Caslon Primary School

Medical Policies

Document live date: September 2014

Document review date: September 2016

Caslon / NHS Partnership

The health of our pupils is of paramount importance, poor health can result in a barrier to learning and it is our aim to support Dudley NHS Primary Care in regularly monitoring the health and well-being of individuals.
Our partnership with the NHS enables us to provide facilities for a number of timed checks to be carried out. For your information these are listed below:

- The Dudley South NHS Primary Care Trust monitors all school Health Advisors caseloads regularly and updated when necessary. This reflects in a good medical liaison between Primary School and Secondary Schools.
- It is important that all medical issues are transferred between schools.
- Caslon Primary's School Health Adviser (SHA) is Mrs Amanda Gibbons and she can be contacted at Halesowen Health Centre.
- The care scheme of work that the SHA offers is:-

Prior to school entry

- Attend new parents evening

School entry (Foundation which = first year at Caslon Primary)

- Liaison with class teacher/First Aid Coordinator
- Health questionnaire to all parents
- Measurement of height and weight
- Hearing Sweep test
- Children who are highlighted with a medical/developmental problem will be offered a selective school entry health assessment or referred to the appropriate agency.

Throughout Primary School

- Referrals from education staff. Reviews of height, weight and hearing will be offered.
- Regular „drop in" sessions for children and parents.

Year 6

- Confidential health questionnaire to all parents on transfer to secondary school.
- Measurement of height/weight

Caslon Primary School has an excellent working relationship with our School Health Advisor. We are working towards promoting good health and ensuring children with any problems are dealt with in a caring confidential manner.

The Medical Policy concerns itself with the:

- Health and Safety of all individuals (see Health and Safety Policy).
- The administration of authorised drugs in the treatment of specific medical conditions.

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1 Asthma Policy

1.1 Introduction

"Asthma is a potentially life threatening condition which demands to be taken seriously. With a child admitted to hospital every 12 minutes because of asthma it is essential that schools – where children spend the majority of their time – are able to support children with asthma in their care.

Asthma has become one of the most important medical conditions in the western world.

Most classrooms will have an average of 4-5 children with asthma making it the most common long term medical condition in schools today. At school a child with asthma has the right to expect:

- Immediate access to their inhaler – if the inhaler is left in the classroom medical box – it will be visible and accessible.
- Appropriate support to fully participate in PE and all activities.
- Help in catching up with lessons after time off school.
- An environment free of asthma triggers such as cigarette smoke".

(Taken from the National Asthma Campaign, 1999.)

1.2 Aims

Caslon Primary School adopts this policy to ensure that pupil"s individual health needs are met in line with the LEA Inclusion Policy.

All supply teachers and new staff are also made aware of the policy.

- To recognise the needs of all the children with asthma.
- To ensure that children with asthma participate fully in all aspects of school life.
- To recognise that immediate access to the child"s inhaler is vital.
- To maintain a high level of awareness throughout the school regarding all named pupils and their needs.

1.3 Guidance

In order to achieve these aims, the following guidance should be carried out:-

- All staff are given basic awareness training about asthma and the use of an inhaler. This training will be updated annually by the school nurse.
- All staff have a clear understanding of the procedure to follow when a child has an asthma attack.

- Inhalers for children are accessible at all times. Inhalers to be kept in their classrooms clearly labelled, either in the classroom medical boxes or carried by the child.

- Inhalers are taken on all school trips and children noted in the Risk Assessment.
- The school maintains a register of asthmatics with up to date medical details which is kept in the office.
- Upon completion of a child's details for the asthma register, parents/carers may give permission to use the emergency inhalers kept in school.
- Emergency inhalers are kept in the Office and renewed by the school nurse.
- The First Aid Co-ordinator will ensure that at the start of each term, staff check that inhalers and epipens are a) in school and b) in date. However, it is ultimately the parents/carers" responsibility to ensure that in date inhalers and epipens are in school.
- It is strongly advised that parents supply a second inhaler to be kept in the school evacuation pack for use in an emergency or to be available if the first inhaler is empty or lost.
- If the second inhaler is used, parents will be notified so that they may obtain a replacement/another spare one.

1.4 Management of Asthma in School

- Early administration of the correct reliever treatment, usually a blue inhaler, will cause the majority of attacks to be completely resolved.
- Parents/carers should supply 2 labelled inhalers and if needed a spacer device.
- Parents/carers should provide written details, on the Dudley Asthma Pupil Form, which are kept in the Office, of the treatment needed in an attack. The child is then put onto the Asthma Register.
- Parents/carers should notify the school of any changes in the treatment, details are evaluated by the school nurse annually.
- All teachers must be aware of the children in their class with asthma and their treatment.
- Teachers should remind pupils whose asthma is triggered by exercise to take their inhaler before the lesson. Each child"s inhaler must be labelled and kept at the site of the lesson.
- If a child needs to use their inhaler during the lesson they will be encouraged to do so. Staff must check if a spacer is required.
- If a child uses their inhaler in school, parents or carers will be informed so they can monitor usage.

1.5 In the event of an asthma attack

- Ensure that 2 puffs of the blue inhaler are taken immediately. Whenever possible do not move the child, give the medication where ever the child is.
- If symptoms do not resolve continue 1 puff every minute for 5 mins.
- If symptoms persist with no change after 5 – 10 minutes revert to Emergency situation.
- Stay calm and reassure the child.

- Stay with the child until the attack is over.
- Encourage the child to breathe slowly and deeply.

- After the attack and as soon as they feel better, the child can return to normal school activities.
- The child's parents/carers must be informed of the attack.
- If a child has repeated attacks and NO personal inhaler is at school, the parents/carers should be contacted. If no communication the school nurse should then be informed.

1.6 In an Emergency Situation

Call the ambulance if:-

- If the child has no inhaler in school
- The reliever has NO effect after 5-10 minutes
- The child is either distressed or unable to talk
- The child is getting exhausted
- You have any doubts at all about their condition
- Continue to give the inhaler 1 puff every minute until help arrives.

1.7 Safety and Hygiene Issues

The drug in the blue inhalers which is used to relieve symptoms is very safe and cannot do any harm if given too much.

No harm will come to a non-asthmatic child that takes an inhaler.

Emergency spacer devices are for universal use and should be washed in warm soapy water, NOT RINSED, and allowed to dry in the air after each use to prevent cross infection.

2. Anaphylactic Policy

2.1 Introduction

Anaphylaxis is an extreme allergic reaction requiring urgent medical treatment.

It is a harmful response by the body to a substance.

Approximately 7% of the population are allergic to certain foods/bites/stings and various types of drugs. So it is therefore very likely that most teachers will come in contact with a child who suffers from an anaphylactic reaction.

If anaphylaxis is dealt with calmly and reassuringly, the child will benefit and other pupils will develop a healthy and accepting attitude towards the condition.

Caslon Primary should ensure that all staff are trained and receive annual up-dates by the school nurse to support the management of anaphylaxis in school.

2.2 Aims

- To ensure that children who have an acute allergy have access to their medication.
- To provide regular information, training annually and up to date awareness of the identified children within the school.
- To provide a safe environment where children are protected from curriculum activities which may aggravate their allergy- i.e. cookery.
- To maintain a high level of awareness throughout the school regarding all named pupils and their needs.

2.3 Key Stage 1

All staff in the relevant year group, will be made aware of any children with Anaphylaxis/allergies and care plans.

Parents will be seen by Amanda Gibbons (Dudley Schools Nurse) and a Care Plan filled in – discussing child's condition, signs and symptoms plus medical treatment.

Copies of care plans will be kept in the relevant classrooms and all staff in that child's year group and lunchtime supervisors, will be made aware of the child's medical needs and care plan procedure.

A photograph will be attached and the forms kept in school office.

Parent/carers must ensure that up to date Epipens are clearly labelled and given to the school office.

The second epipen will (with parental permission) be kept in the School Evacuation Pack in the office for use in an emergency.

2.4 Key Stage 2

All staff in the relevant year group, will be made aware of any children with Anaphylaxis/allergies and care plans.

It is the parents/carers responsibility to ensure the Epipen is in date.

At the start of each term First Aid Co-Ordinator will ensure that all staff check Epipens are a) in school and b) in date. However it is the responsibility of parents/carers to ensure that in date Epipens are provided for their child.

If the child is prescribed a second epipen it will (with parental permission) be kept in the School Evacuation Pack in the office for use in an emergency.

2.5 Emergency Procedure – in the event of an Anaphylactic Attack

A). It is important that immediately a child complains of any of the following severe symptoms the Epipen is given immediately –

- Excessive swelling of lips/ mouth/ tongue
- Difficulty in breathing/ talking
- Drowsiness
- Wheezing
- The child may fall into unconsciousness (child to be put into the Recovery Position and if needed CPR performed.)

The injection can be given through the clothing, into the top of the thigh- to the count of 10, giving a measured dose of Adrenaline.

Only the Epipen prescribed for the named child should be administered, as the dose is pre-set to the child's body weight.

If no change in condition after 5-10 minutes the second Epipen must be given, if prescribed. All treatment relayed to Ambulance staff.

A child cannot be overdosed with Adrenaline, it is better to give the Epipen than not.

When an ambulance is called the Head of School/Assistant head of School or the next senior member of staff in their absence must be informed immediately.

When a child is given their Epipen they must be transferred to hospital and a member of staff should go with them.
Parents/carers must be informed immediately.

It is very important that the used Epipen is sent to the hospital with the child, so the staff can see treatment already had and the time given.

B). Some children have a milder form of the allergy and therefore need only a dose of prescribed antihistamine such as Piriton at the onset of their symptoms. This should be kept in the school office clearly labelled.

Some mild symptoms may be:-

- Facial rash
- Tickly sensation in back of throat
- Muscle ache
- Mild swelling of lips/ mouth/ tongue
- Headache
- They will be able to talk/ breathe normally
- Irritability

If a child presents with any of the above then a dose of antihistamine should be given if it has been prescribed by their Doctor. The dose will be clearly stated on the bottle.

You must stay with the child for at least 30 minutes to ensure symptoms do not become worse. Ensure plenty of reassurance is given.

The child"s parents/carers should be informed, and the child should not be left alone for up to 3 hours afterwards.

The parent/carers must be informed of all treatment given.

3. Epilepsy Policy

3.1 Introduction

One person in every 130 has epilepsy and 75% of people with the condition will have their first seizure before the age of 20. It is therefore likely that most teachers will come in contact with a pupil with epilepsy at some time during their career.

If epilepsy is dealt with calmly and reassuringly, the child will benefit and other pupils will develop a healthy and accepting attitude towards the condition.

- Epilepsy is a descriptive term and not a specific illness or disease.
- It is an altered chemical state of the brain leading to outbursts of extra electrical activity within it.
- People that suffer from epilepsy may have seizures or fits. There are many types of seizures, the most common being Absence (petit mal) and Tonic / colonic stage (grand mal).

Pupils with epilepsy come under the definition of having a disability as described in the "Code of Practise" and are covered by the Special Education Needs and Disability Act (SEND) and the Disability Discrimination Duties.

3.2 Guidance

In 2002 new duties came into place in the Disability Discrimination of Epilepsy – schools must not discriminate against disabled pupils in the provision of education and in respect of admission to schools and in Inclusion.

- The school must not treat disabled pupils less favourably.
- The school must make reasonable adjustments. Schools should plan in advance to meet the needs of a disabled child.
- It is unlawful to exclude a disabled child from school for a reason relating to their disability.
- Epilepsy Management Plans and Alert Charts should be filled in with the parents, kept in the office and a copy sent to the class teacher.

3.3 Aims

Caslon Primary School adopts this policy to ensure that pupil's individual health needs are met in line with the LEA Inclusion Policy.

- To recognise the needs of all children with Epilepsy.
- To ensure that children with Epilepsy participate fully in all aspects of school life.

- To recognise that immediate treatment is vital.
- To maintain a high level of awareness throughout the school regarding all named pupils and their needs.

3.4 Symptoms of Epilepsy

A) *Major Seizures (Tonic / Clonic Stage)*

A seizure of this kind is distressing to watch, we all want to help but there is little to be done.

Sometimes suffers have a warning / aura eg. Certain smell, taste or sensation.

Tonic Stage:

Sufferer falls unconscious
Muscles go rigid
They can go blue in the face
They can bite their tongue

Clonic Stage:

Muscles go into spasm
They will have violent movements of the limbs
They can froth at the mouth
They can become incontinent

The duration of the seizure is hardly ever more than 5-10 minutes. In a severe case another fit could begin straight away, at this point 999 must be called or if the seizure lasts for longer that 5-10 minutes.

After the clonic spasms have stopped the sufferer may go into a sleep, which they should be allowed to do.

B) *Absence (Petit mal)*

These are much briefer and can be numerous.

They have a loss of consciousness for only 1-2 seconds: they will feel 'dazed' afterwards.

3.5 First Aid Treatment of Epilepsy

Major Seizures

- Inform a trained First Aider if possible
- Never leave the child alone until fully recovered

- Do not move the child unless they are in danger
- Move any objects on which they could hurt themselves
- Do not put anything in their mouth
- Do not restrict their movements
- Turn them into the recovery position once the seizure is over and cushion their head
- Provide reassurance / reorientation following the seizure
- Maintain their dignity / privacy at all times
- Normally there is no need to ring 999, ensure parents are contacted to collect the child if required.

Minor Seizures

- Be understanding
- Repeat what has happened / missed in the classroom
- Note that it has happened and how frequent
- Inform the parents

Management of other children's needs

- Stay calm
- Send for another adult
- Reassure the children and arrange for them to leave the room
- Consider a simple explanation of epilepsy for them

3.6 Health and Safety Issues

A) Assessing the Risk

The vast majority of children in schools have good seizure control and will not experience a seizure whilst at school. However, some factors associated with the condition such as side effects of drug therapy may affect the pupil's awareness and their ability to react quickly.

When assessing a child for a task the following factors should be taken into account:

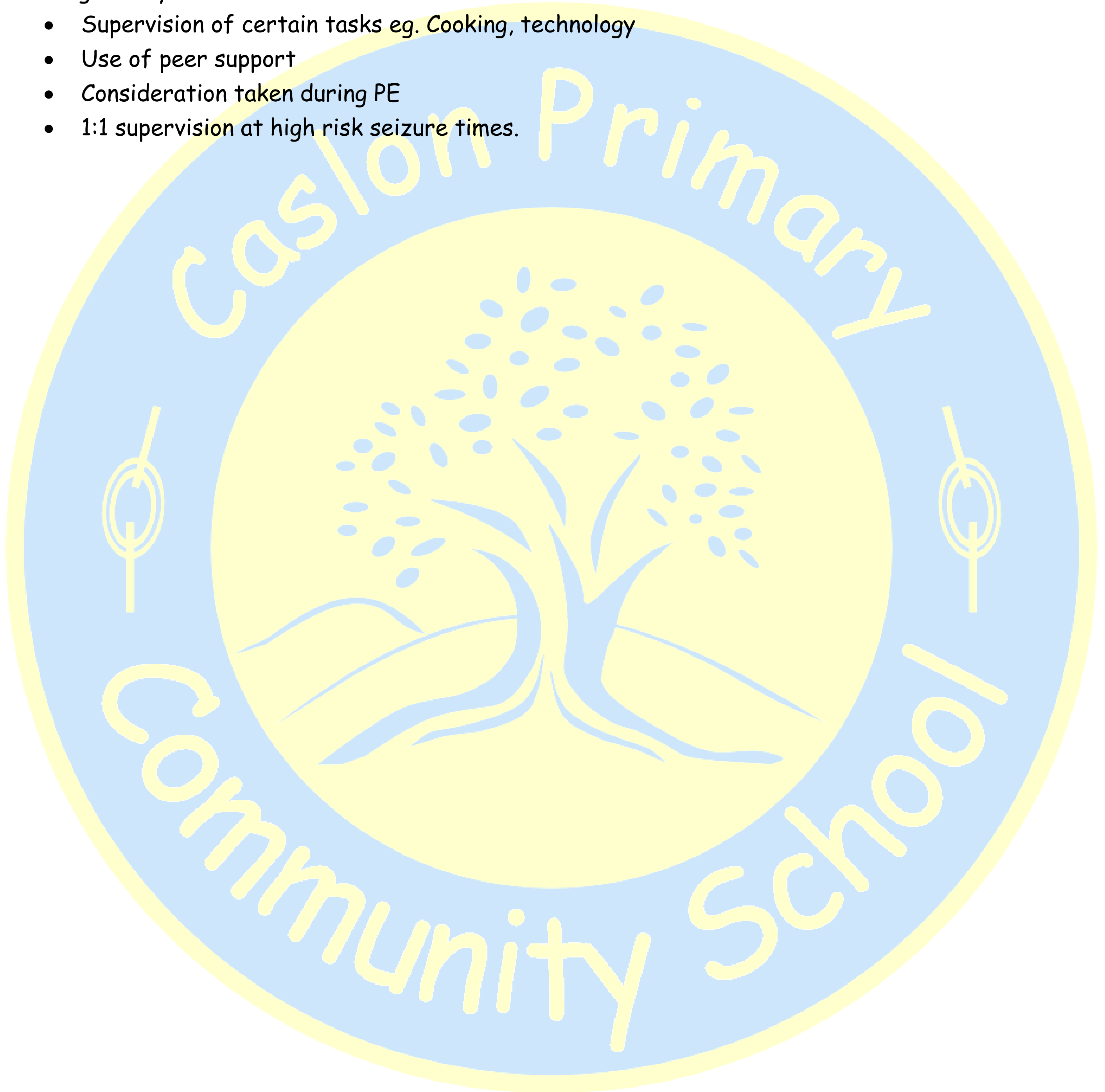
- Follow the child's individual care plan (If medication is to be given in school a care plan will be provided).
- Seizure type
- Frequency of the seizures
- Pattern of the seizures
- Seizure triggers
- Environment (use of white boards etc.)

B) Managing the Risk

The SEND makes it illegal to discriminate against a child as a result of their medical condition. This means that strategies need to be put into place to enable the child to access their full curriculum entitlement.

Strategies may include:

- Supervision of certain tasks eg. Cooking, technology
- Use of peer support
- Consideration taken during PE
- 1:1 supervision at high risk seizure times.



4 Diabetes Policy

4.1 Introduction

Diabetes is a condition where the level of glucose in the blood rises or falls from safe levels. This is either due to the body not producing insulin or because there is insufficient insulin for the child‟s needs of the insulin.

"About one in 550 of school-age children have diabetes and 2 million people in the UK are affected. The majority have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. People with Type 2 diabetes are usually treated by modifying diet and exercise" (Diabetes in school 2006)

The diabetes of the majority of children is controlled by injections of insulin each day or by pump therapy. Most younger children will be on a twice a day insulin regime of a longer acting insulin and it is unlikely that these will need to be given during school hours, although for those who do it may be necessary for an adult to administer the injection. If on pump therapy, it will be necessary for an adult to supervise the entering of data into the insulin pump in order to ensure accuracy of information and ensure safety in that the pump issues a correct dosage of insulin. The child's individual care plan will be followed.

4.2 Aims

- To optimise management of diabetes in the school day
- To ensure that children and young people with diabetes are supported in the administration of insulin by school staff.
- To maintain a high level of awareness throughout the school regarding all named pupils and their needs.

4.3 Role of the staff

- All school staff are made aware of the pupils who have diabetes and are using an insulin pump or who administer insulin via injection.
- Staff whom have agreed to administer insulin via injection or pump therapy will be given appropriate training by the Local Authority.
- Caslon employs a member of staff responsible for complex medical needs whom is trained to manage diabetes within the school.
- School staff will ensure that a trained member of staff is available every school day, and on-site, to give or supervise the injection or pump therapy data entry and will inform the child's parent/carer immediately if a trained person is not available.

- The child's care plan will be followed accordingly and agreed by parents, the Children's Diabetes Nurse Specialist, head teacher and the school staff who have been specifically trained.
- Staff need to be aware that children with diabetes need to be allowed to eat and drink regularly during the day. This may include eating snacks during lesson times or prior to exercise.

4.4 Symptoms of diabetes

- Hunger
- Sweating
- Drowsiness
- Pallor
- Glazed eyes
- Shaking or trembling
- Lack of concentration
- Irritability
- Headaches
- 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.

The child will be given a diary to keep a record of any hypoglycaemic or hyperglycaemic episodes, including blood glucose levels and administration of insulin via a pump or manual insulin injection, with times of day included. This should be sent home at the end of each school day to inform parents/carers.

4.5 Managing Hypoglycaemia

If a child has a hypoglycaemic episode, it is very important that the child is not left alone and that glucose levels are recorded as a diary entry to inform parents/carers at the end of the school day.

In the event of a hypoglycaemic episode, the child should test/or be helped to test their blood glucose level and then the child should be given a fast acting sugar, such as glucose tablets, a glucose rich gel or a sugary drink(as agreed with parents on their health care plan for exact dosage).

The blood glucose levels at the start of the hypoglycaemic episode should be recorded in a dedicated diary for the individual child and tested after an agreed length of time as stated in their care plan, after the administration of a fast acting sugar. The second blood level should again be recorded in the diary and as long as the child is feeling well and the blood glucose level has returned to within normal parameters (as decided by the child's Diabetic Nurse, parents/carers and their health care plan), the child may return to their lessons.

If the blood glucose levels do not return to within normal levels after the administration of a single dose of fast acting sugar, the whole procedure should be repeated. **If the blood glucose levels do not return to normal levels after a second dose of sugar, then the parents/carers should be telephoned and the school will act upon their advice**.

If the child has more than two separate episodes of hypoglycaemia in a school day, then parents/carers should be made aware of this and asked for advice on whether their child should remain in school.

4.6 Managing Hyperglycaemia

Some children may experience hyperglycaemia (high blood glucose level) and have a greater need to go to the toilets or to drink. They may also experience a feeling of nausea, sweating and/or disorientation.

Blood glucose levels should be initially tested to establish an episode of hyperglycaemia and then recorded in the child's blood glucose diary. The child's health care plan should be followed for timescales to retest. Meanwhile, **the child should be monitored at all times.**

The healthcare plan for each child will state at what blood glucose level, staff should test for the presence of keytones in the blood/or ask the parents to come into school to test for keytones themselves. If keytones are present, the parent/carer should be informed and their advice acted upon.

After an agreed length of time (again as stated in the child's healthcare plan and agreed with parents/carers), the blood glucose level should be retested. If the levels remains high, the presence of keytones should again be tested for, and if found still present the care plan should be followed.

If the child should become unconscious then an ambulance should be called immediately, giving all recorded information and record of treatment given to paramedics/hospital staff.

5 First Aid Policy

5.1 Aims

- To maintain an appropriate ratio of qualified staff, at all levels, who undergo regular first aid training
- To secure a sound provision of first aid trained staff for all school based activities both within and outside school
- To ensure the Health and Safety of all pupils throughout the school

5.2 Role of the Staff

- Teachers have a common law responsibility to look after the children in their care.
- Non- teaching staff, act under the direction of the Head of School/Assistant Head of School and the Head of Inclusion.
- General guidance for parents about school procedures is included in the school prospectus.

5.3 First Aid Supplies

First aid boxes are maintained at various locations around the school clearly marked, and the medical room is accessible to all children when needed.

First Aid Boxes contain the following:-

- Selection of plasters
- Disposable gloves
- Triangular Bandage
- Selection of dressings/ bandages
- Tape

There are First Aid bum bags for use on all school trips etc.

5.4 The Administration of Medicines

Parents are advised that children who are unwell should not be sent to school.

Should children require a course of antibiotic treatment that requires 4 dosages a day then school staff will administer one of these doses at the appropriate time – usually around the middle of the day. The parent/carer will fill out the administration of medicine form, kept in the school office. They will give the medicine to the office, fully labelled. The Office staff will store the medicine appropriately, either in a fridge or cupboard in the office. The medicine will be returned to the

parent at the end of the treatment. If the child leaves the school permanently the school will then dispose of the medicine by taking it to a pharmacy. The Office staff will keep a record of any medicines that are administered. All of these forms are located in the Medicine folder in the school office.

The school will not administer antibiotics if the dosage is 3 times per day. These dosages can be given outside of the school day.

In extreme circumstances where children suffer from a serious medical condition, the school may:
1. Administer medication. An Administration of Medicine form to be completed.
2. Allow children to self-administer medication providing the school receives authorisation from both parents and their GP.

5.5 Procedure for Accidental Injury

- If anyone should become ill or suffer injury as a result of an accident the following procedure should be followed:-
- Immediate first aid must be given by the nearest member of staff AS far as knowledge permits, and a message sent to the nearest First Aider.
- The casualty must be given all possible reassurance and ONLY if absolutely necessary be moved. If at all possible the patient should not be left alone.
- A message must be sent to the Office so that the Head of School/Assistant Head of School are informed.
- As soon as possible the parents/carers will be informed.
- Pupils must be sent to hospital immediately by ambulance in the following cases:

Any head injuries and wounds needing stitches
All suspected fractures
Any signs of unconsciousness, even for a few seconds
Anaphylactic shock

N.B. Legally pupils must be sixteen to be given medical treatment without parental consent, however in „Life or Death" situations treatment is given immediately.

- Where parents request ambulance attendance other than for the conditions above, any costs will be met by the family.
- Following the accident the Accident Report book must be completed, and returned to the Office.

5.6 Child Reporting Sickness

The school takes its responsibility for the Health, Safety and Welfare of all our children very seriously. It is vital to have consistent procedures for the handling of day to day illness.

- When a child reports feeling unwell to a member of staff, initially their action is determined by how well they know the child.
- First Aiders/staff will assess whether they think a child needs 'time out' from the classroom/lesson and administer any first aid deemed necessary.
- When first aid is given, a form from the accident and illness register is completed. One copy is sent home and one copy kept in the school office.
- The responsibility for deciding whether a pupil should go home or not, therefore primarily resides with the class teacher/First Aiders.
- In cases where the child has a bump to the head, a „bumped head" form must be sent home. If the bump is a severe one then the parents/carers should be notified and a decision made whether the child should go home.
- If a child has a general bump to the face, then a form is filled in and sent home.
- Parents with a child suffering from a short term serious illness are encouraged to contact the Head of School/Assistant Head of School to negotiate education requirements.
- We do not encourage children to miss lessons and do not allow unsupervised children to stay indoors during breaks, so before a child is sent back to school after an illness, parents should ensure that the child can cope with the whole school day.
- Any child who has been sick should go home as soon as possible, in order to limit the spread of any infection.

5.7 Disposal of medical supplies

- Any equipment used to treat blood-related injury is put into a yellow bag and disposed of appropriately.

5.8 Exclusion Conditions

There are regulated exclusion periods for:

- Fevers
- Infection
- Gastro illnesses
- Skin infections
- General infections
- Infestations

Children should remain away for the regulated time stated on the following pages, to prevent epidemics occurring.

Disease	**Usual incubation period**	**Period of communicability**	**Minimal period of exclusion from school**	
			Cases – subject to clinical recovery	**Contacts – family/close**
Rubella (German measles)	2-3 weeks	7 days before to 4 days after onset of rash	Until recovered/4 days from onset of rash	None
Measles	7-18 days	Just before start of symptoms to 5 days after start of rash	Until recovered/5 days from onset of rash	None
Mumps	18-21 days	7 days before to 7 days after onset of swelling	7 days from onset of swelling	None
Chickenpox and Herpes zoster (Shingles)	14-21 days	1-2 days before to 5 days after onset of rash	Until rash dried – generally for 5 days from onset of rash (+see shingles)	None
Scarlet Fever (streptococcal)	1-3 days	Whilst organism in nose/throat – usually 48 hours from onset	Scarlet fever – 1 week onset Other – when treated	None
Whopping cough	7-10 days	7 days after exposed to 21 days after onset paroxysmal cough	From 3 weeks after onset of cough and fully recovered.	None

Disease	**Usual incubation period**	**Period of communicability**	**Minimal period of exclusion from school**	
			Cases – subject to clinical recovery	**Contacts – family/close**
Diagnosed Norovirus	48 hours	Most infectious when have sickness and/or diarrhoea	Until clinically well and no diarrhoea for 48 hours	Exclusion not routinely needed for contacts or family members
Diagnosed swine flu	1-10 days – or until symptoms cease	Duration of active illness	Until recovered	None – unless other factors are apparent i.e. asthma then flu vaccine recommended
Gastroenteritis of unknown cause – include viral	Viral – may be 12-48 hours	Whilst organism is present in stools	Until clinically well and no diarrhoea for 48 hours	Exclusion not routinely needed for

				contacts or family members
Dysentery (Shigella)	1-7 days	Most infectious when have diarrhoea	Depending on cause, children in Nursery classes may be excluded longer	If symptoms develop, should also be excluded. Some cases may have stool testes if positive may be advised for inclusion. Extra precaution with food handlers – should have stool test.
Salmonella – food poisoning	12-72 hours			
Campylobacter – food poisoning	1-10 days (usually 2-5)	Most infectious when have diarrhoea	In rare cases exclusion may be extended and stool specimens needed – will be a discretion of the CCDC	
Cryptosporidia infection	3-14 days	Less risk transmission when stools well formed		
Giardia infection	4-25 days			
E. Coli – verotoxin producing	1-14 days – usual 1-6 days	Whilst organism in schools	Until normal stools for 48 hours and may need stool specimens – discretion CCDC	Younger family contact may need to be excluded until case well – at discretion of the CCDC
Other Gastrointestinal Illness and Infective Jaundice				
Hepatitis A	15-50 days – usually one month	1-2 weeks before onset to 1 week after onset jaundice	Until one week after onset of jaundice	None
Hepatitis B	48-180 days – usually 60-90 days	Whilst organism in body fluids. Can carry without symptoms	Until clinically recovered	Not required – CCDC will advise
Typhoid fever	7-21 days	Whilst organism in stools or urine	At discretion of the CCDC	At discretion of the CCDC
Paratyphoid fever	1-10 days			
Skin and Other Specific Site Infections				
Impetigo	4-10 days	Whilst purulent lesions. Antibiotics rapidly effective. Some carry organism	Once treatment started for 48 hours	None

Hand, foot and mouth disease – coxsackie virus	3-5 days	Whilst acute illness. May persist in stools for months.	Until clinically well	None
Firth disease (Slapped cheeks syndrome)	3-5 days before appearance of rash	Reduced once rash appears	None	None
Disease	**Usual incubation period**	**Period of communicability**	**Minimal period of exclusion from school**	
Herpes simplex (cold sores)	2-11 days	Until lesion is dry/not secreting	May not practical – until dried	Children with eczema best avoid contact
Conjunctivitis	Vary – 24-72 hours	During active infection	Once inflammation improving and discharge stopped – start treatment	None
Respiratory infections, bronchitis, parainfluenza	1-10 days	Duration of active illness	Until recovered	None
Serious General Infections				
Meningococcal infection - Meningitis	2-7 days	Whilst organism in nose and throat	Until full clinical recovery CCDC will advise	No exclusion – may receive antibiotics
Meningitis - viral	Variable	Variable	Until recovery only	None
Diphtheria	2-5 days	Whilst organism is in throat or nose	At discretion of the CCDC	At discretion of the CCDC
Poliomyelitis	3-21 days	Whilst virus in stools	At discretion of the CCDC	At discretion of the CCDC
Tuberculosis	25-90 days	Whilst organism is in sputum. Non-infectious 2 weeks after start treatment	CCDC and TB nurses will advise	Contacts of cases of pulmonary TB will be screened. CCDC will advise re school contacts
Infestations and Skin Infections				
Lice of head or body - pediculosos	Eggs hatch in 7 days, mature in 8 days	Whilst lice or nits alive on person or clothes	Until treated effectively	Family need to be examined and may be treated
Scabies	2-6 weeks; if re exposure may be only 1-4 days	Until eggs and mites destroyed by treatment	For 24 hours after treatment	Family need treating too
Ringworm scalp - tinea	10-14 days	Whilst active lesions present – can vary infectious	Until started effective treatment – ideally for	None – unless signs infection

			2 weeks after start of treatment	
Ringworm of the body	4-10 days	Whilst lesions present	Until started treatment	None – unless signs infection
Ringworm of feet – athletes foot	Uncertain	Whilst lesions present	No exclusions – can do barefoot activities – treatment is advised	None
Verrucae plantaris – plantar warts	2-4 months ranges 1-20 months	Uncertain – whilst lesions visible	No exclusion from school/activities. May cover with plaster – benefit uncertain	None
Worms – include threadworms	Variable	Until worms treated	Until treated	Family may need treating e.g. threadworms

All the above data is kept in the Office.

5.8 Head Lice

Head lice information letters should then be sent out to the appropriate year group. These letters are kept in the Office.

5.9 Reporting Accidents

<u>Employees</u>

A) All non- notifiable accidents to employees must be recorded in the Dudley Metropolitan Borough Council Accident/ Incident Book, which is a Controlled Document and is kept in the Deputy heads Office.
Entries should be made in the presence of the injured person or their representative, where possible.
If any pupil sustains a severe injury following an accident a Pupil Accident Form must be filled in and forwarded to the Dudley Education Personnel Services immediately after the event and a copy placed in their personal file.

B) All notifiable accidents must be recorded in the same way but the report must also be phoned through to the Education Department within 24 hours of the accident happening. They will then inform the Health and safety Executive.

Notifiable accidents are:-
a) The death of any person on the school site.
b) Any person suffering any of the following:

- Fracture of the skull, spine or pelvis
- Fracture of any bone in the arm, wrist or ankle
- Amputation of a hand, foot, finger, thumb or toe
- Loss of sight or a chemical burn to an eye
- Injuries including burns requiring immediate medical treatment or electric shock
- Any injury resulting in the person being hospitalised for more than 24 hours

Non-Employees.

All accidents to pupils, parents and other members of the public must be recorded in the Accident Book.