



# **PUPIL MEDICAL NEEDS POLICY**

## **RHOS Y FEDWEN PRIMARY SCHOOL**

Draft: June 2025

Agreed by Governing Body: \_\_\_\_\_

Review Date: June 2026

## **Introduction**

This policy is written in response to the guidance contained in the Welsh Assembly Government circular 'Access to Education and Support for Children and Young People with Medical Needs'. The school will continue to be responsible for all children and young people unable to attend school for medical reasons and they should be able to access education without stigma or exclusion. Children and young people covered by this policy may:

- Be recovering from an illness or injury keeping them away from school during recovery;
- Have a long term or recurring illness;
- Have an illness or clinically defined mental health disorder which cause them to be absent for a period in excess of 15 days where medical opinion states they are still unable to access mainstream school.

## **Aim**

Our aim is to ensure that all children and young people in our school continue to have access to as much education as their medical condition allows so that they are able to maintain the momentum of their education and keep up with their studies. The nature of the provision will be responsive to the demands of medical conditions that can sometimes be changeable.

## **Responsibilities**

The school has a designated contact responsible for the education of children and young people with medical needs whose role it is to facilitate communication with all parties and ensure that the school is meeting the needs of all those identified. Whether the headteacher accepts responsibility in principle, for school staff giving or supervising children and young people taking prescribed medication, they should ensure prior written agreement is obtained for any medication to be given. Areas of general responsibility will include:

- Maintaining a list of children and young people with medical condition in school
- Ensuring that contact is maintained with children and young people (and their families) who are away from school due to illness for a period of less than 15 working days, setting of work if they are well enough, forwarding of newsletters etc, welcoming them back to school, ensuring that all staff are aware of their up to date medical situation and ensuring that any adjustments to accommodation and curriculum are made, together with ongoing monitoring of their situation and needs whilst in school
- Keeping the EWO informed of all attendance issues regarding children and young people where there may be medical needs, either physical or mental
- Ensuring that the school register is marked appropriately
- Maintaining contact with the school nurse
- Notifying the EWO if a child or young person is (or is likely to be) away from school due to medical needs for more than 15 working days. This includes those with a recurring illness
- Ensuring that close contact is maintained with them (and their family) and that arrangements are in place for the setting and marking of work. This is particularly important for those for whom a support programme is being arranged
- The school's policy on assisting children and young people with long term or complex medical needs

- Ensuring that all children and young people covered by this policy have access to statutory assessment. The school will also be responsible for requesting special arrangements where necessary

### **Parents/carers and children and young people**

We aim to ensure that parents will be full collaborative partners and have clear information on how they will have access to advice and support during their child's illness. Opportunities to allow the individual child to be involved in making decisions and choices will be considered as appropriate. Points of contact may include the class teacher, Deputy Head Teacher or Head Teacher. In general, pupils are not allowed to carry their own medication. Medication should be stored in one of our locked medicine cabinets.

### **Reintegration**

The school will have a key role to play in successful reintegration and will be proactive in working with all agencies to support a smooth transition and in ensuring that peers are involved in supporting child or young person's reintegration. The plan will always have multi-agency approval.

### **Involvement of Governors**

The Governing body will biennially review this policy seeking advice from key stake holders. This will include Parents, teaching and support staff and appropriate health care professionals. The Governing body shall if required review this policy more frequently, if new or additional medical information becomes available. The Head Teacher Governor or delegated to a representative (Health and Safety link Governor) will update the Governing Body via the head teachers report (confidentially) any incidents where this policy has been applied. The Headteacher or nominated member of staff is responsible for ensuring staff receive regular updates and training. New members of staff and agency staff will receive an appropriate level of information on the first day of their orientation to the school.

### **Emergency Arrangements**

The school's emergency procedures are clearly posted in all offices and the first aid/medical rooms. Please refer to individual Health Care Plans and our First Aid policy.

### **Summary**

The school's policy for the education of children and young people with medical needs should be read in conjunction with: ALN Policy First Aid Policy Equality/Access Policy.

## **Medical Advice on Common Conditions**

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

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

### **ASTHMA– What is Asthma?**

One in ten children and young people in the UK has asthma. The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may say that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will get these symptoms, and some may only get symptoms from time to time.

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

### **Medicine and Control**

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

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

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

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

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

The signs of an asthma attack include:

- Coughing
- Being short of breath
- Wheezy breathing
- Feeling of tight chest
- Being usually quiet

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

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

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

A child with asthma should have a regular review with his/her GP or other relevant healthcare professional. Parents should arrange the review and make sure that a copy of their child's management plan is available to the school or setting.

Children and young people should have a reliever inhaler with them when they are in school or in a setting. Children and young people with asthma should participate in all aspects of the school or setting 'day' including physical activities. They need to take their reliever inhaler with them on all off site activities. Physical activity benefits children and young people with asthma in the same way as other children and young people. Some activities are more likely to bring on asthma symptoms. Some children and young people may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

Reluctance to participate in physical activities should not be forced to take part if they feel unwell. Children and young people should be encouraged to recognise when their symptoms inhibit their ability to participate. Children and young people with asthma may not attend on some days due to their condition, and may also at times have some sleep disturbances due to night symptoms. This may affect their concentration. Such issues should be discussed with the child's parents or attendance officers as appropriate.

All schools and settings should have an asthma policy that is an integral part of the whole-school or setting policy on medicines and medical needs. The asthma section should include key information and set out specific actions to be taken (a model policy is available from Asthma UK). The school

environment should be asthma friendly, by removing as many potential triggers for children and young people with asthma as possible.

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

## **EPILEPSY – What is Epilepsy?**

Children and young people with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time.

Seizures can happen for many reasons. At least one in 200 children has epilepsy and around 80 per cent of such children attend mainstream school. Most children and young people with diagnosed epilepsy never have a seizure during the school day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern that individual children and young people experience. Parents and health care professionals should provide information to schools, to be incorporated into the individual health care plan, setting out the particular pattern of an individual child's epilepsy. If a child does experience a seizure in a school or setting, details should be recorded and communicated to parents including: any factors which might possibly have acted as a trigger to the seizure – e.g visual/auditory stimulation, emotion (anxiety, upset) any unusual 'feelings' reported by the child prior to the seizure – when it happened and how long it lasted whether the child lost consciousness whether the child was incontinent.

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

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

In some cases, such as seizures go on to affect all of the brain and the child loses consciousness. Such seizures might start with the child crying out, then the muscles becoming stiff and rigid. The child may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child's colour may change to a pale blue or grey colour around the mouth. Some children may bite their tongue or cheek and may wet themselves. After a seizure a child may feel tired, be confused, have a headache and need time to rest or sleep. Recovery times vary. Some children feel better after a few minutes while other may need to sleep for several hours.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child may appear 'blank' or 'staring', sometimes with fluttering of the eyelids. Such absence seizures

can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

### **Medicine and Control**

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

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

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

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

An ambulance should be called during a convulsive seizure if:

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

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

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

Training in the administration of rectal diazepam is needed and will be available from local health services. Staying with the child afterwards is important as diazepam may cause drowsiness. Where it is considered clinically appropriate, a liquid solution midazolam, given into the mouth or intranasally, may be prescribed as an alternative to rectal diazepam. Instructions for use must come from the prescribing doctor.

Children and young people requiring rectal diazepam will vary in age, background and ethnicity, and will have differing levels of need, ability and communication skills.

If arrangements can be made for two adults, at least one of them the same gender as the child, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child as far as possible, even in emergencies.

## **DIABETES – What is Diabetes?**

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

There are currently around 1,300 children with diabetes in Wales. Around 97% of these have Type 1 diabetes, meaning that they are entirely dependent on injected insulin to live. There are also a small number of children with Type 2 diabetes and with other rarer forms of the condition, and the incidences of both Type 1 and Type 2 diabetes in children have been rising for a number of years.

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

### **Medicine and Control**

The blood glucose levels of the majority of children with diabetes are controlled by daily injections of insulin. Some children will be on a twice daily insulin regimen of a longer acting insulin and it is unlikely that these children will need to be given insulin during school hours. Increasingly, however, many children with diabetes are moving to a multiple daily injection (MDI) regimen in order to better stabilise their diabetes, it may be necessary for an adult to administer the injection. Some children may control their diabetes by use of an insulin pump, and as in the case of MDI, this is increasingly common treatment.

Most children and young people can manage their own injections, but if doses are required at school supervision may be required, and also a suitable, private place to carry it out.

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

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

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



Children and young people with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class time or prior to exercise. Schools may need to make special arrangements for them if the school has staggered lunchtimes.

If a meal or snack is missed, or after strenuous activity, a child or young person may experience a hypoglycaemic episode (a hypo) during which blood glucose levels fall to low. Staff in charge of physical education or other physical activity sessions should be aware of the need for them to have glucose tablets or a sugary drink to hand.

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

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

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

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

An ambulance should be called if:

- the child's recovery takes longer than 10-15 minutes; and/or
- the child becomes unconscious If the child is unwell, vomiting or has diarrhoea this can lead to dehydration.

If the child is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child will need urgent medical attention.

Such information should be an integral part of the school or setting's emergency procedures but also relate specifically to the child's individual health care plan. Schools can call upon PDSNs for practical support and advice.

### **ANAPHYLAXIS – What is Anaphylaxis?**

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

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

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

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting.

Even when mild symptoms are present, the child should be watched carefully. They may be heralding the start of a more serious reaction.

### **Medicine and Control**

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

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

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

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

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

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

Important issues specific to anaphylaxis to be covered include:

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

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

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

When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child's particular requirements. A 'kitchen code of practice' could be put in place.

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

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

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

National Attention Deficit Disorder Information and Support Service

Tel: Middlesex 02089 522800

<http://www.addiss.co.uk>

National Children's Bureau Council for Disabled Children

Tel: London 20278436000

<http://www.ncb.org.uk>

National Eczema Society

Helpline: 0870 2413604 (Mon-Fri 8am to 8pm)

National Health Service Direct Cymru

Tel: 0845 4647

<http://www.nhsdirect.wales>

NCH Cymru, the Children's Charity

Tel: Cardiff 029 202127

<http://www.nch.org.uk>

Special Needs Advisory Project (SNAP) Cymru

Tel: 0845 1203730