High Hesket CE School

ANAPHYLAXIS, ASTHMA, DIABETES AND EPILEPSY MANAGEMENT PROCEDURES

Approved by	
Name:	Amy Harvey
Position:	Headteacher
Signed:	A Harvey
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Review Sheet

Each entry in this table summarises the changes to these procedures made since the last review (if any).

Version Number	Version Description	Date of Revision
1	New procedures merging the now withdrawn Anaphylaxis Procedures (V3 June 2024) and Asthma Procedures (V5 Nov 2023) and including new information about diabetes and epilepsy to create a single resource of practical information for staff on how to manage the conditions and respond to an emergency in line with their training.	September 2024
2	Updated to include reference to adults with diagnosed anaphylaxis, diabetes or epilepsy and updated links to BSACI model plans New: Sections on School meal and wrap around care providers, other food handlers and safer eating plans. Updated: Reference to stress as a risk factor. References changed from asthma & anaphylaxis procedures to AADE Procedures (incl. diabetes & epilepsy).	February 2025
3	Minor revisions and updated links throughout.	September 2025
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Posters A & B: How to recognise a mild to moderate allergic reaction and what to do.

Benedict Blythe Foundation – Schools Allergy Code

Posters C & D: How to recognise an asthma attack and what to do.

Find all parental consent and medicines administration record cards and sheets, all individual healthcare plan (IHCP) templates, a customisable invitation to parents and carers to help develop the IHCP, and notification letters e.g. for salbutamol use

1. Introduction

These procedures have been developed to support staff who are implementing our *'Supporting Pupils with Medical Conditions Policy and procedures'*.

They cover the four most common severe and life-threatening health conditions that a pupil might have or develop in childhood - anaphylaxis, asthma, diabetes, and epilepsy. The procedures summarise the basic information all staff receive during induction about the conditions, the risks that may need to be understood, measures that may be necessary to control risks, roles and responsibilities, and what to do in an emergency.

1.1 Anaphylaxis

Anaphylaxis is a serious and often sudden allergic reaction, requiring emergency treatment. It occurs when the body's immune system wrongly identifies a food or other substance as a threat. Reactions usually begin within minutes and rapidly progress but can occur up to 2-3 hours later.

Allergic reactions are caused by the sudden release of chemicals, including histamine, from cells in the body. The release is triggered by the reaction between the immune system antibodies (called Immunoglobulin E or IgE) and the food or substance (known as an allergen) it has been exposed to.

The body will have been exposed to the allergen on a previous occasion, although the person may not have been aware of this at the time. On that earlier occasion, the allergen was wrongly identified as a threat and antibodies were made against it, which means that on the next exposure, a serious reaction may occur.

The mechanism is so sensitive that sometimes even tiny amounts of the allergen can cause an allergic reaction. Common allergens that can trigger anaphylaxis are:

- foods (e.g., cereals containing gluten, sulphites/sulphur dioxide (preservatives), celery, crustaceans, egg, fish, lupin, milk, mustard, molluscs, tree nuts, peanuts, sesame, soya);
- insect stings (e.g., bee, wasp);
- medications (e.g., antibiotics, pain relief such as ibuprofen);
- latex (e.g., rubber gloves, balloons, swimming caps).

In the skin, this causes an itchy rash, swelling and flushing, sometimes known as hives. Anaphylaxis involves difficulty in breathing or affects the heart rhythm or blood pressure. Any of the ABC symptoms may lead to collapse and unconsciousness and, on rare occasions, can be fatal.

AIRWAY - - - - - - swelling in the throat, tongue or upper airways (tightening of the throat, hoarse voice, difficulty swallowing)

BREATHING - - - sudden onset wheezing, breathing difficulty, noisy breathing

CIRCULATION - - dizziness, feeling faint, sudden sleepiness, tiredness, confusion, pale clammy skin, loss of consciousness

The severity of an allergic reaction can be influenced by a number of factors including minor illness (like a cold or other infection), poorly controlled asthma, exercise just before or after contact with the allergen, hay fever, stress, aspirin/ibuprofen and, in the case of food, the amount eaten. It is very unusual for someone with food allergies to experience anaphylaxis without actually eating the food: contact skin reactions to an allergen are very unlikely to trigger anaphylaxis in most people with the condition.

In severe cases, the allergic reaction can progress within minutes into a life-threatening reaction. Administration of adrenaline can be lifesaving, although severe reactions can require much more than a single dose of adrenaline. It is therefore vital to contact Emergency Services as early as possible. Delays in giving adrenaline are a common finding in fatal reactions. Adrenaline should therefore be administered immediately, at the first signs of anaphylaxis.

According to Allergy Training for Schools | Anaphylaxis UK, up to 5% of children in the UK have a food allergy. However, the majority of allergic reactions to food are not anaphylaxis, even in children with previous anaphylaxis. Most reactions present with mild-moderate symptoms, and do not progress to anaphylaxis. Fatal allergic reactions are rare, but they are also very unpredictable. In the UK, 17% of fatal allergic reactions in school-aged children happen while at school.

1.2 Asthma

Asthma is a long-term lung condition. It affects the airways (breathing tubes) that carry air in and out of the lungs. causing them to become swollen (inflamed). This makes the airways narrower so less air gets into and out of the lungs.

According to What is asthma? | Asthma + Lung UK (asthmaandlung.org.uk), it is a common condition. In the UK, 7.2 million people have asthma - about 8 in every 100 people.

People with asthma can get symptoms like wheezing, breathlessness, a cough or a tight chest. Sometimes symptoms can get worse quickly. This is an asthma attack.

Symptoms can be triggered by things like exercise, allergens or changes in weather. There are lots of potential triggers and everyone with asthma will have their own set.

At the moment there is no cure for asthma, but most people can control their symptoms well with asthma inhalers and other medicines when they use them as prescribed. Some people may not have symptoms for weeks or months at a time.

When asthma is not well controlled, or for people with severe asthma, attacks happen more often and are more severe and can be life-threatening. Sadly, four people die every day in the UK because of asthma attacks and 2 out of 3 asthma deaths are preventable.

Having frequent asthma attacks can also make asthma worse over time because they can cause scarring in the airways (sometimes called 'airway remodelling') which makes them narrower. Someone with scarred and narrow airways is more likely to have worse symptoms more often.

Most people with asthma who get the right treatment (and take it correctly) and who understand how to manage their symptoms and control their exposure or reaction to triggers, are able to get on with what they want to do in life.

1.3 Diabetes

There are two main types of diabetes:

Type 1 diabetes causes a person's blood sugar to become too high because the body can't make a hormone called insulin.

Type 2 diabetes is high blood sugar levels due to the body not making enough insulin, or the insulin it makes doesn't work properly, known as insulin resistance.

Other types of diabetes include **gestational diabetes**, which some women may go on to develop during pregnancy, **type 3c**, **MODY**, and Latent Autoimmune Diabetes in Adults (**LADA**) (see What is diabetes? | Getting to know the basics | Diabetes UK for more information).

Fewer than one in 10 people in the UK who have diabetes have type 1. The exact causes are not known. Although it's often diagnosed in childhood, people can develop type 1 diabetes at any age and are at higher risk if their mother, father, brother or sister has it.

Insulin is the main treatment, delivered by injection or an insulin pump. Checking and managing blood sugar levels is important to help reduce the risk of serious short or long-term health problems called **chronic diabetes complications** (eye, foot, heart or kidney problems, stroke, nerve damage, gum disease).

Acute diabetic complications can happen at any time and may lead to chronic, or long-term, complications.

- Hypos – when blood sugars are too low.
- Hypers– when blood sugars are too high.
- Hyperosmolar Hyperglycaemic State (HHS)– a life-threatening emergency that only happens in people with type 2 diabetes brought on by severe dehydration and very high blood sugars.
- Diabetic ketoacidosis (DKA) – a life-threatening emergency where the lack of insulin and high blood sugars leads to a build-up of ketones which makes the blood acidic.

Symptoms of type 1 diabetes are known as the 4 Ts, but can also include genital itching or thrush, cuts and wounds that take longer to heal, and blurry eyesight;

- **T**oilet – going for a wee more often, especially at night.
- **T**hirsty – being constantly thirsty and not being able to quench it.
- **T**ired – being incredibly tired and having no energy.
- **T**hinner – losing weight without trying to or looking thinner than usual.

Symptoms for type 2 diabetes in children and young people are the same as those above but may be more obvious. Type 2 diabetes in children is much less common than type 1. Risk factors include a family history of type 2 diabetes, ethnicity and obesity or being overweight.

There is no cure for type 2 diabetes but by losing weight some people can go into remission. This means their blood sugar stays at normal levels and they won't need to take any medicine for it.

Warning signs of a hypo can include, feeling shaky, sweating, hunger, tiredness blurred vision, lack of concentration, headaches, feeling tearful, stroppy or moody, or going pale.

Diabetic Ketoacidosis (DKA) is a serious condition that affects people with type 1 diabetes, and occasionally those with type 2 diabetes (although they are more likely to be affected by HHS). When there is severe lack of insulin in the body, it can't use sugar for energy and starts to use fat instead. When this happens, chemicals called ketones are released. If left unchecked, ketones can build up and make the blood acidic.

In someone already diagnosed with diabetes, the causes can include:

- being ill e.g., with a chest infection, flu, Urinary Tract Infection (UTI)
- high blood sugar levels caused by a growth spurt or puberty
- not taking insulin or missing doses
- surgery or an injury
- high blood sugar caused by menstruation.

The signs of DKA include:

- high blood sugar levels
- being very thirsty
- needing to pee more often
- feeling tired and sleepy
- confusion
- blurred vision
- stomach pain
- feeling or being sick
- sweet or fruity-smelling breath (like nail polish remover or pear drop sweets)
- passing out.

Sometimes, especially in children, there isn't an obvious trigger. Early signs of DKA can be treated with insulin and fluids if recognised quickly. If not, hospital treatment is required.

1.4 Epilepsy

Epilepsy is a neurological condition that affects the brain, causing repeated seizures, sometimes called "fits". Anyone can have a one-off seizure, but it doesn't always mean they have epilepsy. People are usually diagnosed with epilepsy if their doctor thinks there's a high chance they could have more seizures.

Electrical activity is happening in the brain all the time, as the cells there send messages to each other. A seizure happens when there is a sudden burst of intense electrical activity in the brain. This causes a temporary disruption to the way the brain normally works. The result is an epileptic seizure.

There are many different types of seizure. What happens to someone during a seizure depends on which part of their brain is affected, and how far the seizure activity spreads.

During some types of seizure, the person may remain alert and aware of what's going on around them, but have unusual sensations, feelings or movements. With other types, they may lose awareness and behave oddly, or go stiff, fall to the floor and jerk. Some people only have one type of seizure, and some people have more than one type.

When an epileptic seizure starts in one side of the brain, it's called a **focal** seizure. The person can be fully aware of what's happening around them, even if they can't move or respond. It's called a focal impaired awareness seizure when the person's awareness is affected during the seizure. Doctors may also use the words motor, where the main symptoms involve muscle activity, such as jerking, muscles becoming limp

(loss of muscle tone) or repeated movements, or non-motor where the main symptoms don't involve muscles but include things like changes in emotions, thinking and sensation, to describe focal seizures.

Most focal aware seizures are short, lasting between a few seconds and two minutes. Focal impaired awareness seizures usually last between one and two minutes but may be shorter or longer for some people.

When a seizure has a generalised onset affecting both sides of the brain from the start, this is called a generalised **tonic-clonic** or bilateral convulsive seizure. Some seizures start in one side of the brain and then spread to affect both sides. When this happens it's called a focal to bilateral tonic-clonic seizure.

There are 2 phases in a tonic-clonic seizure: the 'tonic' phase, followed by the 'clonic' phase.

During the **tonic phase**, the person loses consciousness, all their muscles go stiff, and if they're standing, they fall to the floor, air might push past their voice box, which can make a sound like crying out, and they may bite down on their tongue or the inside of their mouth.

During the **clonic phase**, their limbs jerk quickly and rhythmically, they may lose control of their bladder and/or bowels, and their breathing may be affected, causing a blue tinge around the mouth.

Most tonic-clonic seizures last between one and three minutes. If a tonic-clonic seizure lasts longer than five minutes, this is called status epilepticus and may need emergency medical treatment.

Status epilepticus happens when a seizure doesn't stop in the usual time, or when someone has seizures one after another without recovering in between. It is a medical emergency that can happen with any type of seizure.

Convulsive status epilepticus is when a tonic-clonic seizure lasts for 5 minutes or more, or one follows another without the person regaining consciousness in between. If either of these things happen, the person needs urgent treatment to stop the status before it causes long-term damage. If convulsive status epilepticus lasts for 30 minutes or longer it can cause permanent brain damage or even death.

Non-convulsive status epilepticus is when a non-convulsive seizure, such as an absence or focal impaired awareness seizure, lasts too long. These can be harder to spot because the signs and symptoms can be less obvious. For example, someone who is in absence status or focal impaired awareness status may appear confused and less responsive than usual or have changes to their speech or behaviour for no clear reason.

Some people are prescribed emergency medicine to treat status epilepticus, usually buccal midazolam given by plastic syringe, between their gums and cheek (sometimes rectal diazepam or, for some children, rectal paraldehyde.

Absence seizures are a type of generalised onset seizure, affecting both sides of the brain from the start.

During a **typical absence** seizure, the person will suddenly stop what they are doing for a few seconds but will not fall. They might appear to be daydreaming or 'switching off' and people around them might not notice. Their eyelids might flutter and they might have slight jerking body or limb movements. In longer absences, they might have some short, repeated actions, they won't know what is happening around them and can't be brought out of it.

One typical absence lasts less than 10 seconds. Some people have hundreds of absences a day, often in clusters, one after another, and they are often worse when they are waking up or drifting off to sleep.

Atypical absences are similar to typical absences, but they last longer (up to 30 seconds), and they start and end more slowly. The person might be able to move around, but their muscles might go limp or 'floppy', appearing clumsy. They may be able to respond to someone during an atypical absence seizure.

People who have atypical absences usually have learning disabilities or other conditions that affect the brain.

After someone has a seizure, it can take a while for their brain to fully recover and they may feel confused.

Epilepsy can start at any age and some types last for a limited time, but for many people, epilepsy can be a life-long condition.

2. Rationale

High Hesket CE School recognises the important part that nurseries, schools, and other settings play in helping children and young people with AADE manage their medical condition well to achieve good health, active learning, and personal independence.

We recognise that some pupils may need time off school or suffer disturbed sleep due to their health which can leave them feeling ill, tired, irritable, and struggling to concentrate or catch up at school.

These procedures centre on the safeguarding of pupils diagnosed with AADE but include principles adaptable to managing other serious health concerns that can lead to pupils experiencing similar struggles.

This school welcomes all pupils, including those who have AADE, and encourages them to achieve their full potential in all aspects of school life by providing a positive educational environment, procedures to control the risks and prevent and manage emergencies, and well-trained staff to implement them.

So that pupils diagnosed with AADE can be fully integrated into school life, we will:

- ensure they can and do participate fully in all aspects of school life, including P.E., design technology, science, arts, drama, educational visits, and other extended school activities by understanding the severity of a pupil's condition and their triggers, assessing the risks and implementing control measures to try to reduce them, and by having sound emergency management procedures;
- have arrangements in place to ensure that those with emergency medicines can get immediate access to them at all times;
- keep a record of all pupils diagnosed with anaphylaxis who have an Adrenalin Auto-Injector (AAI Register) or asthma who have a reliever inhaler (Asthma Register), or diabetes, or epilepsy, and have an Individual Health Care Plan (IHCP) in place for the pupils who need one;
- ensure that the whole school environment, including the physical, social, sporting, and educational environment, is as favourable to them as to their peers without the condition;
- ensure there is an area of school that allows for adequate privacy (and supervision if necessary) where pupils who know they are becoming unwell can go to use their emergency medicines if they are uncomfortable doing so in front of others;
- ensure that all staff and other adults working in the school and who come into contact with pupils with AADE know what the conditions are, what risks are relevant to their work, how to best control them, how to recognise symptoms, and what to do in an emergency;
- ensure all pupils understand AADE so they can support their peers and avoid the stigma sometimes associated with these conditions. This might include how to recognise symptoms and what to do if they think it's an emergency when pupils are old or mature enough and are without close adult supervision;
- take steps to ensure that pupils are not being bullied (both on or offline) because of their medical conditions and apply our anti-bullying procedures to prevent it;
- work in partnership with all interested parties including the governing body, all school staff and other adults, the school or community nurse, parents and carers, other relevant employers of adults working in the school (e.g., cleaning and catering staff), the local health protection team, and pupils to ensure these procedures are implemented and maintained successfully.

3. Managing pupils' emergency medicines

Pupils who have emergency medicines need immediate access to them and are encouraged to carry them as soon as their parent or carer, GP, and teachers agree they are mature enough and their peers would not be at risk. The medicines of children who are not capable of carrying them safely themselves are kept in the staffroom medical cupboard and the school kitchen.

It is explained to all staff as part of their induction that any child who appears to need and/or has asked for their emergency medicine should be given it immediately and what procedure they must follow.

We ask all parents and carers to ensure they equip their child with the minimum doses that their medical practitioner advises them to carry (usually two or more) clearly labelled with their child's name. We will

also ask for a clearly labelled spare that can be kept in a suitable location in school, during term time only, in case the pupil's own runs out, or is damaged, lost, or forgotten.

It is the responsibility of parents and carers to ensure the medicines their child carries have not expired and that the spare provided will last for the entire half term, or they have a plan to replace it. We do not check the expiry dates of children's personal medicines periodically.

If it comes to the attention of staff through their normal duties that a medicine has expired or will expire soon, we will inform a parent or carer and ask them to take it home and provide a replacement.

Teachers are not required to administer emergency medicines to pupils, however many staff at this school are trained and willing to administer, supervise or provide other support to a pupil able to self-administer.

School staff who agree to administer medicines are insured by the local authority to do so when they are acting in accordance with our policies and their training given the circumstances they faced at the time.

Parents and carers will be informed about every use of an emergency medicine on their child.

4. Procedures for the administration of emergency medicines

4.1 Arrangements

The procedure for obtaining and using a pupil's own emergency insulin, buccal midazolam, AAI or inhaler and the school emergency AAI or inhaler are similar with slight variations affecting certain staff e.g., where the easily accessible but secure place pupils' own medicines are kept if they cannot carry them, the nearest spare to their work area etc.

The school emergency AAI or inhaler kit should only be used on a pupil where both medical authorisation and written parental consent have been provided. The pupil having their own prescribed AAI or inhaler is the simplest form of evidence for medical authorisation.

This can also include children at risk of anaphylaxis who have an allergy action plan confirming this, but who have *not* been prescribed an AAI. In such cases, specific consent for use of the spare AAI from both a healthcare professional *and* parent or carer must be obtained. They can use the template Allergy Action Plan available from the British Society for Allergy and Clinical Immunology (BSACI) and give us a copy, so we can follow it in an emergency.

All children with a diagnosis of an allergy and anaphylaxis should have a written Allergy Management Plan. BSACI produces three Paediatric Allergy Action Plans - BSACI, one for each of the 2 manufacturers currently authorised to supply AAIs in the UK and one for children who are not prescribed an AAI. We will use the relevant one or our IHCP template, whichever provides the clearest emergency action plan.

In an emergency which resembles anaphylaxis in a pupil who has not been prescribed their own AAI and who does not have a medical plan that indicates school should administer the school emergency AAI kit either, these rules about parental consent can be ignored **only if** staff have dialled 999 and are being given medical authorisation to use it by an appropriate medical professional. In such situations, the member of staff administering the AAI, in an emergency and acting under medical instruction, does not need to have had any specialist training.

Where a member of staff has been diagnosed with anaphylaxis and has been prescribed an AAI, there is a model Adult Action Plan available from BSACI which can be used and adapted in consultation with the member of staff or other adult who has received an anaphylaxis diagnosis. Agreement should be sought from the individual with the Anaphylaxis diagnosis, that first aiders can be informed of the condition should an emergency situation arise. This information will be confidential and others informed on a need to know basis only.

All children with a diagnosis of asthma should have a written Child asthma action plan (asthmaandlung.org.uk) which they complete with the help of their GP, community nurse and family, which we can use to inform the school IHCP and create an emergency action plan.

Salbutamol inhalers are intended for use where a child has asthma. The symptoms of other serious conditions and illnesses, including allergic reaction, hyperventilation, and choking from an inhaled foreign

body can be mistaken for those of asthma, and the use of the emergency inhaler in such cases could lead to a delay in the child getting the treatment they need.

In an emergency which resembles symptoms of asthma in a pupil who has not been prescribed a reliever inhaler and who does not have a medical plan that indicates school should administer the school emergency salbutamol either, the rules about parental consent can be ignored **only if** staff have dialled 999 and are being given medical authorisation to use it by an appropriate medical professional. In such situations the member of staff administering it, in an emergency and acting under medical instruction, does not need to have had any specialist training.

A pupil who has been prescribed an inhaler for their asthma which contains an alternative reliever medicine to salbutamol (such as terbutaline), should still use the school salbutamol inhaler if their own inhaler is not accessible and consent is held – it will still help to relieve their asthma symptoms and could save their life.

Staff will supervise or otherwise support a pupil who is able to self-administer their own or the school emergency AAI or inhaler, or they will administer it for pupils who are unable to self-administer it in accordance with their training and **Poster A** - 'How to recognise a mild to moderate allergic reaction'; and **Poster B** - 'Signs of anaphylaxis and what to do', or **Poster C** – 'How to recognise an asthma attack'; and **Poster D** - 'What to do in the event of an asthma attack'.

All children with a diagnosis of Type 1 diabetes should have an NHS Diabetes UK/NHS Individual Health Care Plan (Type 1), which they complete with the help of their GP, community nurse and family. We will use it to help us make reasonable adjustments to facilitate prescribed medical care to allow a child to participate in education on the same basis as their peers.

Children with a diagnosis of Type 2 diabetes should have a school IHCP drawn up for them to describe the specific support they need to avoid or manage the risks of becoming hypo or hyper-glycaemic.

Trained staff will supervise or otherwise support a pupil who is able to carry out their own Blood/Glucose monitoring (BGM) checks and administer their own insulin and they will do it for pupils who are unable to.

Where a member of staff has been diagnosed with diabetes, there is guidance on supporting someone with diabetes at work available from Diabetes UK which can be used and adapted in consultation with the member of staff or other adult who has received a diabetes diagnosis. Agreement should be sought from the individual with the Diabetes diagnosis, that first aiders can be informed of the condition should an emergency situation arise. This information will be confidential and others informed on a need to know basis only.

All children with a diagnosis of epilepsy should have a written Care Plan (epilepsy.org.uk). It's an agreement between the person with epilepsy, their healthcare professional, and where appropriate, their parents or carers. The care plan should say how to tell if they are in status epilepticus and what to do. It should also include details of any emergency medicine that has been prescribed, who is trained to use it and when to give it. We will use it or our IHCP template, whichever will help us provide the best support for the child at school.

These plans must be easily available to staff, especially trained staff who may need to refer to them in an ongoing emergency.

Where a member of staff has been diagnosed with epilepsy, there is a model care plan available from epilepsy.org.uk which can be used and adapted in consultation with the member of staff or other adult who has received an epilepsy diagnosis. Agreement should be sought from the individual with the Epilepsy diagnosis, that first aiders can be informed of the condition should an emergency situation arise. This information will be confidential and others informed on a need to know basis only.

4.2 Summary of emergency action - Anaphylaxis

1. Establish that the pupil in difficulty is experiencing an allergic reaction as far as possible and try to keep them calm. Once it has been established that administration of an AAI is required, **call for an ambulance unless to do so would delay treatment.**
2. Lie the pupil flat with legs raised (or sit them up if having breathing problems).

3. Establish the pupil's identity and the correct action to take (posters A and B).
4. Obtain the child's AAI, the child's spare AAI, and/or the school emergency AAI if required.
5. Check the AAI to be administered is correct, not expired, and will be given at the right dose in the right way.
6. Administer or support self-administration of the AAI in accordance with posters A and B **and call for an ambulance**.
7. Record the administration (see Form E3: Record Card Adrenalin Administration).
8. Inform parents or carers as soon as possible after an ambulance has been called.
9. Dispose of any sharps (needles etc.) in the designated sharps container.

If a pupil is having more frequent or more severe allergic reactions to their triggers, we will review the IHCP and inform their parents/carers. The pupil might need to see their GP for a review after which we might also need to review their IHCP with them and their parents.

4.3 Summary of emergency action - Asthma

1. Establish that the pupil in difficulty is experiencing an asthma attack as far as possible and try to keep them calm.
2. Establish the pupil's identity and the correct action to take i.e., whether poster C and poster D should be followed or the pupil's individual S/MART Plan i.e., their Maintenance and Reliever Therapy plan (using only one combination preventer/reliever inhaler – app enabled smart inhalers are not available in the UK yet).
3. Obtain the child's inhaler (and spacer), the child's spare inhaler, and/or the school emergency inhaler and spacer if required.
4. Check the medicine to be administered is correct, not expired, and will be given at the right dose in the right way i.e., whether a spacer is used or there is a S/MART Plan.
5. Administer or support self-administration of the reliever inhaler in accordance with the posters/advice or the pupil's S/MART Plan and/or the pupil's ACP/IHCP **and call for an ambulance if necessary**.
6. Record the administration of the school asthma kit on Form E2: Record CARD Emergency Salbutamol Use or Form E2: Record SHEET Emergency Salbutamol Use which should be inside the kit. If there are privacy or confidentiality issues or a child's asthma is not well-controlled, use of the school asthma kit and the child's own personal supplies can all be recorded together on Form E2: Record SHEET Personal Salbutamol Use.
7. Inform parents or carers as agreed or as soon as possible if an ambulance has been called.

If a pupil appears to be using their reliever inhaler more often than expected according to the needs outlined in their ACP/IHCP, we will inform their parents or carers. We might need to review the child's plan with them, or the child might need to see their GP or a community asthma nurse for an asthma review after which we might also need to review their child's plan with the family.

4.4 Summary of emergency action - Diabetes

1. If the pupil is conscious, obtain the reading from the Continuous Glucose Monitor (CGM) if they wear one **or** ensure, supervise or help the pupil in difficulty test their blood glucose levels to establish whether they are hypo- or hyper-glycaemic - keep yourself and them calm.
2. If the pupil is convulsing, clear the area so they don't hit anything and hurt themselves or if they are unconscious, put them in the recovery position **and call for an ambulance** - then follow the IHCP.

If the pupil is having a **hypo** do not leave them alone and don't make them go anywhere. Follow steps 3-8:

3. Obtain the IHCP first to find out how much is needed and offer the pupil the right amount of something sugary to eat or drink, like Lucozade, a non-diet soft drink, glucose tablets or fruit juice.

4. After 10–15 minutes, check the blood glucose level again. If the level is still low, repeat step 2.
5. Check the blood glucose level again after another 20–30 minutes to make sure that they have returned to normal.
6. Check the IHCP again to see if the pupil will need a follow-on snack after treating a hypo, such as a piece of fruit, biscuits, cereal bar, small sandwich or the next meal if it's due and make sure they get it.
7. Record this administration in the pupils' Type 1 Diabetes School Log Book (diabetes.org.uk) if they have one or another record sheet fit for this purpose.
8. Inform parents or carers in the agreed ways.
9. Dispose of any used sharps in the designated sharps container.

If the pupil is having a **hyper** - follow these steps 3-8:

3. Obtain the IHCP first to find out when the pupil needs insulin and how to give it.
4. Establish if blood sugar levels have only been high for a short time and if another course of action is more appropriate than giving insulin such as drinking water and exercising to bring levels down.
5. If they need extra insulin, ensure, supervise or help the pupil in difficulty administer their insulin and encourage them to drink sugar-free fluids.
6. Follow the IHCP with regard to testing for ketones in the blood or urine, and when a pupil might need to go to hospital. **Call for an ambulance if necessary.**
7. Record insulin administration in the pupils' Type 1 Diabetes School Log Book (diabetes.org.uk) if they have one or another record sheet fit for this purpose.
8. Inform parents or carers in the agreed ways or as soon as possible if an ambulance has been called.
9. Dispose of any used sharps in the designated sharps container.

If a pupil is having more frequent or more severe hypos or hypers, we will review the IHCP and inform their parents/carers. The pupil might need to see their GP for a review after which we might also need to review their IHCP with them and their parents or carers.

4.5 Summary of emergency action – Epilepsy

1. Stay calm, **note the exact time the seizure began**, and **prepare** to administer the emergency medicine and call an ambulance if it becomes necessary e.g. radio, phone, or send a reliable individual to relay information for action to an appropriate person.
2. Protect the pupil from injury (remove harmful objects from nearby) and stop others crowding around them (where possible move others away from the area) – NEVER move them unless they are in immediate danger e.g. on stairs, in the road etc. and then only with proper regard for your own safety.
3. Cushion their head (with a folded jumper, a cushion etc.) to reduce the chance of head injury.
4. Do not restrain them in any way and never put anything in their mouth – allow the seizure to happen.
5. Place them in the recovery position when the convulsions have stopped and check their breathing is returning to normal.
6. If the seizure lasts more than 5 minutes (status epilepticus) **OR** it lasts 2 minutes longer than is normal for them or another time period recorded in the pupil's IHCP or Epilepsy Care Plan **OR** the pupil has one after another without recovering, administer the emergency medicine and **call for an ambulance**.
7. Preserve dignity should continence have been lost or if intimate medication is required (cover with a light blanket or piece of clothing or use blankets to shield the pupil from sight).
8. Stay with them until fully recovered – NEVER give them anything to eat or drink until they are fully recovered.
9. Manage personal cleaning and biohazards according to procedures.

10. Complete an incident record and copy to everyone necessary as agreed in the care plan – write down as much as can be remembered about triggers.

In a wheelchair follow steps 1 and 6-10 above but substitute steps 2-5 above for steps 2-5 below instead:

2. Put the brakes on to stop the chair from moving.
3. Let them stay in the chair during the seizure (unless they have a care plan which says to move them). Moving them could possibly lead to injuries for both you and them.
4. If they have a seatbelt or harness on, leave it fastened. If they don't have a seatbelt or harness, support them gently, so they don't fall out of the chair.
5. Cushion their head and support it gently. A head rest, cushion or rolled up coat or blanket can be helpful.

In water to rescue the person so that steps 1-10 above can be followed:

1. From behind, tilt the person's head so it is out of the water.
2. If possible, move the person to shallow water.
3. Shout for a lifeguard or other adult to help you get the person out of the water.

Once the person is out of the water and steps 1-10 above are being followed, keep them warm.

In addition to the normal reasons one might be required, **call for an ambulance** if the pupil may have swallowed or breathed in water, even if they appear to be fully recovered. There is a potential risk of drowning hours, even days later due ongoing breathing difficulties after the incident due to fluid in the lungs, inflammation, or from developing pneumonia as a result.

5. Managing school AAIs and inhalers

The Human Medicines (Amendment) Regulations 2017 (AAIs) and Human Medicines (Amendment) (No.2) Regulations 2014 (salbutamol) allow, but do not require, schools to keep an adrenaline auto-injector (AAI) or salbutamol inhaler for use in an anaphylaxis or asthma emergency, even if the school does not currently have pupils diagnosed with either anaphylaxis or asthma and governors have decided that keeping a supply will currently benefit pupils significantly.

This decision is under continual review based on the needs of our pupils as they change.

This school has purchased and will manage at least 2 AAIs in case of an anaphylaxis emergency occurring both on and off site at the same time where a child's own AAI or spare is not available or safe to use. It could potentially save their life. In exceptional circumstances, a 'spare' AAI can be used in the event of an emergency to save the life of someone who develops anaphylaxis unexpectedly or for the first time. **This decision does not in any way release parents or carers from their absolute duty to ensure that their child attends school with a fully functional AAI containing sufficient medicine for their needs.**

5.1 Obtaining AAIs and inhalers for school

This school will buy AAIs and inhalers from a pharmaceutical supplier in writing confirming the following:

- the name of the school.
- the purpose for which the product is required; and
- the total quantity required.

We will use the template letter in the Annex to the Department of Health and Social Care (DHSC) guidance Using emergency adrenaline auto-injectors in schools to get the right supplies.

5.2 School emergency kits

5.2.1 AAI kit

Each emergency AAI kit should contain:

- 1 or more AAI(s).
- Instructions on how to use the device(s).
- Instructions on storage of the AAI device(s).
- Manufacturer's information.
- A checklist of AAIs, identified by their batch number and expiry date with monthly checks recorded.
- A note of the arrangements for replacing used AAIs.
- Sharps box or container.
- A list of pupils to whom the AAI can be administered (AAI Register).
- An administration of AAI record card/sheet.

5.2.2 Asthma kit

Each emergency asthma kit should contain:

- 2 salbutamol metered dose inhalers (MDI).
- At least two single-use plastic or disposable spacers compatible with the inhaler (see https://bit.ly/3nATvmj for disposable spacers compatible with Ventolin and Salbutamol inhalers).
- Manufacturer's information and instructions on using the inhaler and spacer/ plastic chamber.
- Instructions on how to administer the inhaler using a spacer/plastic chamber e.g., https://www.rightbreathe.com/ or How to use your inhaler | Asthma + Lung UK (asthmaandlung.org.uk) or the inhaler manufacturer's videos.
- Advice that disposable salbutamol inhalers and spacers are for use by one person only because of the risk of cross-infection. Instructions on storing and disposing of single use inhalers/spacers and/or instructions on cleaning and storing inhalers and spacers that are not disposable and are allocated and limited to the use of one person.
- The issuing pharmacist's contact information.
- A checklist of inhalers, identified by batch number and expiry date, with monthly checks recorded.
- A note of the arrangements for replacing the inhaler and spacers.
- A list of children permitted to use the emergency inhaler as detailed in their IHCP or other written parental consent (asthma register).
- A record of administration (i.e., when the inhaler has been used).
- Pen.
- Asthma champion's name and contact details.

5.3 Storage and care of school AAIs & inhalers and pupils' emergency medicines

It is the responsibility of parents or carers to provide enough of the right medicine, in working condition, with a spare to remain in school during term-time only, and to check regularly that neither has expired.

It is the responsibility of the Headteacher and Office Manager to arrange for or remind pupils who keep a spare lot of emergency medicine at school, to take it home with them every holiday and bring it back at the start of the next half term. This also serves to provide parents and carers the opportunity to carefully examine it for defects or expiry and test and clean it if necessary.

It is the responsibility of Headteacher and Office Manager to maintain the school emergency AAI and asthma kit(s) ensuring that:

- on a monthly basis the AAIs are present and in-date and that the inhaler and spacers are present and in working order, and the inhaler has sufficient number of doses available;
- replacement AAIs and inhalers are obtained when expiry dates approach and we have signed up to receive any manufacturer AAI expiry alerts available;
- replacement spacers are available following a single use;

- the AAIs are being stored at room temperature (in line with manufacturer's guidelines) and protected from direct sunlight and extremes of temperature;
- the plastic inhaler housing (which holds the canister) has been cleaned, dried, and returned to storage following use, or that replacements are available if necessary.

The school emergency AAI and asthma kit/s will be clearly labelled and kept separately from pupils' own spare AAIs or inhalers to avoid any confusion in the staffroom. This is a safe and suitably central location in school, known to all staff, and to which all staff have access at all times, but in which the medicine is out of easy reach and sight of children. They will not be locked away.

Storage will always be in line with manufacturer's guidelines, usually below 30°C and protected from direct sunlight and extremes of temperature. Spacers will not be stored in plastic bags to avoid them developing a static charge that causes the asthma medicine stick to the spacer rather than being delivered into the lungs.

An inhaler should be tested before use e.g., held away from the face while spraying one or more puffs as necessary. As it can become blocked again when not used over a period of time, testing will be carried out before each use and monthly as part of the working order checks.

To avoid possible risk of cross-infection and because it goes directly in the mouth and can only be cleaned with gentle detergents, the plastic spacer cannot be reused by a different person and could be given to the child who used it to take home/keep labelled with their name in school for future personal use. The inhaler itself however can usually be reused, provided it is cleaned after use. The canister of salbutamol should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place. The canister should be returned to the housing when it is dry, the cap replaced, and the inhaler returned to the designated storage place. If there is any risk of contamination with blood i.e., if the inhaler has been used without a spacer, it should not be re-used but disposed of.

5.4 Disposal

This school is registered online at www.gov.uk/waste-carrier-or-broker-registration as a waste carrier so that we can legally dispose of spent, expired, or faulty AAIs or return them to be recycled by the manufacturer and will follow the manufacturer's or our pharmaceutical suppliers' guidelines on disposal.

6. Staff training on and use of emergency medicines

The individual responsible for overseeing the protocol for use of the school emergency medicines, monitoring its implementation, identifying training needs, and for maintaining the registers is the headteacher.

All staff are trained:

- To recognise the range of signs and symptoms of an allergic reaction, asthma attack, hypo or hyper-glycaemic event, seizure or absence.
- To understand the rapidity with which they can progress to a life-threatening reaction, and that symptoms can appear very mild at first.
- To appreciate the need to administer emergency medicines as soon as possible once recognised.
- To understand how to distinguish symptoms of an asthma attack from choking, anaphylaxis or other conditions with similar symptoms.
- In how to respond appropriately to an emergency, what checks or tests to carry out before administering an emergency medicine.
- On the policy for supporting pupils at school with their medical conditions, our procedures, and their role in both.
- How to check if a child is on the anaphylaxis or asthma register and whether parental consent is held to administer school supplies of emergency medicines.
- How to access and use the pupils' own, the pupil's spare, or the school spare emergency medicines.
- How to dispose of any sharps or other soiled/used materials safely and appropriately.

- Who the designated members of staff are and how to access their help.

Pupils are involved in age and developmentally appropriate ways in our emergency procedures e.g., fetching help or equipment, to increase community awareness of severe medical conditions, build peer-to-peer resilience, promote leadership skills, and reduce stigma or bullying.

Designated staff have a specific responsibility for helping to administer the school emergency medicines, i.e., they have volunteered to help a child use the school emergency AAI or inhaler, are trained to do so, and are identified in these procedures as people to whom all staff can turn to for support in an emergency.

Designated staff are trained in everything that all staff are trained in listed above and:

- responding appropriately to a request for help from another member of staff.
- recognising when emergency action is necessary.
- practical instruction in how to use the different AAI devices pupils use and salbutamol through a spacer.
- making appropriate records of allergic reaction; and
- ensuring parents are informed.

Not every designated member of staff is trained in every type of emergency medicine administration.

We arrange specialist training for designated staff and use online resources and introductory e-learning modules for all staff available at http://www.sparepensinschools.uk, (although this is not a substitute for face-to-face training), specific training or advice offered by the school or community anaphylaxis nurse, EpipenOfficial YouTube | Administering a Jext adrenaline auto-injector, or another suitably qualified professional to inform our practice when managing pupils who have anaphylaxis.

We ask children with inhalers to demonstrate to their teachers how they use it, with parental support, if necessary, to understand their technique, to compare it with their asthma care plan and training staff have received.

We use How to use your inhaler | Asthma + Lung UK (asthmaandlung.org.uk), free and accredited online training from the George Coller Memorial Fund, manufacturer's user training materials, and specific training or advice offered by the school or community asthma nurse or another suitably qualified professional to inform our practice when managing pupils who have asthma.

When a pupil needs support with the emergency administration of insulin or buccal midazolam or similar, we engage with community and school nurses to get the right training for designated staff.

7. Record keeping

At the beginning of each school year or when a child joins our school, parents/carers are asked if their child has any medical conditions on their enrolment form.

All parent or carers of pupils with emergency medicines are asked to complete an IHCP or other care plan with advice from their GP or asthma, diabetes or other community nurse where needed, to help us manage their child's exposure to triggers and their symptoms during school activities (see section 4.1 for links to a number of templates we rely might on).

The information will be used to update the school anaphylaxis or asthma register and these procedures to include:

- Known risk factors for AADE.
- Whether a pupil has been prescribed salbutamol, AAI(s), insulin, buccal midazolam etc. (and if so what type, dose, frequency etc.).
- Where a pupil has been prescribed salbutamol or an AAI, whether written parental consent has been given for use of the spare school emergency supplies of salbutamol or AAIs which may be different to the personal reliever inhaler or AAI prescribed for the pupil.
- A photograph of each pupil to allow a visual check to be made (this will require parental consent) which is made available to all school staff and other adults working in the school where necessary to ensure medicines are administered appropriately.

The use of **any** emergency medicine will be recorded including:

- Where and when the reaction, attack, hyper/hypo-glycaemic event, or seizure took place (e.g., PE lesson, playground, classroom).
- How much was given, and by whom.
- When and how the person given it was transferred to hospital for further monitoring.
- When and how parents were contacted to inform them (hospital discharge documentation should be sent to the pupil's GP to inform them of the emergency incident).

The use of a pupil's own reliever inhaler is recorded and notified if necessary as agreed with parents/carers.

We review all IHCPs and other care plans at least annually, asking parents and carers to update their existing plan or exchange it for a new one, and we remind them to tell us as soon as possible if their child's condition or medical needs changes.

8. Food allergens and safer eating

This school is aware that:

- as many as 1 in 50 pupils has a nut allergy
- children can be as dangerously allergic to other common food and non-food allergens e.g., milk, egg, latex etc. and it would be impossible to ban them all
- free-from environments can create a false sense of security and don't prepare pupils for the world outside school
- a nut-free policy still cannot guarantee that we would be a nut-free site because pupils and staff bring food and other items like deodorant sprays into school.

However, sometimes, the risk to an individual pupil from exposure to their allergens is so high and difficult to manage that we may try to take additional school-wide action to protect them for as long as the risks are unacceptable if we don't. For example:

- Ensure all vending machines stock snacks that comply with legislation on healthy eating and the School food standards practical guide - GOV.UK (www.gov.uk), and make support for healthy eating available from staff. Consider exposure to allergens and how clear allergen information is before vending products are changed or any new supplier or contract is agreed.
- Educate and engage with parents and carers and the wider school community by:
    - Asking parents and carers to clearly label their child's bottles, other drinks, and lunch boxes with their name, but especially those items from the homes of children with food allergies.
    - Requiring parents and carers to take responsibility for checking that food purchased from the school canteen is suitable for their child before ordering and encourage them to teach their child how to check allergen information when being given food or ordering it for themselves and to discourage their friends from trying to swap or share with them.
    - Requiring written parental consent before a child can share or buy and consume food or drink treats at school e.g., share a birthday cake brought in by another child or eat a cake the child bought at a school morning bake sale.
    - Requiring all food items brought into school or donated with the intention of sharing or selling them to raise money to be labelled with the allergens they may contain.
- Educate staff on:
    - Allergen labelling and measures to prevent cross-contamination, especially during the handling, preparation and serving of food e.g., preparing food for children with food allergies first; careful cleaning (using warm soapy water) of food preparation areas and utensils.
    - Safer use of food or other allergens in crafts, cooking classes, science experiments and special events e.g., fetes, assemblies, cultural events, and the substitutions, restrictions or protective measures necessary e.g., wheat-free flour for play dough or cooking.
    - Where to find relevant guidance e.g., on creating Safer Eating Plans in the Food Safety section of our Health & Safety Policy, on safely managing food activities in risk assessments etc.

- Educate pupils that:
  - unlabelled food can pose a greater risk of allergen exposure than packaged food with precautionary "may contain traces" label;
  - trading and sharing food, food utensils or food containers is discouraged to protect and not to upset people.

Our main focus will always remain on education and awareness raising and our procedures and hygiene arrangements to manage risk.

8.1 School meal and wraparound care providers

Extra-curricular activities and out-of-school clubs operated by this school are open to all pupils equally and those with anaphylaxis are encouraged to participate in everything we offer alongside their peers.

To enable pupils with anaphylaxis to participate as safely as possible, we ensure that all teaching, teaching support staff, sports coaches, and other activity leaders who run school activities outside of normal school hours are aware of our anaphylaxis procedures, the pupils they need to be applied for, and how to minimise anaphylaxis triggers and reactions.

8.2 Other food handlers

Other potential food handlers (food technology, classroom baking, cookery club, nursery, other staff and PTA members serving snacks and treats etc.), will be made aware of information about the 14 Food Allergens | Anaphylaxis UK, so they can take it into account when planning any food-related activities for children with known allergies. Staff are also trained to be alert to signs that a child may have a previously unknown allergy or has developed a new one.

Staff or volunteers working with food in play, the curriculum, or other school activities will receive enough instruction on and should follow the good practice outlined in Section 10.1 above to manage exposure to allergens.

9. Exercise and activity - PE and games

Taking part in sports, games and physical activities is an essential part of school life for all pupils but can be a trigger for pupils with AADE.

To maximise participation by and minimise the risks to these pupils we:

- Take reasonable steps to make the activities we offer accessible so that they can participate alongside their peers e.g., moving an outdoor activity indoors at times of very high pollen counts, kit checks that include personal, spare, and school AAIs, inhalers etc.
- Ensure all staff and other activity leaders are aware which of the pupils they work with have AADE, how to recognise an emergency, what to do, and have access to the pupil's own, pupil's spare, and the emergency AAI/asthma kit AAI/asthma register e.g., in the school emergency asthma kit they might need to use.
- Require all activity leaders to remember to include emotions and pollen in their dynamic risk assessments and take steps to control triggers where possible including regularly reminding pupils at risk how to reduce their environment or exercise-related triggers or reduce their response to triggers.
- Require all activity leaders to encourage pupils experiencing worsening symptoms to stop, take action to slow or stop the symptoms e.g., eating something, using their reliever inhaler, and to sit out quietly until their symptoms have gone before starting the activity again. Anyone experiencing symptoms must not be left alone until they feel better and are continuing with normal activities.
- Have a simple procedure for ensuring pupils' own emergency medicines are easily available to them during activities when they are not competent to or cannot physically carry them which is clearly communicated with signage if necessary. Procedures vary slightly depending on the pupils and locations, but they all involve the principle of staff gathering clearly labelled personal inhalers, storing them in a hygienic manner which is immediately accessible to pupils throughout activities, carrying or having access to a pupil's own spare inhaler if they have one, and returning them.

- Have clear learning objectives for and plans for the inclusion of pupils with AADE who are too unwell to participate in physical activities e.g., referee, coaching, or other lower risk role.
- Take steps to reassure parents, carers, and pupils that we understand their condition and can help them manage it and be active.

10. Out of hours

Extra-curricular activities and out-of-school clubs operated by this school are open to all pupils equally and those with AADE are encouraged to participate in everything we offer alongside their peers.

To enable them to participate as safely as possible, we ensure that all teaching, teaching support staff, sports coaches, and other activity leaders who run school activities outside of normal school hours are aware of our procedures, the pupils they need to be applied for, and how to minimise triggers and reactions.

11. School environment

Schools have a duty of care for the health, safety, and wellbeing of pupils and must identify the seriousness of the risks to their health from exposure to known triggers and take reasonable action to eliminate or manage the risks. This school does all that we reasonably can to ensure the school environment is as favourable to pupils with AADE as it is to their peers without those medical conditions.

We recognise that stress can be a key factor in determining how successfully a pupil can manage their health which can affect their mental health, physical health and their ability to learn and grow alongside their peers. [Insert at least one provision aimed at preventing stress & improving pupil mental health that

Areas of the curriculum we pay particular attention to which may expose pupils to triggers like allergens, humidity, extremes of temperature, fumes, smoke, dust, pollutants, flashing lights, sugary food & drinks etc. include science, design technology, food technology, art, religious studies, drama, PE, and outdoor activities.

We do not own or keep animals that create known triggers and where contact is unavoidable e.g., in the presence of disability service animals or on educational visits off-site, we carefully manage situations that may cause a reaction.

This school has a strict 'no smoking/vaping' policy in force throughout the site, both indoors and outdoors, and steps are taken to ensure that staff and other adults leading or supervising off-site visits follow this policy.

This school is kept well ventilated to control humidity and temperature, and to prevent dust accumulation, damp, and mould through open doors and windows in line with our security and our fire risk assessment and through forced ventilation.

We actively look for damp and mould problems through normal premises condition monitoring and take action to prevent and deal with incidents as a high priority.

When we have pupils or staff with severe symptoms triggered by dust, we will ensure classrooms and any other areas necessary are regularly wet dusted to reduce dust and dust mites.

When contractors are on site, regular discussions take place with them to ensure that their work will not increase risks to pupils or staff in an unmanageable way e.g., create fumes, smoke, dust, flashing lights etc.

Where possible, grassed areas are not mowed during school hours, and we avoid keeping pollinating plants inside school buildings.

Rooms where pupils change their clothing are well ventilated and pupils are encouraged to use unscented and non-aerosols deodorants or other permitted products.

We consider the possible effects of flashing lights on photo-sensitive epilepsy in drama, performances, science, trips off-site etc.

12. Off-site and residential visits

On-site procedures to manage AADE must be suitably adapted to be carried out off-site by the visit leader,

Visit leaders may need to identify significant health and medical needs at the earliest planning stages, seeking advice from EVC coordinator, if necessary, to ensure equality of access to the curriculum and to be suitably prepared for their visit, for example:

- to understand which pupils, *have AADE.*
- *the severity of their symptoms.*
- *relevant triggers to be avoided and how exposure could happen.*
- *their treatment or care plan, especially out-of-hours arrangements* which school is normally unfamiliar with, and the role of staff.
- and the pupil's competence in carrying and administering their own emergency and other medicines.
- distance from emergency services at any point in time on the visit.

Parental consent to attend a residential visit may need to include a review of and additions to an IHCP because a medicine or other treatment school does not normally manage is required.

All medicines provided for educational visits must be handed over to school already clearly labelled with the pupil's full name.

13. When a pupil is falling behind in lessons

If a pupil is missing a lot of time at school, or is distracted by their symptoms or health worries, or is always tired because their medical condition is disturbing their sleep at night, the class teacher, will initially talk to the parents/carers to develop a plan to support better management of their symptoms and/or to prevent their child from falling behind. If appropriate, the member of staff taking this initial action will then talk to the school or community nurse and SENDCo about the pupil's further needs.

We recognise that it is possible for pupils with anaphylaxis, asthma, diabetes, and epilepsy to have special education needs (SEN) due to their medical condition which may also be a disability under the Equality Act 2010.

14. Bullying

Whilst bullying can happen to any pupil, this school recognises that those who feel or seem different to others can be particularly vulnerable. Our Anti-bullying procedures which are part of the Whole School Behaviour Policy will be used and enforced in any situation where a pupil is being bullied or intimidated, both online and offline, due to their medical condition.

15. Disclaimer

While every effort will be made to ensure appropriate medical attention is sought at the earliest opportunity in the event of a pupil experiencing a medical or health emergency, this school cannot accept responsibility for adverse events when parents/carers have failed to provide the medicines or working devices their child needs to manage their medical condition.

16. Access to and review of procedures

The AADE Procedures will be accessible to all staff and other adults working in the school and the community on request. A printed copy is available from the school office.

These procedures will be reviewed annually or when procedures in school change and a review becomes necessary.

How to recognise a mild to moderate allergic reaction

Symptoms include:

- sneezing and an itchy, runny or blocked nose (allergic rhinitis)
- itchy, red, watering eyes (conjunctivitis)
- wheezing, chest tightness, shortness of breath and a cough
- a raised, itchy, red rash (hives)
- swollen lips, tongue, eyes or face
- tummy pain, feeling sick, vomiting or diarrhoea
- dry, red and cracked skin

A child will not necessarily experience all of these symptoms in the same episode.

ACTION:

- Stay with the person, call for help if necessary
- Locate adrenaline auto-injector(s) in case needed
- Give antihistamine according to the child's allergy treatment plan
- Phone parent/emergency contact
- **WATCH FOR SIGNS OF ANAPHYLAXIS**

Signs of anaphylaxis

Airway	Breathing	Consciousness
Persistent cough	Difficult or noisy breathing	Persistent dizziness
Hoarse voice	Wheeze or persistent cough	Becoming pale or floppy
Difficulty swallowing		Suddenly sleepy, collapse, unconscious
Swollen tongue		

IF ANY ONE (or more) of these signs are present:

1. Lie child flat with legs raised: (if breathing is difficult, allow child to sit)
2. **Use Adrenaline auto-injector* without delay**
3. Dial 999 to request ambulance and say **ANAPHYLAXIS**

***** IF IN DOUBT, GIVE ADRENALINE *****

After giving Adrenaline:

1. Stay with child until ambulance arrives, do NOT stand them up
2. Commence CPR if there are no signs of life
3. Phone parent/emergency contact
4. If no improvement after 5 minutes, give a further dose of adrenaline using another autoinjector device, if available.

Anaphylaxis may occur without initial mild signs: **ALWAYS use adrenaline auto-injector FIRST in someone with known food allergy who has SUDDEN BREATHING DIFFICULTY** (persistent cough, hoarse voice, wheeze) even if there are no skin symptoms

How to recognise an asthma attack

Signs that someone may be having an asthma attack include:

- Symptoms that are getting worse e.g. coughing, breathlessness, wheezing, or having a tight chest
- The reliever inhaler is not helping relieve symptoms or is needed more than every four hours
- Being too breathless to speak, eat, walk, or sleep
- The person's breathing is getting faster, and they feel like they cannot catch their breath
- Their peak flow score is lower than normal
- They complain of a tummy or chest ache (more commonly a tummy ache in younger children)

Symptoms will not necessarily occur suddenly. They often come on slowly over a few hours or days.

DIALL 999 FOR AN AMBULANCE IMMEDIATELY IF:

- There is no working reliever inhaler available
- The child feels worse despite using a reliever inhaler
- The child does not improve after taking 10 puffs of their reliever inhaler
- The child:
    - Appears drowsy, confused, exhausted, or dizzy
    - Has blue tinged lips, nails, tongue, gums, skin, or ears
    - Has collapsed

Give paramedics the child's medicines.

What to do in the event of an asthma attack

Do <u>not</u> follow this procedure if the child having the suspected asthma attack is on a MART treatment plan. Say where MART personal action plans can be found.

- Keep calm and reassure the child
- Encourage the child to sit up straight
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with the child while the inhaler and spacer are brought to them
- Immediately help the child to take **one** puff of salbutamol via the spacer
- If there is no immediate improvement, continue to give **one** puff at a time **every 30-60 seconds**, up to a maximum of 10 puffs
- Stay calm and reassure the child. Stay with the child until they feel better and can return to school activities
- If the child does not feel better or you are worried at **ANYTIME** before you have reached 10 puffs, **CALL 999 FOR AN AMBULANCE**. Give attending paramedics the child's medicines.
- If an ambulance does not arrive within **15 minutes** give another 10 puffs in the same way

Inform parents or carers as agreed (no matter how minor) or as soon as possible (if serious).