trachea); it travels through the larger branches (airways or bronchi) then the smaller branches and twigs (bronchioles) until it reaches the leaves (the air spaces or alveoli). The surface area of the alveoli is equivalent to that of a tennis court and it is here that the oxygen passes from the air into the blood stream while carbon dioxide passes out in the opposite direction.

In asthma the airways become narrowed making it more difficult for the air to move to and from the air spaces. The lining of the airways becomes inflamed making the airways twitchy and irritable. An irritation or stimulus can then cause coughing and tightening of the muscles surrounding the airways which makes them narrower. There is also swelling in the lining of the airways which may cause mucus (phlegm) to be produced. Over time the cells lining the airways may become damaged.

The result of all this is that the diameter of the airways is reduced by muscle spasm, swelling of the lining, the production of sticky mucus and damage to the lining cells.

How Common is it?

Asthma is a common disease through the world. In the United Kingdom it affects at least 5% of adults and more than 10% of children - a total of at least three million people!

It is affecting more people than ever before. In adults, males and females are equally affected whilst in children the ratio of boys to girls is about 2:1. Asthma can develop at any age but most commonly in childhood and the fourth and fifth decades. Symptoms develop in 50% of asthmatic children by the age of three and in 80% by the age of 5 years.

Because of the nature of the condition there are often long periods when people feel cured because they have absolutely no symptoms. This symptomless state (remission) can continue for months or years. The maxim "once an asthmatic, always an asthmatic" is a salutary reminder that one you have had asthma you will always have the tendency to have it again. It is better to think of asthma going into remission rather than being cured.

How Serious is it?

Asthma is a very variable disease and ranges in severity from being nothing more than an **occasional nuisance** to being a severe **life-limiting** and indeed **life-threatening** illness.

A survey of young asthmatics aged 4-17 years revealed that:

- half experience symptoms at least once a week.
- one quarter suffer symptoms most days.
- half experience some difficulty walking upstairs because of their asthma.
- two thirds have at some time had to miss PE because of their asthma.
- one third wake at least once a week because of their asthma.
- one in twenty wake every night because of their asthma.
- one third sometimes miss school because they are too tired.
- one quarter miss more than two weeks school per year because of their asthma.
- one quarter attend hospital each year with an acute asthmatic exacerbation.

There are a total of **100,000 hospital admissions** for asthma each year in the United Kingdom and **2000 deaths**. *Over one third of these deaths occur in the under 65's.*

What are the Provoking Factors?

They do not cause asthma but may precipitate the onset of symptoms or an attack of asthma.

1. Allergies

For many people allergies are the most important trigger for their symptoms or attacks. The substance causing the allergy is known as the allergen. The most important allergen in the United Kingdom is excreted in the faeces of the house dust mite. This is a ubiquitous microscopic inset (0.3mm) which feeds on human skin scales - once they have been shed! It needs a warm humid environment and lives in furnishings, soft toys and bedding - there may be over one million in your mattress!

The other major allergens are feathers, animal fur or hair (particularly from dogs, cats and horses), grass and pollens (generally maximal between May and July), tree pollens (generally maximal between February and May) and mould spores.

2. Upper Respiratory Virus Infection (Colds and "Flu")

This can precipitate episodes of asthma at any age, but particularly affects **young children** who may remain completely free from symptoms at other times. This contributes to the peak of asthma attacks that occur in the autumn.

3. Exercise

All forms of exercise but particularly running (and especially running in cold conditions) can bring on symptoms of asthma within a few minutes. This is particularly relevant on the school sports field as treatment is usually effective in preventing or alleviating this sort of asthma.

Swimming is often promoted as a suitable exercise for individuals with asthma because the warm moist conditions of the swimming pool are less likely to provoke exercise-induced asthma. However problems may arise in overcrowded or poorly maintained pools if the level of chlorinous vapours is high because these substances are very .....

4. Emotional Factors and Stress

Over-excitement or indeed any stress or emotion can precipitate or worsen an attack of asthma.

5. Atmospheric Conditions

Changes in weather and temperature are well known to provoke symptoms. Smoky and polluted atmospheres have also been implicated. *Cigarette smoke is particularly bad news for asthmatics and both active and passive smoking should be avoided.*

6. Drugs

Certain drugs can trigger asthma in certain people. The most important of these is **Asprin** because it is available without prescription. It is not generally recommended that it be given to children under the age of 12 years (for other reasons) but can cause serious attacks in 1-2% of adults with asthma.

7. Foods

Food is rarely a cause of asthma and usually the asthma is part of a generalised allergic reaction. Symptoms often develop within minutes of eating and the cause is usually obvious. Examples may include nuts, milk, shellfish and eggs.

What are the Symptoms?

The main symptoms of asthma are shortness of breath, wheeze, cough and chest tightness.

1. Shortness of Breath

The body has to work harder than usual to carry out the normal process of breathing. This is especially apparent during exertion. Many asthmatics complain of tiredness during and after an acute exacerbation - this may be evident to the point of exhaustion.

2. Wheeze

This is caused by the turbulence of the air currents which whistle through the narrowed airways. There may be no wheeze in very mild asthma. Paradoxically there may be no wheeze in severe asthma when air cannot get into or out of the lungs.

3. Cough

The airways are irritable and twitchy with an inflamed lining. Coughing is often worst at night, and often productive of phlegm. The phlegm is usually a product of inflammation of the airways rather than infection. It may be the only presenting symptom, particularly in childhood.

4. Chest Tightness

During an asthma attack the lungs expand because air gets trapped in them. This stretches the membrane surrounding the lungs, the chest walls and the muscles between the ribs.

IMPLICATIONS FOR SCHOOL

SCHOOL ASTHMA POLICY

It is the responsibility of the Governing Body to ensure that all reasonable and practical steps are taken to safeguard the health and safety of pupils when they are authorised to be on school or other educational premises or where they are engaged in authorised activities elsewhere.

Asthma Education

The school should have a responsibility to advise all its staff on **practical** asthma management. The school nursing service could be involved to advise and offer support.

Parents

The school should ask all parents whether their child has asthma. It would help to keep a register of all asthmatic children and this could include details of the treatment that each child uses and in particular any inhalers which need to be used at school.

Access to Inhalers

Reliever inhalers (usually blue) are of particular importance. **It is essential that the child has access to this inhaler at all times**. A delay in taking this treatment can lead to a severe attach, and in rare cases could be fatal. Relievers commonly used are: *Salbutamol, Ventolin, Salamol, Aerolin, Bricanyl, Terbutaline.*

The Teacher should encourage the child to have easy access to their reliever inhaler on school trips, on the sports field and at break and lunchtimes.

Nebulisers

Children with severe asthma may use an electric compressor called a nebuliser to deliver their asthma drugs. The school nurse or the child's GP should liaise with the school to give correct management advice for these children.

Sports

Sports teachers should be aware that a number of pupils with asthma take a dose of their reliever inhaler before exercise, and may need to use their inhaler again on the sports field or in the swimming pool. If a child seems over-reliant on their inhaler than this concern should be communicated to the child's parent as this may mean that the child's asthma is poorly controlled.

Trigger Factors

Many things can trigger an asthma attack. This may be because of allergy to e.g. pollen or animal hair but just as important are irritants such as cigarette smoke or chemical fumes. Every attempt should be made to ensure that asthmatics are not exposed to cigarette smoke. Care may also be taken if pets are kept in the classroom. Similarly it is good practice to use fume cupboards in science rooms to avoid fume inhalation.

COTHERSTONE PRIMARY SCHOOL

Executive Headteacher: Mrs C. A. Matthewman
Cotherstone, Barnard Castle, Co Durham, DL12 9QB
Tel: 01833 650491
e-mail: cotherstone@durhamlearning.net

Date:

Dear Parent,

School Asthma Care Plan

This letter has been sent to you as the parent of an asthmatic child. You will be pleased to know that the school takes its responsibilities to pupils with asthma very seriously. The school has an Asthma Policy to enable all staff members to help your child.

I would be grateful if you would help fill in the requested details on the attached School Asthma Care Plan. If you are in any doubt about the treatment details then please take the sheet to your child's doctor or nurse who will explain your child's asthma treatment to you, this will enable you to complete the attached form.

The completed record will have details of your child's treatment and what steps need to be taken if they have an asthma attack at school. It is very important that the record is updated if the treatment is changed at a future date.

I look forward to receiving this important record and thank you in advance for your co-operation in this important matter.

Yours sincerely

Head Teacher

COTHERSTONE PRIMARY SCHOOL

To be Completed by the Child's Parent

SCHOOL ASTHMA CARE PLAN

Name of Child: _____ Date of Birth: _____

Address: _____

Tel. No: Home _____ Parental Work _____

General Practitioner: Name _____ Tel. No. _____

Regular treatment to be taken in school time:

N.B. If this treatment can be taken twice daily at home then the treatment device does not need to be brought to school.

Name of Treatment (and Device) _____

When is it taken? _____

How is it taken? _____

Treatment to be taken before exercise:

For sudden shortness of breath, wheeze, cough or chest tightness

Name of Treatment _____

How is it taken? _____

I confirm that:

*a) My child is able to take responsibility for the self-administration of his/her asthma medication and is able to carry his/her asthma device at school.

*b) My child is not able to self-administer his/her medication and will require assistance.

**Please delete a) or b)*

Parental Signature _____ Date _____

WHAT TO DO IF A CHILD HAS AN ASTHMA ATTACK AT SCHOOL

1. Ensure the child takes their **reliever** medication - this is usually blue.

   It should open up the narrowed airways quickly.

2. Keep **calm**, give the child reassurance.

   Attacks are frightening - stay calm - the child has probably had attacks before. It may be a comfort to hold the child's hand but do not put your arm around their shoulders as this can be restrictive.

3. Help the child to **breathe**.

   Encourage slow deep breathing. Keep the child sitting upright or leaning slightly forward - do not let them lie down. Keep the room well ventilated and loosen any restrictive clothing.

CALL A DOCTOR URGENTLY IF:

- two doses of reliever have no effect after ten minutes
- or the child is distressed or unable to talk
- or the child is becoming exhausted
- or you have any doubts about the child's condition
- or your are uncertain about the severity of the attack

If you cannot obtain a doctor then call an ambulance.

WHAT ARE THE TREATMENT DEVICES?

There is a large and growing array of inhalation delivery devices. The expiry dates is stamped on each device.

1. Metered Dose Inhaler

The pressurised aerosol (metered dose) inhaler (MDI) is the most commonly used device. It is cheap but requires very good co-ordination during the breathing in of the drug.

Under the age of four and until a child can differentiate between sucking and blowing, a MDI is often used together with a spacer device (e.g. Volumatic, Nebuhaler, Fisonair). Spacer devices may also be used by older children for inhalation of topical steroids or of a "reliever" during an acute attack.

Most children up until the age of ten (and many thereafter!) have difficulty acquiring the necessary technique. The Autohaler is a special MDI which overcomes co-ordination problems as the drug is released automatically upon breathing in through the mouthpiece.

2. Dry Powder Device

These do not require co-ordination as the drug is breathed in as a dry powder. There are various devices available: e.g. Accuhaler, Aerohaler, Cyclohaler, Diskhaler, Rotahaler, Spinhaler, Turbohaler.

3. Nebuliser

A nebuliser is a machine which breaks up liquid drugs into tiny droplets, forming a mist which is breathed in. It is an effective way of delivering treatment for children with severe asthma. When children who use nebulisers are admitted to school and when children at school start to use nebulisers, Head Teachers should liaise with the school doctor or school nurse with regard to management with and administration of the nebuliser. This should include how the nebuliser is used, how often it should be used and when to seek help. Electric nebulisers need to be serviced from time to time.

Device usage instructions appear on the pages following with the kind permission of the National Asthma Training Centre.

DIABETES

Basic Information

Diabetes is a failure of the body to produce enough of the hormone Insulin. Insulin is necessary to convert glucose from the diet into energy to nourish the body and brain.

It is a failure of the pancreatic gland to produce enough insulin to control the blood sugar level and is in part an inherited tendency.

How Does it Affect Children?

Injections

Children with diabetes need to take Insulin by injection every day, usually once or twice and occasionally more often. As the dose is necessarily fairly constant the amount of carbohydrate in the diet must also be fairly constant and meals must be eaten at regular times. Snacks may be needed between meals.

Diet

As with any child, high fibre and limited fat are encouraged but it is only carbohydrate that is regulated.

Carbohydrate means sugar, starch and cereals and it is found in sweets, biscuits, potatoes, bread, pulses, milk etc.

The children and their parents will know how much carbohydrate they should have for meals and snacks. They will refer to "grams of carbohydrate" or "exchanges".

e.g. 1 Digestive biscuit = 10 grams of carbohydrate = 1 exchange

Do not be alarmed. The family will be able to explain other foods and the hospital Dietician or Diabetic Liaison Nurse can help.

Encouragement Needed

Children with diabetes may need extra encouragement to lead active independent lives and fully participate in school activities. They should not be over protected but do need a subtle eye kept on them, especially when first diagnosed.

The child should be encouraged to let friends know about the condition and how they can help.

Some consideration is necessary with careers advice e.g. joining the Armed Forces and holding a Public Service Vehicle licence may not be possible but most diabetics can obtain a regular driving licence.

Special Problems in the Classroom

Be prepared for difficulties arising from any special treatment of diabetic children e.g. the allowance of snacks and the wearing of bracelets.

Remember the child does not want to feel different and may rebel against advice more than the injections.

These children often resent being told what they can and cannot do.

Dispelling the Myths

The illness is not caused by eating too much sugar.

With good treatment a full and normal life can be lead.

Special Provision Needed

Allow

- the child to carry a supply of sugary sweets in case of "hypos", especially on the playing field.
- meals and snacks to be eaten at specified times (this may mean eating in the classroom and during exams).
- extra snacks before sport and other exercise which can otherwise lead to a low blood sugar.
- the child to use the lavatory (if the blood sugar is high the child may make a lot of urine).
- the wearing of identity bracelets/necklaces.

For School Trips

Check that the child has:

- sugar/drinks in case of emergencies.
- sufficient food for journeys with extra in case of delay.
- syringes or "pen" for injections.
- insulin bottles and spares in case of breakages.
- equipment to test blood and urine.
- written details of diet plan and Insulin dose and storage requirements.

Further Information

The British Diabetic Association
Youth Department
10 Queen Anne Street
London
W1M 0BD
Telephone: 071 3231521

The Dietician
either at Pinderfields Hospital
Wakefield 201688
or Pontefract Health Authority
0977 791221

Diabetic Liaison Nurse
Pinderfields Hospital
Wakefield 201688
Diabetic Centre
Pontefract 600600 Ext. 6212

IMPLICATIONS FOR SCHOOL

If there is a child with know diabetes in the class it is sensible for the teacher, parents and child to discus the problem together. Advice can also be sought from the School Doctor and Nurse, the Diabetic Liaison Nurse and Dietician.

The teacher needs to know what kind of treatment is being taken, how and when it is needed and how competent the child is at being able to control the diabetes.

They may find it helpful to know how the individual child behaves when hypoglycaemic and staff should know the child keeps the supply of sugar. They are advised to keep an emergency supply themselves.

Acute Episodes - How to Help

If the symptoms of a "hypo" should occur, the child should be given some sugar (which should always be at hand) and have a snack such as some milk and biscuits.

The hypoglycaemic child may not co-operate and sweet drinks may prove easier to give. If recovered the child may continue with the lesson. If not, or if too sleepy to take the sugar, call for help.

Insulin can only be given by injections. This is normally given before and after school, but some children have injections from a "pen" before each meal. This allows more freedom about the timing an size of meal and makes snacks unnecessary. However, time and private space may need to be negotiated with each child to enable an injection to be given before the midday meal.

Restrictions or Limitations

Never

- send an unwell diabetic child out of the class unaccompanied. They should be escorted by a responsible person.

- detain a diabetic child at meal times or after school unless proper arrangements have been made for eating and Insulin.

"Hypos"

When a child with diabetes has a low blood sugar it is called an Insulin reaction, hypoglycaemic attack or "hypo".

This may be caused by a delayed meal or unplanned vigorous exercise or occasionally too much Insulin.

The symptoms vary from one child to another but may include:

- dizziness
- pale or flushed complexion
- faintness
- confused or drunken behaviour
- tremors or irritable behaviour

If not treated promptly it may progress to drowsiness and unconsciousness (see treatment).

A diabetic child will have a high blood sugar before diagnosis. This may recur later and suggest a need for treatment to be reviewed. The clues include thirst, passing a lot of urine, weight loss and sweet smell of the breath (like pear drops). The problem is more gradual in onset than a hypoglycaemic attack.

COTHERSTONE PRIMARY SCHOOL

Executive Headteacher: Mrs C. A. Matthewman
Cotherstone, Barnard Castle, Co Durham, DL12 9QB
Tel: 01833 650491
e-mail: cotherstone@durhamlearning.net

Date:

Dear Parents,

We have been informed that you child has been diagnosed as diabetic. I would be grateful if you could complete the form below:

Child's Name _____

Contact Information

Contact 1		***Contact 2***	
Name	_____	Name	_____
Tel. No.	_____	Tel. No.	_____
Relationship to Child	_____	Relationship to Child	_____
G.P.	_____		
Clinic Contact	_____		

Typical symptoms shown by child if experiencing low blood glucose (hypoglycaemia).

Details of fast acting sugar that should be given should _____ experience a "hypo".

Fast Acting Sugar	**Quantity**
_____	_____

Any other necessary instructions.

I understand that medicines should be delivered to _____ and that this is a service which is subject to agreement with the school.

Signed _____ Date _____

Address _____

_____

CARE PLAN

Cotherstone Primary School

_____ has been diagnosed as diabetic. This is usually regulated by insulin injections and a controlled diet.

He has 2 insulin injections at home each day - 1 before breakfast and 1 before teatime.

Blood tests will be carried out at home as necessary.

Usual food intake during normal school day

Morning and afternoon snack.
Packed lunch.

At morning and afternoon breaks _____ must have a snack. This will usually be a piece of fruit, 2 biscuits (digestive) or occasionally, a packet of crisps.

_____ will supply the snack food.

_____ will bring a packed lunch to school.

There are two types of insulin reaction that we must be aware of:

Hyperglycaemia (Hyper) indicates a high blood sugar level accumulates over a period of time.

Hypoglycaemia (Hypo) indicates a low blood sugar level likely to occur in school can develop in minutes responds rapidly to treatments.

Usual symptoms for a hypo can be:

pale, sweaty
shakiness
irritable, aggressive behaviour
headache
staring eyes, drowsiness
dizziness

At home Mrs. _____ has noticed that when _____ blood sugar level is low he becomes aggressive and uses obscene language.

Treatment for Hypoglycaemia (hypo)

Intake of easily available sugar is essential i.e. 3 dextrosol tablets, fun size Mars bars, mini bottle Lucozade, or equivalent of sugary coke.

Following this intake _____ requires complex carbohydrate i.e. an apple, 2 biscuits (digestive/ginger snap), or if this occurs just before lunch a portion of potato from the school kitchen.

Mrs. _____ will provide school with an "emergency snack food " store

Use of hypostop (concentrated glucose in jelly form)

Should _____ become hypo and unable to take food or become semi-comatose then hypostop should be given.

Directions for use:

Lie _____ on his side.
Unscrew top of hypostop.
Squirt approximately a third of bottle into pouch of cheek nearest to ground or smear along gum margin.
_____ should respond within minutes. Once _____ comes around he needs to be given an intake of complex carbohydrate (i.e. apple or 2 biscuits).
If _____ does not respond, repeat the hypostop and phone for an ambulance using 999. Parents should also be contacted.

Physical Exertion - i.e. PE, Swimming, Football

_____ required an additional snack (i.e. piece of fruit/2 biscuits) prior to physical exertion.

Out of School Activities

When _____ goes off school premises i.e. on educational visits, to other premises for lessons etc. he must always take a supply of emergency snack food and hypostop. Should _____ go hypo at these times then the above procedures must be followed.

Home/School Book

A home/school book will operate whereby staff and parents can communicate information such as if _____ has been "hypo" etc.

Signed _____ Date _____
Parents

_____ School _____ Position _____ Date

Name of Child:

Date of Birth:

_____ has been diagnosed as diabetic.

_____ has a packed lunch and a morning and afternoon snack. She eats the snacks in the hall, usually accompanied by a friend. _____ brings her snack from home.

_____ may experience low blood glucose (hypoglycaemia).

Look out for the following symptoms:

Hunger
Drowsiness
Pallor
Glazed eyes
Shaking
Mood changes or lack of concentration.

Unexplained crying is also a typical symptom for _____

Treatment for Hypoglycaemia

Fast acting sugar should be given immediate. _____ should be given **60ml of Lucozade**. This will be provided from home.

Outings

Extra food such as fruit or sandwiches should be taken in case of delays.

Should _____ become unconscious then she should be given hypostop (¼ bottle). This is kept in the fridge in the staffroom.

EPILEPSY

SEIZURE DISORDERS

Epilepsy is a condition in which recurrent seizures occur usually spontaneously.

About 1/200 of the population will have some form of epilepsy at some time in their lives.

A seizure is a sudden disturbance of consciousness, sensation, movement and posture due to abnormal activity in the brain.

There are many types of epilepsy. The most common ones in school children are:

1. Generalised seizures
2. Typical absence seizures

1. Generalised Seizures (Grand Mal)

A typical generalised seizure may come on without any warning causing the child to become stiff, lose consciousness and exhibit twitching of the eyes, mouth or limbs.

The eyes may roll up and some frothing of the mouth may be seen.

Bladder control may be lost during the seizure which may last for a few minutes.

The child may be drowsy or fall into a deep sleep afterwards.

Occasionally there may be some weakness of the limbs for a few hours after the seizure but recovery is usually complete.

2. Typical Absence Epilepsy (Petit Mal)

This is seen more commonly between the ages of 4 and 8 years, being more common in girls.

It is characterised by momentary staring, vacant expression and momentary loss of consciousness.

Over 90% of seizures last between 5 and 15 seconds.

Warning is rare and abnormal movements, if any, are usually minor.

The child may stop speaking and stare in mid sentence.

On recovering from the seizure the child may have forgotten what was being said.

An episode during physical activity can be mistaken for clumsiness.

Absences may be variable in frequency, as many as several per hour.

All seizures are due to electrical short circuits within the brain. These are sometimes localised but when they spread they cause unconsciousness.

How Does Epilepsy Affect Children?

Psychosocial Problems

Psychological and social factor including low self-esteem, social isolation and perceived stigmatisation can lead to development of personality disturbances.

Although certain types of epilepsy (complex partial seizures) may predispose children to sudden outbursts of violent or disruptive behaviour, some disturbances may result from psychosocial factors other than those due to epilepsy and should be managed as such.

Effect of Drugs Taken for Epilepsy

Modern drug treatments are usually effective in controlling epilepsy, and will rarely need to be taken during school hours.

Occasionally side effects such as drowsiness and irritability may be noticed in school. These should be reported.

School Performance

Seizures may occur in children of all levels of ability.

Frequent and uncontrolled seizures, particularly typical absence seizures, will interfere with learning.

Only a small minority of patients with epilepsy show changes in cognitive functioning.

Changes affecting intellect, memory and language can result from adverse effects of anti-epileptic drugs in high doses.

IMPLICATIONS FOR SCHOOL

EPILEPSY

The teacher's observations of the child are often helpful in assessment and monitoring of epilepsy.

They are often the first to notice absence attaches and should feel free to express their concerns to the school nurse or doctor, parent or GP if worried about anything.

1. Generalised Seizures (Grand Mal)

There is very little to do during an acute episode.

The most important things to do are:

- move the child only if there is danger from sharp or hot objects or electrical appliances. Let the seizure run its course and observe the following simple guidelines.
- cushion the head with something soft (folded clothing will do) but do try to restrain convulsive movements.
- do **not** try putting anything at all between the teeth.
- do **not** give anything to eat or drink.
- loosen tight clothing around the neck, remembering that this could frighten a semi-conscious child. This should be done with care.
- do not call for an ambulance or doctor unless you suspect status epilepticus (see emergency care).
- as soon as possible turn the child onto its side in the semi-prone (recover/unconscious) position, to aid breathing and general recover. Wipe away saliva from around the mouth.
- be reassuring and supportive during the confused period which often follows this kind of seizure. If rest is required, arrangements should be made for this purpose.
- if loss of bladder control has occurred cover the child with a blanket. Arrangements should be made to keep a change of clothes at school if this is a regular occurrence.

It is not always necessary for the child to be sent home following a seizure, but each child is different. It may be wise to contact the parent if the period of disorientation after a seizure is prolonged. Ideally, such decisions should be taken in consultation with the parent, when the child's condition is first discussed, and a procedure (Care Plan) established.

2. Absence Seizure

No special measures.

Note the attach and report if this happens to any child not known to the school doctor and parent.

Emergency Care

The majority of seizures do not require medical care.

However, there are exceptions of which the teacher should be aware.

- when a seizure shows no sign of stopping after a few minutes,

  or

- when a series of seizures takes place without the child properly regaining consciousness in between. (status epilepticus)

In these cases the child should be taken to the nearest hospital offering emergency facilities.

Restrictions

1. The majority of children can attend normal school and participate in all sport.

2. The following should be avoided:

   - swimming alone
   - cycling in traffic (N.B. Wearing a helmet is advisable in any case)
   - boxing

3. Swimming may be allowed as long as fits are under control **and the child can be closely observed in the water. Medical opinion is needed**.

4. Participation in other games should be encouraged. Provided their fits are properly controlled there should be virtually no need for restrictions.

Considered judgement should be used and calculated risks may have to be taken.

Encouragement Needed

Participation should be encouraged in the same way as it is with all other pupils.

Careers guidance may be useful at an early age.

While most forms of employment would be open to a young person who has (or has had) epilepsy, there are still a few statutory limitations which might affect career choice. These are mainly concerned with driving and working with heavy machinery.

Special Problems in the Classroom

Witnessing a seizure may cause distress to other children.

However, if dealt with calmly and with reassurance from the teacher it may also be used as a positive experience.

Classmates may develop confidence and competence in helping to deal with these attaches and supporting their affected friend.

Dispelling the Myths

- Epilepsy is not synonymous with brain damage or mental handicap.
- It is not a mental illness.
- It is not caused by evil spirits.
- An isolated fit is not necessarily epilepsy.

COTHERSTONE PRIMARY SCHOOL

COMMUNITY CHILD HEALTH

ADMINISTRATION OF EMERGENCY MEDICATION

Name _____ Date of Birth _____

I, _____ being the parent of _____, give permission for the staff of

_____ School to administer _____ (drug and dose)

to my child if it is necessary. I understand that the teaching staff and special support assistants are not medically qualified but have received appropriate training in the administration of the drug. I understand that my consent is necessary so that staff can act in loco parentis.

I will take responsibility for replacing medication before the expiry date.

The procedure will be carried out in accordance with the agreed medical management plan of _____ (date of plan)

I will inform the school **in writing** if any changes in these instructions are necessary.

Name	Signature	Date

Emergency Medication Record

Date	Time	Signature I	Signature II	Outcome

COTHERSTONE PRIMARY SCHOOL
COMMUNITY CHILD HEALTH

MEDICAL MANAGEMENT PLAN

Name _____ Date of Birth _____

_____ has epilepsy. One of the manifestations of this condition is a 'fit or 'convulsion'.

During such an episode _____ may fall to the ground, twitch and lose consciousness.

Management is as follows:

1. Stay with _____ and call for help. Try to note the time.
2. If possible, lie _____ on the floor with head to side, away from harmful structures. Release tight clothing, e.g. collar. Place something soft under head. DO NOT put anything in mouth or try to prevent convulsive movements.
3. Second person collect rectal diazepam from Head Teachers Office.
4. If convulsions last longer than ___ minutes, administer rectal diazepam.
5. First person stay with _____ and quietly reassure - (s)he will eventually relax and sleep may follow.
6. Second person telephone:
   Parent Tel:
   Local Nurse Tel:
   Emergency Contact Tel:

   If no reply, telephone 999.
7. If fit does not respond to treatment within ___ minutes, telephone 99 as well as parent/carer.
8. When parent/carer arrives they will take responsibility for further management.
9. If ambulance is called give staff details of event and medication plus discarded rectal tube for disposal. On arrival they will take responsibility for further management.
10. Complete attached medical record.

		Plan date	
Staff Grade Paediatrician			
School Teacher		Parent	
Review Dates		Parent	

ADDITIONAL DETAILED INFORMATION

PROTOCOL FOR THE MANAGEMENT OF A CHILD DURING A CONVULSION

Action Required	Rationale
1st Person	
Stay with the child but CALL FOR HELP.	A convulsing child should not be left alone.
Look at your watch and note the time.	The timing and length of convulsion is helpful to medical staff in deciding future management.
Lie the child down on the floor on his/her side with the head slightly face down.	This allows the tongue to fall forward and not occlude the airway. It also allows excessive saliva to drain out.
Fingers or other objects should not be placed in the child's mouth.	Services no purpose and may cause damage to your fingers or the child's teeth.
Pull the child away from any harmful structure i.e. furniture of heating appliances.	Injury may be caused during the twitching phase of the fit when movement can be erratic.
If the child is still convulsing after 3 minutes, rectal Diazepam should be given, most cases. The time of administration should be noted.	Diazepam shortens the duration of the fit. Relevant if further drug therapy is needed.
Once the child has relaxed out of the convulsion a deep sleep may follow. Stay with the child until the ambulance arrives.	The time the convulsion ended should be noted, not the time the child woke up.
Provide explanation and reassurance if the child wakes before the ambulance arrives	Often up-setting for the child, especially if the convulsion occurred in the presence of school friends.
2nd Person	
The second person should assume responsibility for the following: (a) Phone an ambulance. (b) Bring the Diazepam from the cupboard. (c) Contact parents or significant other. (d) Make notes of the sequence of events to bring to the hospital.	

FACT SHEET

RECTAL DIAZEPAM

RAPID DELIVERY - GENTLE ALTERNATIVE

Use of Diazepam

Diazepam is commonly used, versatile medication which has been available in this country for over 30 years.

It is one of a class of medicines called benzodiazepines, all of whom have five properties[(1)]:

- induce sedation and sleep
- induce amnesia
- reduce anxiety and agitation
- relax muscles
- stop convulsions (in epilepsy)

In epilepsy, diazepam abolishes the abnormal electric activity in the brain which is responsible for the convulsion. It is used to prevent and treat continuous or prolonged seizures, which, if uncontrolled, might cause irreversible brain damage and even death [(2,3)].

How Diazepam Works

Diazepam acts specifically on the brain and central nervous system, where nerve pathways are interrupted at specific junctional points called synapses.

Synapses are bridged by transmitter substances which are released from nerve endings when a nerve impulse arrives. In this way, 'messages' are carried to all parts of the body, controlling our functions and actions. Normally, this mechanism is controlled by a balanced distribution of transmitters, some of which can excite, and some of which inhibit neurotransmission.

The major inhibitory neurotransmitter in the brain is gamma aminobutyric acid, or GABA. If GABA activity is reduced because of stress, medication, illness, or trauma, overexcitation occurs causing anxiety, wakefulness, muscle spasms, and convulsions[(4)].

Diazepam works by binding to benzodiazepine receptors at the synapse, and boosting GABA activity so that it counterbalances the influence of excitatory neurotransmitters. It thus reduces anxiety, wakefulness, muscle spasms, and convulsions [(1,4)].

Routes of Administration

Orally

Diazepam can be taken by mouth but absorption is slow, with plasma levels reaching a peak in 30 to 90 minutes.

Intravenously

Intravenous diazepam is very fast acting and peak concentrations are reached within 1 to 5 minutes [5].

These routes may be inaccessible or inconvenient in certain situations where patients have difficulty swallowing, when consciousness is impaired, when a doctor or nurse is not available, or during convulsions. In these situations, rectal diazepam is used.

Rectally

Rectal diazepam offers rapid delivery in a gentle alternative form. Most patients achieve peak serum levels within 6 to 10 minutes [3,5].

When to Use Rectal Diazepam

We know that rectal diazepam is used to prevent and treat continuous and prolonged seizures. However, the question "how will I know when to give it?" will inevitably be asked. This question can best be answered by stating that those caring for the person who has epilepsy should get to know how the seizures present in that particular individual's epilepsy - the form they take, the normal duration of the seizure, how they recover from it. This information can also be obtained from the person' parents if they care for them continuously. From this knowledge and understanding, the carer will be able to recognise when that individual is having their normal type of seizure (which doesn't require any form of prompt attention other than the usual care given for seizures) and when that individual is having seizures which require prompt attention in order to prevent:

- **severe, prolonged or continues seizures**

- **seizure clusters**, which can develop from severe or prolonged seizures, which, as their name suggests, occur in rapid succession over a period of several hours.

- **status epilepticus**, which refers to seizures which are repeated without a return to consciousness or to a prolonged seizure lasting as long as half an hour [2,6]. The longer seizures continue, the more difficult they are to control, and the higher the risk of brain damage.

In these situations, it is essential to stop seizures as soon as possible, and first-line treatment with rectal diazepam is highly effective. The correct dose should produce effective blood levels within 10 minutes [3].

The availability of treatments which allow seizures to be maintained within the community means that individuals can lead as normal a life as possible, whilst reducing the risks associated with prolonged seizures.

References

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4. Goodman Gilman A, Goodman LS, Rall TW, Murad F (eds). Goodman and Gilman's The pharmacological basis of therapeutics. Seventh edition. MacMillan Publishing Company, 1985.

5. Richens A, Perucca E. Clinical pharmacology and medical tratment. In Laidlaw J, Richens A, Chadwick D (eds). A Textbook of Epilepsy. Fourth edition. Churchill Livingstone, Edinburgh, 1993.

6. Walsh GO, Delgado-Escueta AV. Status Epilepticus, Neurol Clin, 1993; 11 (4) : 835-856

SECTION THREE

SUPPLEMENTARY INFORMATION

Supporting Pupils with Medical Needs in School: Circular 14/96 - Department for Education and Employment and Department of Health

SUPPLEMENTARY INFORMATION

USEFUL ADDRESSES

Action Asthma
PO Box 230
Bradford
West Yorkshire
BD7 1BR

Asthma Management Centre
232 Tower Street
Brunswick Business Park
Liverpool
LS 4BJ
Tel: 0151 7071199

Asthma Training Centre
Winton House
Church Road
Startford-upon-Avon
CV37 6HB
Tel: 01789 296974

British Lung Foundation
8 Peterborough Mews
Parsons Green
London
SW6 3BL
Tel: 0171 3717704

British Soceity of Allergy and Immunology
Level D
South Academic Block
Southampton General Hospital
Tremona Road
Southampton
Tel: 01703 777222

Chest, Heart and Stroke Association
(Scotland)
65 North Castle Street,
Edinburgh
EH2 3LT
Tel: 0131 2256963

Health Education Authority
Hamilton House,
Mabledon Place
London
WC1H 9TX
Tel: 0171 3833833

National Asthma Campaign
Providence House
Providence Place
London
N1 0NT
Tel: General Enquiries 0171 2262260
Helpline 0345 010203
(charged at local rates)

USEFUL CONTACTS AND HELPLINES

Voluntary Support Groups

Action for Sick Children
Argyle House
29-31 Euston Road
London
NW1 2SD
Tel: 0171 8332041

Aid to Children with Tracheostomies
215a Perry Street
Billericay
Essex
CM12 0NZ
Tel: 01277 654425

The Anaphylaxis Campaign
PO Box 149
Fleet
Hampshire
GU13 9XU
Tel: 0252 318723

British Allergy Foundation
23 Middle Street
London
EC1A 7JA
Helpline: 0171 600 6166

Cancerlink
18 Britannia Street
London
WC1X 9JN
Tel: 0171 8332451

or

9 Castle Terrace
Edinburgh
EH1 2DP
Tel: 0131 2885557

British Diabetic Association
10 Queen Anne Street
London
W1M 0BD
Helplin: 0171 3231531

British Epilepsy Association
Anstey House
40 Hanover Square
Leeds
LS5 1BE
Helpline: 0345 089599

Cystic Fibrosis Trust
Alexander House
5 Blyth Road
Bromley
Kent
BR1 3RS
Tel: 0181 4647211

Hyperactivity Children's Support Group
71 Whyke Lane
Chickester
West Sussex
PO19 2LD
Tel: 01903 725182

National Asthma Campaign
Providence House
Providence Place
London
N1 0NT
Helpline: 0345 010203

National Eczema Society
163 Eversholt Street
London
NW1 1BU
Tel: 0171 3884097

The National Society for Epilepsy
Chalford St. Peter
Gerrards Cross
Buckinghamshire
SL9 0RJ
Tel: 01494 873991

The Psoriasis Association
7 Milton Street,
Northampton
NN2 7JG
Tel: 0604 7111129

The Sickle Cell Society
54 Station Road
London
NW10 4UA
Tel: 0181 9617795

Terrance Higgins Trust
52-54 Grey's Inn Road
London
WC1X 8JU
Tel: 0171 2421010