PLYMOUTH COLLEGE

MEDICAL POLICY

including Early Years Foundation Stage (EYFS)

Last reviewed:	**July 2026**
Next review date:	**August 2027**
Responsibility:	**Assistant Head (Pupil Welfare)**

Principles and Aims

Plymouth College aims to create a safe, inclusive and welcoming environment, in which all children and young people enjoy attending every day and participating fully in all areas of school life. We therefore aim to make provision for pupils who become unwell whilst with us through our Health Centre and in the boarding houses so that they can continue to attend and participate fully.

Children and young people with medical conditions have the same right to education as their peers. They should be able to attend regularly, be safe, feel fully included and welcome, and enjoy their life in school. We therefore aim to identify which of our pupils have medical conditions that may require adjustments or provision to be made to ensure that they can participate equally fully and safely as their peers.

This policy sets out how we make medical provision for all pupils at Plymouth College, including those with medical conditions.

The principles that underpin our provision for pupils with medical conditions are:

- To create an environment that is fully inclusive, so no pupil is unable to participate in lessons, visits, trips or extra-curricular opportunities as a result of their medical condition. We are committed to removing barriers to participation and will adopt a “can do” attitude to finding solutions.
- To promote the wellbeing of pupils with medical conditions.
- To make reasonable adjustments where a medical condition is a disability.
- To ensure that children and young people with medical conditions have their voice heard and are enabled to become increasingly self-sufficient in managing their condition as they grow and develop.

- To work closely with children, young people and their families to understand the impact a medical condition has, and to ensure that assumptions are not made about what (if any) support is required or desired.
- To recognise that some medical conditions are invisible, may fluctuate, evolve or reoccur, that children and young people may mask the impact, and that some pupils may have multiple medical conditions.
- To protect children and young people's dignity and human rights.
- To celebrate diversity and to be committed to eradicating stigmatising or bullying behaviours towards those with medical conditions.
- To develop a culture of continuous improvement when it comes to supporting children and young people with a medical condition.

Definitions

"School" refers to all key stages at Plymouth College, including EYFS and sixth form.

"Parents" refers to anyone with parental responsibility, including carers.

"Pupils" refers to all children and young people who attend Plymouth College, regardless of age.

A "medical condition" is a specific physical or mental health issue or illness that can be diagnosed by healthcare professionals based on symptoms, tests or examination. These conditions, which include chronic diseases, require management or treatment and can affect an individual's functioning. If the school has to put arrangements in place to support children and young people with the condition (whether formally diagnosed or not), then it is considered to be a medical condition within the scope of this policy.

"Gillick competent" is a legal principle determining that children under 16 can consent to medical treatment without parental knowledge or permission if they possess sufficient understanding, intelligence, and maturity to fully appreciate the proposed treatment, its risks and consequences.

Acronyms used in this policy:

LAB	Local Area Board
IHP	Individual Healthcare Plan
CD	Controlled drugs
EYFS	Early years and foundation stage
SEND	Special Educational Needs and/or Disability
EHCP	Education and Healthcare Plans
ISP	Individual Support Plan

Useful Contacts

School Nurse	01752 505 145 (Health Centre) 145 internal 07973 872678 (School Nurse's Mobile)	
Assistant Head	01752 505139	
Prep Reception	01752 505101	
School Doctor	01752 205555	
Eye Infirmary	01752 431648	
Derriford Hospital	Ask for ED	01752 202082
Cumberland Centre	Minor injuries unit	01752 434400
NHS 24 hour professional medical advice service		111

Identification of pupils with a medical condition

When a pupil is added to the school roll, parents will be asked to complete a questionnaire detailing any medical conditions which may require additional support in school. The school nurse will receive any responses directly. Any previous educational settings will also be contacted to ask if the pupil has an existing Individual Healthcare Plan (IHP). Should it become evident that a child or young person does have a medical condition which may require additional support in school, the school nurse will meet with them individually to discuss how it affects them (although this could be part of the IHP creation and review process).

This should ensure that any arrangements are in place from the pupil's first day on roll.

Parents of existing pupils are contacted annually to update any information about medical conditions of their child(ren) in case any new diagnoses have been made or where existing diagnoses have changed. As with new pupils, the results of this questionnaire will be shared directly with the school nurse and our medical records updated accordingly. This information could also require an IHP to be created or for an existing one to be reviewed.

Examples of specific medical conditions that are common or significant can be found in Appendix A, including an indication of how the school might need to respond.

Identification of staff and visitors with a medical condition

The school asks staff to complete a Pre-employment Medical Questionnaire to identify any medical conditions and support they may need as part of their employment.
Return to work meetings are held following a period of absence that will identify any adjustments that may need to be made in relation to any medical conditions.
As medical conditions emerge or develop, staff are able to discuss this with the HR department.

When visitors arrive at the school site, they will be told (by Checkie) to inform their host of any medical conditions that may need additional support or adjustments during their visit.

Children and Young People with a Disability

Children and young people with medical conditions may have a disability and, if so, will be protected by the Equality Act 2010.

A child or young person is deemed to have a disability if they have a physical or mental impairment and the adverse effect on the carrying out of normal day-to-day activities is "substantial" and "long term" (i.e. it has lasted or is likely to last for at least 12 months). A child under the age of six who has an impairment which does not have a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities is included in the definition of disability where the adverse effects would be considered "substantial" and "long term" in a child over six.

Certain health conditions are automatically deemed to meet the definition of disability. Schedule 1 to the Equality Act states that a person who has cancer, HIV infection or multiple sclerosis is always a disabled person. In addition section 4 of the Equality Act 2010 (Disability) Regulations 2010 state that a person who is certified as blind, severely sight impaired, sight impaired or partially sighted by a consultant ophthalmologist is deemed to have a disability.

If an impairment would have a substantial adverse effect without treatment or correction, it will be in scope of the Act even if treatment or correction is provided (for example through medical treatment). Similarly, conditions which have a substantial effect but fluctuate or recur will be considered to have a long-term impact if the substantial effect is likely to recur. The definition of disability is set out further in Guidance on matters to be taken into account in determining questions relating to the definition of disability.

Children and young people with a disability will have an IHP and positive action will be taken to ensure they are able to fully participate, be included and feel safe at school through reasonable adjustments, as detailed in the Equal Opportunities policy. Consideration for the impact their disability has on their mental health and wellbeing will be given, and the necessary support offered.

Individual Healthcare Plans

Who may require an Individual Healthcare Plan?

As soon as the school becomes aware that a pupil has a medical condition (usually through the parental questionnaires collected by the school nurse), the school nurse will discuss with them and their parents the specific circumstances and impact of their medical condition. If it is clear that the school will need to put supportive arrangements in place for the pupil (even if it is temporary, e.g. a fracture or concussion), an Individual Healthcare Plan should be created.

It is not necessary for a formal diagnosis to be made before an IHP is created. If there is a clear impact on their ability to attend, learn and participate fully in school life, an IHP is required.

Consideration should be given to those children for whom their medical condition fluctuates, evolves or appears hidden. An IHP should always be created for any child or young person with a medical condition where there is a high risk that emergency intervention will be needed.

- *Prescribed medication.* Whenever a child is required to take prescribed medication during the school day (or in boarding), an IHP should be put in place.
- *Personalised care plans.* For many medical conditions, healthcare professionals will issue a personalised care plan or action plan. These should be shared with the school by the parents and included in the IHP.
- *Reasonable adjustments.* If a child or young person has a medical condition that constitutes a disability and requires the school to make reasonable adjustments to its policies or practices, an IHP will be required. The IHP must detail what adjustments need to be made, and how or when they may be required.

Not all medical conditions require an IHP. If there is little or no impact on the child or young person whilst they are at school, or if arrangements can be made under this policy (e.g. by administering over the counter medication in the Health Centre), then an IHP is unnecessary.

Ultimate responsibility for deciding whether a child or young person requires an IHP lies with the Head, in discussion with the pupil, their parents and any healthcare professionals.

How should an Individual Healthcare Plan be created and reviewed?

If it has been decided that an IHP is necessary to support a pupil with a medical condition, the school nurse will liaise with the pupil, their parents, any relevant healthcare professionals and other staff in school to create the IHP.

The IHP would normally be reviewed annually. However, there are circumstances which might trigger a review sooner than that, such as:

- The needs of the child or young person's condition changing over time, for example if they have an Acquired Brain Injury
- Their prescribed medication changing
- Their personalised care or action plan being updated by a healthcare professional
- A serious incident or near miss occurring.

As the child or young person grows up, they may be able to take more responsibility for their medical condition. Therefore, they should always be involved in the review process of their IHPs to ensure they are enabled to take safe ownership of their condition.

What does the Individual Healthcare Plan need to contain?

An effective IHP will capture the key information about a pupil's medical condition, along with a clear record of the arrangements required in school to keep them safe, included and supported.

The amount of detail in each IHP will vary considerably between individuals depending on the complexity of their medical condition, but a template used to create it can be found here.

The IHP must include:

- Name of the child or young person, their date of birth and their most recent photo from iSAMS.
- Contact details for parents.
- A brief summary of the medical condition.
- Details of any additional requirements, support or reasonable adjustments for the child or young person whilst they are in school, and how the school will meet them. If these arrangements are different for school trips, visits and co-curricular activities, this should be specified.
- Details of any medication they may need to take whilst at school including how and when to be administered, who will administer it (including cover arrangements if someone with specific training is required to administer it), complications or side-effects to be aware of, and written permission from parents for their child to self-administer if appropriate.
- How the medical condition impacts on the child or young person's learning and emotional wellbeing, and steps taken by the school to mitigate against this.
- If the medical condition means it is likely that the pupil's attendance will be impacted, details for how they will be supported to catch up on missed learning must be stated.
- How well the child or young person can take responsibility for their own needs, including in an emergency. It should be clearly stated if they are able to self-medicate.
- How to identify an emergency and how to respond.
- Reference to any personalised care or action plans.
- If staff need specific training to support a medical condition, those staff should be named, their training details recorded, and cover arrangements for their absence stated.

Who is the IHP shared with?

Once the IHP has been created, it should be shared with the pupil and their parents. A discussion can then be had to decide who else in school needs access to it and the IHP is shared accordingly.

The Head will review the IHP and decide if it needs adding to the school's risk register.

Should a pupil move to a different educational setting, the IHP will be shared with them ahead of their move to ensure any arrangements or support are in place from their first day.

Management and administration of medication

The school is able to store and administer non-prescription, prescription and controlled medication in the Health Centre, the Prep School and the boarding houses. This ensures that children and young people are able to quickly access the medication they need, especially in the case of an emergency or if they are in pain. Wherever possible, children and young people should be allowed and encouraged to carry their own medication to self-administer. Medicines should only be administered when it would be detrimental to their health or school attendance not to do so.

Children under 16 should not be given prescription or non-prescription medicines without written consent from their parents, which is obtained in the annual health questionnaire, and parents (or house parents of boarders) will be informed when any medication has been administered. There could be, however, exceptional circumstances where medicine has been prescribed or administered to a child or young person without the knowledge of their parents, and the child or young person would either have to be able to demonstrate Gillick competency or be at a significant risk of harm if parents were told for this to occur.

Non-prescription medication

The school stocks certain over-the-counter medications in the Health Centre, Prep School and boarding houses. See Appendix B for a complete list. It is the responsibility of the school nurse, with support from boarding matrons, to ensure that the non-prescription medications stored on school site are within date and to complete stock checks regularly. They are kept within locked cupboards (or locked refrigerators if necessary).

Non-prescription or over-the-counter medication is licensed by the Medicines and Healthcare products Regulatory Agency (MHRA) as safe for use without a GP prescription.

A child under 16 should never be given medicine containing aspirin unless prescribed by a doctor. Medication (for example for pain relief) should never be administered without first checking maximum dosages and when the previous dose was taken.

It is appropriate for non-prescription or over-the-counter medicines to be administered by the school nurse, a member of staff, or to be self-administered by the child or young person, following written permission by the parents.

Boarding pupils can keep non-prescription medicine in their lockable drawer in their rooms so long as the boarding house parent is informed, it is agreed that they are competent to do so, that parents have given consent and that they are informed of potential side effects and what to do if they have taken an incorrect dose or out of date medication.

Following the administration of non-prescription medication, a record is made in iSAMs or through the boarding medication log which details the following:

- Name of pupil
- Date
- Time

- What was administered
- Dose
- Reason
- Any side effects that occurred

Prescription medication

Where clinically possible, medicines (including controlled drugs) should be prescribed in dose frequencies which enable them to be taken outside school hours. However, if it is necessary and appropriate for pupils to take prescription medication during school hours (or in boarding) they should not be prevented from doing so.

We accept prescribed medicines that are in-date, labelled, provided in the original container as dispensed by a pharmacist and include instructions for administration, dosage and storage. Prescription medication can be stored in locked cupboards (or refrigerated if necessary) in the Health Centre, Prep School or boarding. Children should know where their prescription medication is being kept so that they can access it quickly. Some pupils may choose to self-administer and carry their medication themselves, but only if this is deemed appropriate and if parental consent is obtained.

Where a child has prescription medication, it may be appropriate for there to be an Individual Healthcare Plan in place detailing where it is to be stored, who is to administer it and the possible side effects. If specific training is required to administer the medication, the IHP should detail which people have the necessary training and the cover arrangements in the event they are not available to administer it.

Boarding pupils can keep prescription medicine in their lockable drawer in their rooms so long as the boarding house parent is informed, it is agreed that they are competent to do so, that parents have given consent and that they are informed of potential side effects and what to do if they have taken an incorrect dose or out of date medication.

Following the administration of prescription medication, a record is made in iSAMs or through the boarding medication log which details the following:

- Name of pupil
- Date
- Time
- What was administered
- Dose
- Reason
- Any side effects that occurred

Parents (or house parents of boarders) will be informed when prescription medication has been administered.

Controlled medication

Where clinically possible, medicines (including controlled drugs) should be prescribed in dose frequencies which enable them to be taken outside school hours.

All controlled medication is stored, administered, recorded, and disposed of in full compliance with the Misuse of Drugs Regulations 2001 and the DfE's Supporting children and young people with medical conditions and allergies guidance. Controlled drugs (CDs) are stored securely in a locked, non-portable cabinet within the Health Centre. If medication needs to be given in the boarding houses it is signed in and out as required to their locked, non-portable cabinet. In the Healthcare centre only the School Nurse can access and administer controlled medication, in boarding members of staff with medicines training will access and administer the controlled medication. The cabinet is accessible only with a key that is locked in a separate lock box or key cabinet.

Each administration of a controlled drug is recorded in an individually assigned Controlled Drug Book with a separate page for medication. The record includes the name of the medication, dosage, time of administration, name of the administering staff member, and the remaining quantity of the drug. This will also be documented by the School Nurse on iSAMS. Administration is witnessed by a second staff member with the School Nurse, and this is documented. If this is not able to happen daily due to staff availability, the School Nurse will ensure that an overall Controlled Drug check is done with another member of staff at least once each term. In boarding administration of controlled drugs will always be with 2 members of staff, this will be documented in the students individual Controlled Drug Book. If this is not documented the School Nurse will be informed.

Controlled medication must remain in its original packaging, clearly labelled by a pharmacy, and must not be altered or transferred between containers. Students are not permitted to carry controlled drugs on their person, unless specific, documented exceptions have been assessed and authorised by the School Nurse and parents/guardians.

All controlled medication will be returned to parents/guardians at the end of each term; no controlled medications should be stored during the school holidays in the Healthcare Centre or the Boarding House. The School Nurse will contact parents/guardians to remind them they need to be collected, or if agreed between the School Nurse and Parents/Guardians the student and sign the medication out at the end of the day and take it home. Parents/guardians will be informed by the School Nurse if controlled medication is going out of date or if further stock is needed, parents/guardians are responsible for collecting to dispose of the medication or supplying more stock. This will be documented clearly in the Controlled Drug Book and on iSAMS.

The School Nurse will ask parents/guardians for proof of prescription for each controlled medication stored and administered in school, this is to ensure that the student is recieving the correct prescribed dose.

Where a child takes controlled medication at school or in boarding, it is necessary for there to be an Individual Healthcare Plan in place detailing where it is to be stored, who is to administer it and the possible side effects. If specific training is required to administer the medication, the IHP should detail which people have the necessary training and the cover arrangements in the event they are not available to administer it.

All incidents involving errors, discrepancies, or concerns regarding controlled drugs are reported immediately to the School Nurse, and a Medical Incident Form is completed. In serious cases, further guidance may be sought from the prescribing GP, pharmacy, or NHS 111. The school ensures that all procedures regarding controlled drugs are reviewed regularly and that training for relevant staff is kept up to date.

This section applies equally to day and boarding students, and reflects the school's wider safeguarding responsibility to uphold pupil health and safety while meeting medical needs with professionalism, confidentiality, and care.

Asthma inhalers and spacers

Where a child or young person has been prescribed an inhaler, the school should create an IHP with them, their parents and the school nurse.

Wherever possible, children and young people should be enabled to carry their own inhalers and spacers. If they are deemed unable to take responsibility for this, the inhaler should be stored somewhere that is easily accessible to them, which will be detailed on their IHP. During IHP reviews, thought should be given as to whether they are now able to carry their own.

The school nurse will obtain and store emergency inhalers and spacers in line with the Department of Health's guidance on the use of emergency salbutamol inhalers in schools.

The emergency inhalers are able to be used by children and young people who:

- Have written permission from their parents (which must be clearly documented in their IHP)
- Have a diagnosis of asthma or have a prescription for a salbutamol inhaler
- Are unable to use theirs because it is unavailable (e.g. it is broken or empty)

The school nurse will oversee the supply, storage, care and disposal of any emergency inhalers kept at school.

- Supply - the school nurse will acquire emergency inhalers
- Storage - emergency inhalers are stored in cupboards accessed by a rip tag in the Health Centre, the prep school and the boarding house (where there is identified need).
- Care - the school nurse will take responsibility for ensuring they are in date
- Disposal - when emergency inhalers need disposing of, the school nurse will take them to the local pharmacy

Where a pupil is identified as being eligible to use the school's emergency inhaler, the trip leader for any off site activity will take responsibility for ensuring it is carried with a member of staff at all times.

School staff will receive annual training on how to recognise the signs of an asthma attack, how to respond and how to support a child or young person with using their inhaler. Please see appendix D for more information.

When the emergency inhaler has been used, it will be documented on iSAMs and parents informed. If it is a boarding pupil, it will also be recorded on the boarding medication log and house parents informed.

Disposal of medication

Medications contain active ingredients that, if not disposed of correctly, can have harmful effects on people, animals, and the environment. Medications are separated from other types of waste, such as general rubbish or clinical waste, ensuring that they are handled and disposed of correctly.

Over-the-counter medicines are typically classified as non-hazardous pharmaceutical waste and can often be returned to pharmacies for safe disposal.

Prescription and controlled medicines will be returned to the parents for disposal wherever possible.

Medicines that need disposing of will be stored securely in a tamper-proof container within a locked cupboard until they are taken away by the school nurse, the boarding matron or signed back to the parent.

First Aid and Emergency Situations

Plymouth College recognises the importance of first aid provision in safeguarding the health, safety and welfare of pupils, staff and visitors. We aim to ensure that first aid is administered promptly and competently by qualified personnel. That there are adequate first aid facilities and trained staff are available at all times and that the school policy complies with the Early Years Foundation Stage framework, Health and Safety at Work Act 1974, and HSE and DfE guidance including: First Aid in Schools – DfE and Health and Safety (First-Aid) Regulations 1981 – HSE.

All staff are expected to familiarise themselves with first aid arrangements and comply with this policy, some students are given the opportunity to gain a first aid certificate through the Duke of Edinburgh Award Scheme, Btec Sports, CCF or taught it in RSE.

EYFS Provision

At least one person with a full Paediatric First Aid qualification (PFA) is present on site at all times while EYFS children are in attendance and accompanies them on all off-site trips.
Most EYFS staff members and relevant support staff hold valid PFA certificates, reviewed annually.

Outward-Bound and Specialist Staff

Staff leading Duke of Edinburgh, CCF and outdoor education activities hold appropriate advanced outdoor first aid qualifications.

Training Records

All staff first aid training is logged and maintained by the School Nurse and HR which is updated regularly.

First Aid Provision and Equipment

The School Nurse acts as the appointed person responsible for coordinating first aid provision and training, maintaining equipment and stock and supporting staff with medical guidance.

The Health Centre is open from 8.15am to 5.15pm, Monday to Friday, and is the main treatment area for medical and first aid emergencies. The Health Centre consists of the nurses office and a dedicated sick bay where students can rest. These 2 rooms are close to handwashing facilities, toilets and are not used for teaching. Staff are able to access the Health Centre and be seen and advised by the School Nurse.

If a pupil becomes unwell during the school day, it is the decision of the School Nurse (or the Attendance Officer in her absence) or a member of SLT as to whether they should be allowed to go home (or back to boarding). Pupils will not be permitted to travel home independently if they are unwell, and parents will be asked to make arrangements to collect them from the Health Centre or the Prep Medical Room.

First Aid Boxes

Clearly marked first aid boxes (green with white cross) are located in strategic areas: science, DT, art, PE, vehicles, and offices. See Appendix C for a full list. There are also first aid kits on each school minibus. Contents are compliant to the British standard first aid kit contents and restocked on an interim basis by the departments and checked annually by the School Nurse.

First aid kits should always be suitable for the purpose of keeping the contents in good condition and readily available to use.

Off-site kits are available and tailored for specific trips (e.g. sports, DofE, residentials) which should be carried by the members of staff at all times when off site. Main sports staff have their own first aid kits issued by the Health Centre when offsite. Other coaches can book out first aid kits from the Health Centre as required. Heads of Sport take responsibility for ensuring their coaches and team managers are equipped with first aid kits on all away matches and offsite training sessions.

Staff members are responsible for contacting the School Nurse via this Request Form to request bespoke medical kits as required for specialist trips such as residential, overseas expeditions and sports tours etc.

Automated External Defibrillators (AEDs)

- AEDs are located outside MK Hall, and offsite at Delgany and Whiteworks
- Staff receive training as appropriate.

Each AED is stored in a heated cabinet with a rip-tag securing the door for easy emergency access. All AED locations are clearly signposted, and staff will be informed of their locations during induction. The School Nurse is responsible for checking that each AED is in full working order, ensuring that electrode pads are in date and batteries are charged and arranging and documenting professional maintenance checks. All checks are recorded in the AED Maintenance Log, which is available for internal review and external inspection.

See Appendix E for guidance on how to use an AED.

Eye Wash Facilities

Provided in Science labs, DT rooms, Art rooms, and the Health Centre.

What to Do in a First Aid Situation

All staff should take precautions to avoid infection and follow basic hygiene procedures. Staff should have access to single-use disposable gloves and hand-washing facilities, and should dispose of and take care when dealing with blood or other bodily fluids and dressings or equipment in the yellow bags provided in the Health Centre, boarding houses or Prep Reception.

All Prep classrooms have disposable gloves. Sponges should not be used for injuries on the rugby field. There is a sharps box for needles in the Health Centre.

Serious Accidents or Medical Emergencies

1. The School Nurse should be called
2. The situation will be assessed. If required, an ambulance will be called by the Nurse or staff member at the scene
3. The School Office should also be made aware of the problem and will coordinate the porters to meet the ambulance
4. The casualty will be accompanied to hospital by the parent/guardian, School Nurse or staff member
5. In all cases, parents/guardians should be contacted as soon as possible and be expected to relieve the School Nurse or staff member
6. In the case of a boarder, the matron or member of staff on duty will accompany the pupil
7. Teaching staff should be alerted through iSAMS as to why the child is absent from lessons.

If a child or young person experiences a life-threatening medical emergency, anyone – staff, volunteers or bystanders – may take reasonable action to save their life. The law recognises that rescuers act under extreme pressure. People who attempt to save a life in good faith are protected, even if an injury occurs while giving emergency care (for example, broken ribs during CPR are common and not a sign of wrongdoing).

Guidance on paediatric life support can be found in Appendix F.

Minor Accidents

1. The School Nurse should be called
2. The situation will be assessed and the casualty will be treated in the Health Centre
3. If the School Nurse deems it necessary, she will contact parents or boarding staff to alert them to the situation
4. The casualty will be returned to lessons if the School Nurse feels they are fit to do so or may be allowed to go home with parents if deemed necessary. In this case, the casualty will remain in the Health Centre until parents or boarding staff collect them

5. The School Office and teaching staff should also be made aware of the situation if the pupil is not attending lessons.

Record Keeping and Reporting

All first aid and medication administered is recorded by the School Nurse and Prep Receptionist on iSAMS and parents/guardians are informed.

Staff must complete an online Google Form for accidents and incidents they witness or help with. Early Years incidents use a paper form signed by parents/guardians on collection.The Head of Early Years reviews these on a termly basis. Parents are informed if there is an injury that will require a visit to either A&E or a minor injuries unit.

Prep students with head injuries will be sent home with a Head Injury Form. Senior school students who sustain head injuries will be assessed by the School Nurse and their parents/guardians will receive a phone call and an email containing their current condition, how the head injury occurred and the NHS Guidance for Head Injuries.

All medical assessments carried out by the School Nurse and the Prep Receptionist are documented on iSAMS. Serious injuries are reported to the HSE by the Estates Manager/Health and Safety Officer under RIDDOR regulations.

Serious incidents and medical near misses

A serious incident is any event relating directly to a medical condition in which a child, young person, member of staff or visitor with a medical condition or allergy is harmed or is placed at an immediate and significant risk of harm, including situations requiring emergency medication, urgent clinical intervention or attendance by emergency services.

A “near miss” is an event relating directly to a medical condition that did not result in harm but had the clear potential to do so, for example, where an error, omission, or system failure could reasonably have led to a serious incident had circumstances been only slightly different.

Where a serious incident or near miss occurs involving a child or young person with a medical condition, the incident should be recorded, and include the following detail:

- Who was affected;
- What happened, when and where;
- Why the incident occurred (as far as is known);
- How staff and students responded;
- what was done to support the individual;
- whether emergency services were called;
- How the incident concluded.

It should also be reported to the child or young person’s parents. The Assistant Head and the nominated governor for medical conditions and allergies will review the serious incident and

near miss log, and report to the LAB, alongside any statutory reporting (e.g. Health and Safety Executive).

A serious incident or near miss should prompt a review into any relevant IHPs, policies and procedures.

Consideration will be given to the emotional impact a serious incident or near miss may have on the pupil, their family, other children or young people in the community and staff.

Concerns, disagreements and complaints

Following a serious incident or a near miss, or if there are concerns around the support provided to a child or young person with a medical condition, the pupil or parents can follow the school's complaints procedure.

Visits, trips and co-curricular activities

It is the school's intention to ensure that a medical condition should never be a barrier to a child or young person participating in any school visit, trip or co-curricular opportunity or activity. Consideration will always be given to ensuring that any and all co-curricular provision is accessible to all.

When organising a school trip, the lead member of staff will obtain current and up to date medical information for pupils participating in the activity (both through the most recent medical information stored on iSAMs and by asking parents to complete additional medical information forms for residential trips or high risk activity). They must then ensure that any necessary individualised arrangements are put in place to support children and young people with medical conditions that require specific provision, that any barriers to participation are removed and that reasonable adjustments are made for those with disabilities. This can be done in consultation with their IHP (if they have one), the school nurse, the pupil and the parents. The lead member of staff will be asked to sign off on the trip documentation that they have done this and to include any relevant risk assessments.

Off-site kits are available and tailored for specific trips (e.g. sports, DofE, residentials) which should be carried by the members of staff at all times when off site. Main sports staff have their own first aid kits issued by the Health Centre when offsite. Other staff can book out first aid kits from the Health Centre as required via this Request Form.

Some off-site kits may contain over the counter medication, if deemed appropriate by the school nurse. There should be at least one member of staff suitably trained to administer this if necessary, and a record and stock check should be kept. If a child or young person has prescription medication or is prescribed a controlled drug, or requires emergency medication (such as an inhaler and spacer), the lead staff member should discuss with the school nurse how to store, administer and record this whilst on the trip. Wherever possible, pupils should be enabled to take responsibility for their own medication.

Emergency inhalers and spacers should be taken on all off site activities whenever there is a pupil attending who has a diagnosis of asthma or a prescribed inhaler. Checks should also be made before departure that they have their own inhaler with them, or if they are not deemed able to take responsibility for their own, that a member of staff carries it and the child is able to quickly access it if it is needed.

Supporting boarders with medical conditions

The boarding houses have access to first aid kits and have facilities to store over the counter, prescribed and controlled medication. There will be sufficient members of the team with a first aid qualification to ensure 24 hour first aid provision. All boarding staff are trained in administering medication.

The administration of medication and first aid is recorded on the boarding medication log. The School Nurse will then ensure the medical records are transferred onto iSAMs for a complete record. The boarding matrons and the School Nurse are responsible for ensuring that any medication in the boarding houses is in stock and in date.

If a boarder has a medical appointment arranged for them, they are supervised by the boarding matrons, or other appropriate staff if they are unavailable.

If a boarder becomes unwell with an infectious illness, they are required to stay in the isolation rooms, and boarding staff will routinely check on them. A “sick room log” is created to document the care they have received and to ensure effective handover between duty staff.

In the event of a medical emergency out of hours, there is always a named member of boarding staff on duty and they could consult 111 for medical advice, or take a boarder to the Urgent Treatment Centre at the Cumberland Centre, or the Emergency Department at Derriford Hospital. In the event of a medical emergency that requires an ambulance, 999 would be called.

Early Years and Foundation Stage

We promote good health, including oral health, in the early years through our curriculum.

Medication can be administered to children in EYFS following the same procedures as above. Prescription and non-prescription medication will only be administered if written permission has been obtained from parents. Parents are informed via iSAMs when medication has been administered.

At all times, there is at least one member of staff in the department who holds a Paediatric First Aid qualification and has up to date Intimate Care training.

Children with Special Educational Needs and / or Disability, and Education and Healthcare Plans

Children and young people with Special Educational Needs and / or Disability (SEND) will have either an Individual Support Plan or a Pupil Passport. Should they have a medical condition that requires them to have an IHP, this information should be incorporated into their ISP.

Some children and young people with an Education Healthcare Plan (EHCP) may have specific healthcare provision detailed in Section G. This information may not contain the practical, supervisory or emergency information needed for their day-to-day care, and so these should still be detailed in an IHP, which could be incorporated into their Individual Support Plan.

When creating an IHP, thought should be given to how this may impact any examination access arrangements that have been put in place for a child or young person. The school nurse will liaise with the SENCo when devising an IHP for a pupil with access arrangements.

Admission

Children and young people with medical conditions are entitled to a full education and have the same rights of admission to school as other children and young people. In line with the Equality Act 2010, our admissions criteria do not treat applicants who may be considered to be disabled less favourably than others who are not. Where a child or young person's medical condition may have adversely impacted their attendance or attainment, this will be taken into account during the application process.

The school's accessibility plan contains more information about this.

Attendance

Children and young people with medical conditions have poorer school attendance than their peers, whether as a result of the condition itself or absence due to medical appointments. This brings the risk of lost learning or additional pressure through the need to catch up, as well as having an impact on their emotional health and wellbeing. The school maintains ambitious targets for all pupils in relation to attendance, but these targets will be adjusted for those whose medical condition makes it difficult for them to attend school, or who may have medical appointments during the school day. A punitive or pressured approach to school attendance would be wholly inappropriate, and we will work to support any child in removing barriers to attendance and to reintegrate after a period of absence.

Where children and young people require frequent medical appointments or additional support interventions, these should be scheduled outside of the main school day wherever possible. The school will work with the child or young person's parents and the relevant healthcare professionals to understand the frequency, likely timings and length of medical appointments so that advance planning can help to minimise the impact on the child or young person's education or assist in catching up where needed.

All children must receive a full-time education, unless this would not be in their best interests because of their health needs.
If part-time school attendance is in their best interest, this can be arranged in discussion with the pupil, their parents, the school nurse and the Head of Year or Senior Attendance Champion. This should be a temporary arrangement with regular review dates. This arrangement can be flexible if the medical condition is likely to fluctuate.
Should a part-time timetable be arranged for a pupil with a social worker or with an EHCP, the local authority will be informed.

Where a child or young person is unable to attend school due to their medical condition, the local authority is responsible for ensuring that suitable, high quality education provision is made under Section 19 of the Education Act 1996. Arrangements can be made once a child or young person has 15 days or more absence due to their medical condition (consecutive or unconsecutive).

Safeguarding

The statutory guidance on Working together to safeguard children is clear that preventing the impairment of children's mental and physical health or development forms part of safeguarding and promoting the welfare of children. Please refer to our safeguarding and child protection policy for more information.

Mental Health

Good mental health and wellbeing improves standards in schools and helps children and young people achieve and thrive in education, setting them up well for life and work.

Children and young people are taught about recognising common mental health conditions, strategies for maintaining positive mental health and where to go for support when concerned about their mental health. We also deliver education on how to maintain positive mental health, even in light of adversity such as living with a medical condition.

Staff are trained in recognising signs of poor mental health and how to refer to the appropriate internal and external services.

Where a child or young person is affected by a mental health illness, the appropriate care and support (within school and to external agencies) will be signposted to them and consideration given as to whether an IHP is necessary. Pupils will be asked to nominate a trusted adult in school that they can go to if they need additional help at any point. Should a safety plan be necessary for any pupil, this will be attached to their IHP but careful consideration given as to who that is shared with.

Please refer to the mental health policy for further information.

Mobile Phones

The school is a phone-free site (more details can be found in our mobile phone policy).

The School recognises that some pupils may need access to a device for medical reasons, such as diabetes monitoring. In such cases, appropriate medical evidence must be provided and approval must be given by the Designated Safeguarding Lead.

Where approved, a Medical Device Pass will be issued. Use must be limited to the agreed medical purpose and should not extend to general personal use. Any misuse may result in the exemption being reviewed.

Information sharing

Information concerning a child or young person's medical conditions can be deeply personal. Nevertheless the school will need to hold, use and share this information in order to ensure the child or young person receives the support they need to stay safe and be included in education.

A child or young person's health information is considered special category data under UK GDPR, which means it is highly sensitive and has additional legal protections. Whilst there is a lawful basis to hold, use and share a child's special category health data when this is necessary, it will be done in a controlled and respectful way, because unnecessary sharing can reduce children's confidence in practitioners and can be embarrassing for children and young people who may not want to be singled out.

We will take a child centred approach when considering what information needs sharing and with whom, and ensure that staff are regularly trained in the need for maintaining confidentiality. Our Data Protection Policy further supports this.

Insurance and Indemnity

The school has Medical Malpractice and Medical Liability insurance coverage under the Public Liability and Professional Indemnity policy, provided by Global Galaxy Education.

Appendix A: Specific medical conditions

Medical conditions frequently found in schools

Children and young people may present with many medication conditions. We have provided short summary information about a number of common or significant conditions, indicating how schools, colleges or early years settings might need to respond.

Acquired brain injury

Acquired brain injury (ABI) is an umbrella term for any illness or injury to the brain that happens after a period of expected development, both via traumatic causes (e.g. falls, assaults, road traffic accidents) and non-traumatic causes (e.g. illnesses/infections, strokes, brain tumours, lack of oxygen). An ABI can impact on all aspects of a child or young person's functioning: physical, cognitive, emotional, behavioural, communication and social. Neuro-fatigue is also highly prevalent. ABI is a common but often under-recognised condition in schools. In 2018 over 40,000 children presented to hospital with an ABI of some kind. By age 18, an estimated 0.85-2.73% of children and young people will have experienced a hospital admission for a condition associated with an ABI.

ABIs can range from mild (e.g. concussion) to severe. Concussions are typically short-term medical conditions. ABIs can require support ranging from simple adaptations in the weeks after an injury to long-term individual support or even changes in school placement. All ABIs need to be monitored throughout a child or young person's time in education, as new needs can emerge or evolve as the brain develops.

When returning to school after an ABI, a child or young person will require a timely and flexible response to their acquired needs. They are likely to need an Individual Healthcare Plan and may require support to address any special educational needs, as well as training for staff and peers, adaptations to the environment, curriculum and teaching methods, and coordination of multi-professional meetings. This should be planned alongside health professionals and should utilise advice from specialist services and organisations.

The United Kingdom Acquired Brain Injury Forum provides information about supporting and maintaining a child's return after ABI, concussion guidance for schools, and signposts to key resources and supporting organisations.

Arthritis and related musculoskeletal and rheumatic conditions

Around 5% of children and young people aged 0–19 in the UK live with a musculoskeletal (MSK) condition, meaning many children and young people may face daily challenges related to joint pain, fatigue, or mobility. Rheumatic conditions affect the soft tissues, joints, bones, cartilage, tendons, ligaments and muscles.

Juvenile Idiopathic Arthritis (JIA) is a chronic autoimmune condition, diagnosed before the age of 16, in which the immune system mistakenly attacks the body's own joints. This causes inflammation, leading to symptoms such as pain, stiffness and fatigue; the emotional toll can also be high. There is no cure. Almost one in five children and young people with JIA have uveitis, a type of inflammation that affects the eye.

These conditions can affect movement around school, writing, concentration, participation in PE and stamina. Symptoms often fluctuate unpredictably. Children and young people also have to also manage the side effects of medications they take. Some children and young people will be absent to attend treatment, appointments and to manage their condition. Reasonable adjustments such as extra time to move between lessons, adapted seating, writing support, flexible PE activities, or rest breaks can make all the difference to a pupil's wellbeing, outcomes and participation. Furthermore, children and young people face misconceptions that arthritis only affects older adults. Understanding, inclusion and wellbeing support are vital.

Good communication between school staff, the young person, and their family is essential. A regularly updated Individual Healthcare Plan helps ensure needs around symptom management, wellbeing and medication are met. Musculoskeletal conditions vary dramatically for each individual and so education providers need to meet with the child or young person and their family to gain an understanding of the individual impact and how best to support them.

Information, IHP templates, training, tools and specialist support are available from Arthritis UK, Children's Chronic Arthritis Association, Lupus UK Youth and NRAS | Rheumatoid arthritis charity.

Asthma

Asthma is the most common long-term condition among children and young people and one of the leading causes of school absence. On average, there are two children with asthma in every classroom in the UK, and 1.1 million children are currently receiving asthma treatment. Asthma remains among the top 10 causes of emergency hospital admissions among children and young people in the UK.

There were 54 child deaths due to asthma and 19 from anaphylaxis between April 2019 and March 2023, as set out in the National Child Mortality Database Report on Asthma and Anaphylaxis. All of the children who died from anaphylaxis and had known allergies were also diagnosed with asthma. Further, 87% of schools are in neighbourhoods with air pollution above WHO guidelines, while 1654 schools are exposed to air pollution more than double the WHO guidelines. All of the children who died due to asthma were exposed to air pollution above WHO guidelines.

Asthma exacerbations are typically precipitated by identifiable triggers. In individuals with allergic asthma, exposure to airborne allergens such as pollen, house dust mite debris, pet dander and mould spores is a common trigger of worsening symptoms and exacerbations in sensitised people. Viral respiratory infections (such as rhinovirus, flu, RSV, and COVID-19), allergen exposure, and air pollution are recognised as among the most common contributors to acute asthma exacerbations, with evidence of synergistic interactions that can increase severity in sensitised children. Exercise and cold air can also cause symptoms. Common symptoms include coughing, wheezing and breathlessness out of proportion to effort, and a tight chest. An asthma attack occurs when symptoms are severe, and breathing becomes difficult.

Poor air quality worsens asthma and increases asthma attacks, and those in deprived areas with poorer nutrition suffer increased negative health effects from poor air quality. Clean air is a core asthma control measure. Good ventilation, air quality monitoring and supplemental HEPA air filtration are essential, especially when ventilation is limited and outdoor air is polluted. Systematically integrating and embedding clean indoor air into legal health and safety duties,

policies, procedures and practices will reduce pressure on staff and ensure consistency and support without too much extra work.

Children and young people known to have asthma should have their own reliever inhaler at school to treat symptoms and for use in the event of an asthma attack. Schools may also stock "spare" asthma reliever inhalers for use in an emergency if an individual's prescribed device is unavailable. If they are able to manage their asthma themselves they should keep their inhaler on them, and if not, it should be easily accessible to them. In some cases children and young people with suspected asthma will be prescribed a reliever inhaler before they receive a formal diagnosis.

Where children and young people travel long distances to their school, college or early years setting, consideration should be given to how the risks of asthma should be managed.

Further information is available through Asthma friendly schools.

Spare emergency asthma reliever inhalers

The Human Medicines (Amendment) (No. 2) Regulations 2014 permits schools to buy salbutamol inhalers, without a prescription, for use in emergencies. The emergency salbutamol inhaler should only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication. The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty). Guidance is available on Emergency asthma inhalers for use in schools.

Keeping an inhaler for emergency use could prevent an unnecessary and traumatic trip to hospital for a child, and potentially save their life. Parents are likely to have greater peace of mind about sending their child to school. Having a clear policy on how and when the inhaler should be used will ensure staff know what to do in the event of a child having an asthma attack.

Schools which choose to keep an emergency inhaler should establish a policy or protocol for the use of the emergency inhaler as part of their medical conditions policy. The policy should cover:

- arrangements for the supply, storage, care, and disposal of the inhaler and spacers, including checking that they are in-date and in working order;
- how children and young people who have been diagnosed with asthma or prescribed a reliever inhaler are identified;
- securing written parental consent for use of the emergency inhaler, to be recorded on their Individual Healthcare Plan;
- ensuring that the emergency inhaler is only used by children with asthma with written parental consent for its use;
- training for staff in the use of the emergency inhaler;
- keeping a record of use of the emergency inhaler and informing parents or carers that their child has used the emergency inhaler.

Bladder and bowel (continence) conditions

It is estimated that bladder and bowel (continence) problems affect more than 1.5 million children and young people in the UK. These issues include but are not limited to: constipation, soiling, daytime wetting accidents, delayed toilet training and bedwetting. For many children and young people their continence problem will be chronic, meaning it could persist for many years or keep recurring. Other children and young people may have an underlying condition that requires lifelong management.

These conditions can have a devastating impact on a child's learning, development and wellbeing. Children and young people with continence issues are at high risk of bullying and withdrawing from social situations. Most suffer embarrassment and stigma. Furthermore, continence difficulties may also be associated with behavioural or psychological problems, poor self-image and peer victimisation.

Children spend a significant proportion of their day at school, college or early years. Education settings need to manage continence issues effectively by supporting and promoting the principles of good bowel and bladder health. This includes providing access to drinks, clean and safe toilets and toileting support.

Guidance on Managing continence problems in schools provides a framework to help education, health and social care professionals understand bladder and bowel difficulties and issues faced by children and young people in educational settings. For further information on bladder and bowel conditions in children visit www.eric.org.uk and www.bbuk.org.uk.

Cancer

Around 4,200 children and young people under 25 are diagnosed with cancer every year in the UK. Undergoing treatment for cancer can often result in significant missed time from education, in long, continuous periods or intermittently throughout treatment. This can be due to many factors, including:

- being admitted to hospital;
- intensive treatment requiring frequent hospital attendance;
- being treated in specialist hospitals far from home;
- treatment side effects, such as sickness, pain, and fatigue;
- being immunocompromised and needing to stay out of public settings, such as following chemotherapy or a stem cell transplant;
- generally feeling too unwell to engage in education.

After treatment ends, children and young people can suffer from "late effects" (or "long-term effects"), side effects of having cancer and its treatment which begin or persist after treatment ends. There are many kinds of late effects, but some which might have a greater impact on education are, for example:

- mobility changes;
- concentration and learning changes or impairment;
- hearing loss;
- fatigue; pain.

There may be particular neurological or cognitive impacts for children and young people impacted by brain tumours.

Cancer treatment can be traumatic and also have a significant impact on children and young people's mental and emotional health which can persist long after treatment ends. They may also be dealing with other physical changes such as hair loss, weight changes, scarring and changes to the onset of puberty (either accelerated or delayed) which may impact on their self-esteem and socially. They may have other anxieties about having fallen behind, having been isolated from friends for long periods or other health anxieties such as worrying about cancer coming back. This can cause anxiety and trauma around returning to education.

Cancer treatments such as chemotherapy and stem cell transplants can impact the immune system, so infection risk can be a concern when returning to education, especially for younger children who may be susceptible to childhood illnesses such as measles, chicken pox and other infections. Schools, colleges and early years settings need to be vigilant and inform families of children and young people with cancer immediately of outbreaks or incidences of illnesses amongst children and young people.

During treatment, children and young people may be absent from their usual education provider for long periods. Most specialist children's cancer hospitals have education departments to help patients keep up with school work as much as possible, and facilitate taking exams where necessary. A keyworker (e.g. clinical nurse specialist or social worker) will support communication and coordination with education providers and the hospital, so that an education plan can be put in place, work can be in line with their usual class and learning materials can be shared to support educational progression.

Keyworkers will also help coordinate Individual Healthcare Plans and education plans so that after treatment, the "home" school, college or setting is aware of the child or young person's health and educational needs after treatment.

In some instances, home tuition may be appropriate or required, for example if the child or young person is required to isolate due to being immunocompromised. The hospital clinical and education teams, key workers, and education provider should support referrals to the local authority to put alternative provision in place where the child or young person cannot attend school on the advice of a medical practitioner (Education for children with health needs who cannot attend school).

Other actions which may support children and young people with cancer returning to education are:

- Planning and coordination between all parties - hospital teachers, school, college or university staff, clinicians, social workers and the family;
- Short visits before formal return to education;
- Phased returns or part-time schedules;
- Regular communication with designated staff or support workers;
- Flexibility in attendance and support to take time off for appointments;
- Extra time for coursework and extensions to deadlines;
- Access arrangements or special considerations for exams;
- Access to notetakers;
- Extra help from teachers or learning support assistants;
- Access to specialist/supportive equipment;
- Help for food needs (e.g. access to storage for chilled food/specialist food, or being able to eat extra snacks in class);

- Staff awareness of cancer and its impact.

Further information can be found through Education - Young Lives vs Cancer and Dealing with school - The Children & Young People's Cancer Association.

Childhood Liver Disease

There are over 100 different childhood liver diseases. Most are life threatening and the reason why they occur is often unknown. Although rare, childhood liver disease will be diagnosed in over 400 children per year. There are only three specialist centres in the UK for childhood liver disease and these are Leeds General Hospital, Birmingham Children's Hospital and Kings College Hospital, London.

Treatment is often centred on dealing with the consequences of liver disease – increased liver damage, ascites, portal hypertension, vitamin deficiencies and failure to thrive. Treatments vary with the nature of the disease and include dietary management, medication and surgery, including transplant. Ongoing medical monitoring is essential. Liver transplantation may be necessary if liver damage is substantial and, following surgery, will mean a lifetime of immunosuppressant medication and higher susceptibility to infection.

Childhood liver disease can be invisible and the condition will affect children and young people in different ways. It is a chronic condition which will have acute periods which necessitate hospital admissions. Schools, colleges and early years settings should put in place Individual Healthcare Plan recognising the child or young person's signs and symptoms and supporting necessary absence related to their condition. Childhood liver disease can impair cognitive development in some children so may result in special educational needs.

Further information can be found at Liver Information and Advice | Children's Liver Disease Foundation and Children – British Liver Trust & Children's Liver Disease Foundation Publications including an Education Pack for educational settings.

Clinically Vulnerable children and young people

Some children and young people are clinically vulnerable. This means they have an underlying health condition, or combination of conditions, that places them at higher risk of becoming seriously unwell than their peers from infections and other factors, such as environmental factors, or that can negatively influence a child or young person's health and result in complications or a longer recovery period. Clinical vulnerability is associated with long-term conditions, fluctuating conditions and treatments or "invisible" conditions. The level of risk may change over time. Children and young people who are immunocompromised or immunosuppressed will be clinically vulnerable.

Schools, colleges and early years settings should work in partnership with the child or young person (where appropriate), their parents and any healthcare professionals involved in their care to understand how the child or young person's condition affects them and what support will enable them to attend, learn and participate safely. Where arrangements are required, these should be set out in an Individual Healthcare Plan, including how to respond in an emergency. Schools, colleges and early years settings should have regard to relevant current public health guidance in supporting clinically vulnerable children and young people, alongside their existing infection prevention and control arrangements. This may include, where appropriate, supporting good respiratory and hand hygiene; ensuring good ventilation of indoor spaces (Ventilation and

air quality in education and childcare settings); cleaning and environmental hygiene practices; reducing avoidable close contact during periods of increased infection risk; and supporting children and young people to follow any individual clinical advice provided to them, so that they are able to access education safely alongside their peers. Where a child or young person chooses to wear a protective mask for health reasons, schools, colleges and settings should support this choice and ensure that they are not discouraged or treated unfavourably for taking proportionate steps to protect their health.

Further information can be found at Clinically Vulnerable Families | Work School & Lives.

Coeliac disease

Coeliac disease is a serious autoimmune condition triggered by the consumption of gluten. Exposure to gluten causes damage to the small intestine and can result in significant symptoms including abdominal pain, fatigue, nutritional deficiency and impaired growth, as well as longer-term health risks if not properly managed.

Children and young people with coeliac disease require safe meal provision, and awareness among staff of how exposure to gluten can occur and how it affects the child's health, attendance and wellbeing.

Coeliac UK supports those with coeliac disease for which the only treatment is a gluten free diet for life. The Coeliac UK website offers guidance and advice to everyone involved with supporting a child with coeliac disease in school, including training resources for caterers and parents, as well as templates to support the appropriate care plans and safe food provisions.

Congenital heart disease

Congenital heart disease (CHD) refers to structural or functional problems of the heart present from birth. CHD manifests symptoms such as breathlessness, fatigue, chest pain, dizziness, or fainting. This often limits a child or young person's ability for physical exertion, affecting participation in the full school day. After cardiac treatment, including surgery or interventional procedures, children and young people may experience ongoing or long-term effects, either from their underlying heart condition or from the treatment itself. This can include: fatigue and reduced tolerance of physical exertion or exercise; motor skill delays or reduced stamina; reduced concentration or slower processing speed (sometimes associated with reduced oxygenation); feeding or nutritional challenges; and ongoing pain or discomfort.

Depending on the severity of their condition and any interventions required, children and young people with CHD may need to miss significant periods of education. Absence may occur in long consecutive periods or intermittently. It may be caused by being admitted to hospital for planned or emergency cardiac surgery; recovery periods following surgery or cardiac catheterisation procedures; ongoing outpatient appointments, monitoring, and diagnostic tests; and treatment in specialist cardiac centres far from home. Collaborative planning between hospital school teams, clinical teams, school or college staff, and families is important. Where the child or young person has been absent due to surgery and recovery, short pre-return visits can be helpful to prepare them for routines and minimise anxiety.

Children and young people with complex CHD, including single-ventricle physiology or those who have undergone staged surgeries, may have neurodevelopmental or cognitive

vulnerabilities. These can include challenges with attention, working memory, executive function, and social communication, which may affect learning and classroom engagement.

Experiences of cardiac surgery, repeated hospital admissions, or living with a long-term cardiac condition can be emotionally and psychologically challenging. Children and young people with CHD may experience anxiety about their health, fear of overexertion, concerns about visible scars, or worries about being seen as “different” by their peers.

Some children and young people with CHD may be at increased risk of infection, especially those with cyanotic heart disease, those recovering from surgery, or those taking certain medications (e.g. immunosuppressants following transplantation). Viral illnesses such as flu, RSV, or measles can be particularly serious. Schools, colleges, and early years settings should promptly inform families of any relevant outbreaks so that appropriate precautions can be taken. During periods of treatment or recovery, children and young people with CHD may be absent from their usual education provider for extended periods. Specialist cardiac centres often have hospital school provision that supports continuity of learning and ensures curriculum alignment. Clinical nurse specialists, cardiac liaison nurses, or designated keyworkers typically coordinate communication between health teams and education providers so that an appropriate education plan can be developed, and learning materials shared.

Other actions which may support children and young people with congenital heart disease returning to education include:

Regular communication with designated staff members and staff awareness and training on CHD and its impact on daily functioning;

- Flexibility around attendance and medical appointments;
- Phased returns or reduced timetables where fatigue is an issue;
- Careful planning for meals, hydration, and medication access;
- Access to supportive seating, temperature control, or adapted equipment;
- Support for handwriting speed, notetaking, or motor challenges where relevant;
- Reasonable adjustments for PE and physically demanding school activities;
- Provision of rest breaks or access to quiet spaces when fatigued;
- Special consideration for exams, including rest breaks or extra time.

Further information can be found at Education Resources | Little Hearts Matter.

Cystic fibrosis

Cystic fibrosis (CF) is a genetic condition affecting over 11,000 people in the UK which causes a build-up of mucus in the lungs, digestive system and other organs, causing a wide range of challenging symptoms affecting the entire body. CF is a varied condition and every child and young person will have individual support needs to ensure they can access a full educational experience. Specialist clinical teams provide care for those with CF and can advise on how to support them in education settings. This guidance should be key in developing Individual Healthcare Plans.

Children and young people with CF will require daily treatment, mainly at home, often including physiotherapy, nebulisers, and complex medication regimes. Many will need to take pancreatic enzymes with every meal and snack; they should be supported with this in school and be able to access these easily or carry them with them to self-administer when they are capable of

doing so. Some children and young people with CF will also have diabetes, which is likely to require management during the school day. Attendance at regular specialist NHS clinics is vital for management of the condition.

Children and young people with CF frequently struggle with energy levels. It can be helpful for a school, college or setting to have a designated private, quiet area which would support those with CF if they are exhausted and need to rest due to their condition. A healthy environment is important; this can include minimising damp, mould and dusty environments, considering infection risk from coughs and colds in other students and staff, and ensuring students with CF are not exposed to second hand smoking/vaping (including in school toilets, in spite of clear rules). The risk of cross-infection means people with CF are advised not to meet face to face with each other, which can have implications for schools with more than one pupil with CF, or with a pupil and a staff member with CF. Specialist NHS CF teams can advise on risk assessment and management.

As well as affecting the lungs, CF also affects the digestive system, which may mean that students with CF need to eat different things or eat at different times, or may need quick and discrete access to a toilet throughout the day.

CF is often covered as part of the secondary school curriculum, and students with CF (or with a family member/friend with CF) may need support through this. Treatment for the condition is changing rapidly, and text books and online resources can often be out of date. Children and young people will have differing levels of awareness of their condition and its effects, and may or may not have shared their diagnosis with their peers. Those affected by CF and their families should be made aware in advance when CF will be taught in their lessons, and supportive discussions should be held (and documented on the child or young person's IHP) to establish how they will be supported.

The charity Cystic Fibrosis Trust provides resources for teachers and schools: Cystic fibrosis information for teachers and other resources including information packs, class passes and a IHP template.

Diabetes

Diabetes is a serious condition with two main types: type 1 and type 2 diabetes. Both are serious conditions where the blood glucose level is too high either because the body is unable to produce a hormone called insulin (type 1) or doesn't produce enough of it (type 2). Most children and young people with diabetes will have type 1, but cases of type 2 are rising amongst children and young people.

Diabetes can affect a child or young person's learning because it can cause difficulties with attention, memory, processing speed and perceptual skills if blood glucose levels are not managed. On average, children with type 1 diabetes miss nine extra school sessions per year, but have similar GCSE attainment to their peers without diabetes. Many children and young people with diabetes use medical technology like continuous glucose monitors (CGMs) to enable them to do so with greater ease and accuracy. CGMs help people with diabetes avoid dangerous high (hyper) or low (hypo) blood glucose levels and are connected to mobile phone or smartwatch apps that display glucose readings, send hypo alerts and allow parents and carers to follow a children or young person's levels remotely.

All children and young people with type 1 diabetes need to administer insulin. Some children and young people with type 2 diabetes will administer insulin, though they may be treated with other medications. Insulin can be administered with an insulin “pen” but many children and young people with type 1 diabetes will use an insulin pump that is attached to the body and releases insulin regularly. Insulin pumps can be connected to CGMs to create a hybrid closed loop (HCL) system that automatically adjust insulin delivery based on glucose readings from a CGM. Insulin pumps and HCL systems require some manual input which is typically done with a mobile phone via an app.

It is vital that children and young people with diabetes are supported to keep their blood glucose levels in a healthy target range to avoid hypos and hypers. Exercise and food intake impact blood glucose levels alongside other factors like stress and illness. It is important that schools, colleges and early years settings agree measures to support children and young people to monitor glucose levels closely, interpret them and take steps to mitigate any negative effects. This should not be a barrier to being included in school activities. For example, a child or young person with diabetes should be able to enjoy all kinds of physical activity but will need support to plan in advance as exercise can lower glucose levels and risk hypos. Because of this, they might need to have an extra snack before, during and after physical activity, alter their insulin dose and check their blood glucose more regularly. In many cases older children and young people may be able to manage their own blood glucose levels. They should be encouraged to take increasing levels of responsibility in doing so, where it is safe and appropriate – but this process will still require ongoing support from staff in the school or college.

Further information about managing diabetes in schools can be found at Diabetes in Schools | Diabetes UK .

Eczema

Atopic eczema (also called atopic dermatitis) is a common, relapsing inflammatory skin condition that affects up to 20% of children. It presents with dry, itchy, red/inflamed skin with patches that can ooze or crust during flares. It typically involves the skin creases (behind knees, inside elbows), hands, wrists, neck and around the eyes but can be so severe that the whole body is affected.

Triggers can include irritants (soaps, detergents, fragrances), heat/sweating, stress, illness, exposure to allergens, rough fabrics, and environmental factors. The mainstay of treatment is regular application of moisturisers and anti-inflammatory creams such as steroids. In more severe cases, oral or injected medicines are needed.

Eczema can affect sleep, concentration, mood, self-esteem and participation in sport; visible eczema may contribute to stigma or bullying, and frequent flares can increase absence for appointments or infections.

Schools, colleges and early years settings should have a simple, child-centred plan agreed with parents/carers (and the young person where appropriate). This should encompass:

- The need to apply skin creams such as moisturisers and steroid creams (including permission, privacy and hand-hygiene);
- correct use and safe storage of prescribed creams such as topical steroids

- identification and avoidance of known triggers (e.g. swapping soaps for emollient substitutes, managing heat/sweat, accommodating cotton uniforms)
- any reasonable adjustments that are needed (extra time to apply emollients, letting students carry moisturisers, access to cool rooms, non-punitive responses to scratching, support for sleep-related fatigue).

Staff should be able to recognise red flags that need same-day parental contact/clinical advice (rapidly worsening redness, weeping/crusting of the skin, pain, fever, spreading rash, eye involvement), and should actively support wellbeing (anti bullying, inclusive adaptations for PE and sport, and exam/support measures if sleep disruption is significant).

Further information can be found through the NHS overview of atopic eczema and the National Eczema Society.

Epilepsy

Epilepsy is one of the most common long-term conditions for children and young people (affecting around one in 220 children), but it affects each person differently and there are many types of seizure. Some seizures are more noticeable than others and they may happen quickly or continue for a few minutes. Signs of a possible seizure include:

- Uncontrollable jerking or shaking;
- Losing awareness and staring blankly into space;
- Becoming rigid or collapsing;
- Changes in vision;
- Strange sensations.

Epilepsy can have a significant impact on a child or young person's education, even if seizures are controlled or do not occur during the day.

Individual Healthcare Plans are essential to help staff in a school, college or setting understand each child or young person's epilepsy so they can be kept safe and included. The IHP should include a description of their seizure types, impact on learning and emotional wellbeing, what to do when a seizure happens and what constitutes an emergency. This may be different for each child or young person and will need to reflect any care plan or emergency plan issued by their healthcare team.

When a seizure occurs, it is important to time the seizure, stay with the young person, reassure them and keep them safe. Most seizures stop by themselves without the need for treatment, but some young people may need access to emergency epilepsy medication. Seizures that go on too long can cause damage to the brain or may lead to death.

Staff will need to be trained in how to give emergency medication safely. Training should meet the standards set out in the Epilepsy Nurses Association (ESNA) guidelines on emergency medication training.

The charity Young Epilepsy has free information and resources for professionals working in education: For educators | Young Epilepsy.

Fluctuating conditions

Conditions which have a substantial effect but fluctuate or recur will be considered to have a long-term impact if the substantial effect is likely to recur. Further information is provided in section C5 of in Guidance on matters to be taken into account in determining questions relating to the definition of disability.

Hypermobility spectrum disorder

Some people may be able to extend their joints further than is usual – this is known as being hypermobile or double-jointed. Hypermobility is quite common in the general population, especially in children and, on its own, is not necessarily a problem. However, hypermobility can be associated with long-term, widespread pain, frequent dislocations, damage to the tissues surrounding joints and fatigue. When hypermobility comes with these problems it is called symptomatic hypermobility. People who are hypermobile may also struggle to sense the position of their joints (this is called having poor proprioception). This can make them appear clumsy and can lead to falls and other injuries.

There are 13 types of Ehlers-Danlos syndrome (EDS), a group of genetic (heritable) conditions affecting the connective tissue which is found throughout the body. Connective tissue holds joints and internal organs in place and is an important structural component of skin, blood vessels and other tissues. In EDS, a certain kind of connective tissue (collagen) is fragile and stretchy. This can cause symptoms throughout the body. The most common type is hypermobile EDS. The remainder are relatively rare, though vascular EDS (vEDS) can be life-threatening.

Symptoms can vary widely between children and young people with hypermobility and EDS, even in those from within the same family. The same individual may experience huge variation in how their condition affects them day by day and over their time.

- Children and young people with joint hypermobility (JHS) or EDS may present as being distracted, fidgety and uncooperative in class. This could be caused by a range of factors including pain, the need to move for joints to be comfortable and/or to stop muscle spasms, difficulty writing, tiredness or anxiety.
- Tiredness caused by JHS or EDS may present as slowness in the body and in thinking, gradually getting worse through the day. Sometimes bouts of extreme tiredness might cause the pupil to fall asleep. Those who have postural tachycardia syndrome (PoTS), which can be associated with JHS and EDS, may experience worse tiredness in the morning but this may also be prolonged after a PoTS flare.
- Children and young people may experience a general persistent pain, muscle spasms or sensory pain. At times they may appear “brain fogged”, with difficulty thinking or concentrating.
- Children and young people may not be able to keep up with their peers in the playground, may be less able to participate in social activities outside of school and may experience anxiety, making maintaining friendships challenging. They may need extra emotional understanding and support.
- Particularly severe symptoms may affect attendance, as will the frequent medical appointments which often come with having the conditions. Most children and young people with JHS or EDS want to fully participate in school life but find it too challenging physically and mentally in the school environment.

Further information and resources on hypermobility and EDS can be found at School toolkit for JHS and EDS.

Immunocompromise and Immunosuppression

Some children and young people may have conditions or treatments making them Immunocompromised (IC) or Immunosuppressed (IS). This means their immune system is less able to fight infections. This may be due to an underlying condition affecting immune function or as a result of medical treatment, such as chemotherapy, organ transplant medication, high-dose steroids, or other immune modifying therapies. The level of immune suppression may vary over time depending on treatment or recovery. Immunocompromised or immunosuppressed individuals are at increased risk of infection and serious illness, including those transmitted through close contact and through the air in indoor environments.

Schools, colleges and early years settings should work in partnership with parents and, where appropriate, the child or young person's clinical team to understand any specific precautions which may be required. They should consider what support will enable safe attendance and participation, including remote education where attendance is not possible for health reasons. These arrangements should be set out clearly in an Individual Healthcare Plan, including how to respond if the child or young person becomes unwell or is exposed to infection. Schools, colleges and early years settings should have regard to relevant current public health guidance in supporting immunocompromised or immunosuppressed children and young people, as well as their existing infection prevention and control arrangements. This includes measures to reduce transmission of infections spread by respiratory droplets and aerosols, such as maintaining good respiratory and hand hygiene, ensuring adequate ventilation of indoor spaces, following cleaning and environmental hygiene practices, and implementing reasonable adjustments. Arrangements should be designed to enable the pupil to access education safely alongside their peers, while maintaining confidentiality and preventing stigma.

Inflammatory bowel disease (IBD)

Inflammatory bowel disease (IBD) includes Crohn's disease and Ulcerative Colitis. These are lifelong conditions caused by inflammation in the gut, which can make children and young people feel unwell at times (flare-ups), with periods when symptoms are better controlled (remission). Symptoms can include urgent and frequent diarrhoea, tiredness, pain, difficulty concentrating, weight loss, delayed growth or puberty, and some children and young people may also experience symptoms affecting their joints, skin or eyes; treatment can include medicines, nutritional support, hospital procedures or surgery.

Crohn's and Ulcerative Colitis are often unpredictable and can vary from day to day. Schools, colleges and early years settings may need to make reasonable adjustments to help children and young people manage their condition and take part fully in education. This may include unrestricted access to toilets, flexibility around attendance (including attending hospital appointments), timetables, physical activity and assessments, access to medication, rest breaks, and support for emotional wellbeing.

For further resources on how to support children with IBD visit Crohn's & Colitis UK, NICE guidance on Ulcerative colitis and NICE guidance on Crohn's disease.

Long Covid

Long Covid is a condition involving persistent symptoms following SARS-CoV-2 infection. Presentation varies and may include fatigue, cognitive impairment, breathlessness, autonomic

dysfunction, pain, mobility impairment, and exacerbation of pre-existing respiratory, allergic, neurological or immune-related conditions.

Children and young people with Long Covid may experience fluctuating and unpredictable capacity. Schools, colleges and early years settings should therefore be flexible and responsive, with adjustments that may include reduced or flexible timetables, rest breaks, environmental adaptations and examination adjustments where appropriate. For some children and young people, periods of reduced attendance, home-based learning, or sustained rest may be necessary in line with the known fluctuating nature of the condition.

Emerging evidence indicates that some children and young people with Long Covid may have increased respiratory sensitivity or exacerbation of allergic or asthmatic conditions. Environmental factors such as poor air quality and inadequate ventilation may therefore have heightened impact. Schools, colleges and early years settings should consider both infection prevention and environmental health measures.

Further information, resources and educational materials are available from Long Covid Kids, including an educational toolkit and a IHP template.

Mast Cell Activation Syndrome (MCAS) and Mast Cell disorders

Mast Cell Activation Syndrome (MCAS) is a complex, multi-system condition involving inappropriate activation of mast cells - cells which play an important role in immune defence and allergic responses. When activated, mast cells release chemical mediators (such as histamine) which can affect multiple body systems. Symptoms can be episodic, fluctuating and unpredictable. MCAS affects multiple body systems including the skin, gastrointestinal system, cardiovascular system, respiratory system and neurological functioning. Symptoms vary between individuals and can include flushing, hives, abdominal pain, nausea, diarrhoea, headaches, dizziness, faintness, rapid heart rate, fatigue, cognitive difficulties (“brain fog”), joint pain and, in some cases, anaphylaxis. Some children and young people may also have associated conditions such as hypermobility spectrum disorders, Postural Tachycardia Syndrome (PoTS), asthma or migraine. Triggers vary significantly between individuals and may include foods, temperature change, infection, stress, exercise, medication, insect bites or stings, environmental exposures (including fragrances, aerosols or cleaning products), or sometimes no clearly identifiable trigger.

MCAS can have a substantial impact on attendance, stamina and participation. Symptoms may fluctuate daily or even within the same day. Fatigue can be significant and may worsen after exertion. Cognitive symptoms may affect concentration, processing speed, memory and communication. Some children and young people may experience repeated absences due to flares, hospital appointments or emergency care. Others may struggle to tolerate aspects of the physical school environment, particularly where airborne triggers such as fragranced products, poor ventilation or cleaning chemicals provoke symptoms. The unpredictable nature of the condition can cause anxiety, social isolation and reduced confidence, particularly if peers or staff do not understand the condition.

MCAS will require an Individual Healthcare Plan. This should set out: known triggers and preventative strategies (including environmental adjustments where required), early warning signs of a flare or systemic reaction, medication requirements and arrangements for access to medication and emergency procedures where anaphylaxis risk exists. Children and young

people with MCAS are likely to need access to rest breaks and a quiet space, flexible timetabling and phased returns after absence, adjustments to physical education (where exertion triggers symptoms) and examination access arrangements to reflect physical health difficulties, fatigue or cognitive impact.

Depending on the triggers for an individual child or young person, schools, colleges and early years settings may need to consider fragrance-aware or low-chemical classroom practices, careful selection of cleaning products and attention to ventilation.

Where a child or young person has been prescribed an adrenaline auto-injector, staff should be trained in its use and clear emergency protocols must be in place. As symptoms can fluctuate significantly, support arrangements should be reviewed regularly and adapted as needed. Schools, colleges and early years settings should work collaboratively with parents or carers and relevant healthcare professionals, recognising that families often develop detailed expertise in managing the condition.

Further information and resources are available at www.mastcellaction.org.

ME/Chronic fatigue syndrome

Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS) and Long Covid are recognised as the leading causes of medically-related persistent and prolonged school absence and long term educational loss for children and young people. ME/CFS is a complex, chronic medical condition affecting multiple body systems Children and young people with ME/CFS experience post exertional malaise disproportionate to the activity which caused it, debilitating pain and fatigue and unrefreshing sleep, among other symptoms. Some children and young people will experience related cognitive difficulties (sometimes described as “brain fog”), which may include problems finding words or numbers, difficulty in speaking, slowed responsiveness, short-term memory problems and difficulty concentrating or multitasking. The NICE guideline for ME/CFS provides further information. Long COVID shares many similarities with ME/CFS.

To support a child or young person with ME/CFS, their education needs to be paced, flexible and, depending on the level of severity, often part time. Schools, colleges and early years settings should adopt flexible practices that ensure that participation in education does not exacerbate symptoms or cause long term deterioration.

Some children and young people can remain in a school, college or early years setting with the support of reasonable adjustments including rest breaks and flexible timetables. They may also need wellbeing support, a quiet room, hall and/or lift pass, extra time between lessons and exam adjustments. Others may be unable to sustain participation, even in home-based learning, due to the profound impact of their symptoms.

Children and young people with ME/CFS can move between levels of severity with very little warning. Their capacity to engage in education can change markedly over time with Post Exertional Malaise, Post Exertional Symptom Exacerbation, Orthostatic Intolerance, pain and often extreme, debilitating fatigue unrelieved by sleep, directly limiting what they can manage.

For a minority of young people with ME/CFS, their symptoms are so debilitating that they are unable to participate in any form of education unless and until they experience sufficient health improvements. Where health needs are so severe that they prevent participation in the medium

to long term, individualised planning is necessary to protect long term educational outcomes and life chances.

Further information and resources are available through Action for ME's Guide for Educators together with an Action for ME Individual Healthcare Plan template.

PANS / PANDAS

Paediatric Acute-onset Neuropsychiatric Syndrome (PANS) and Paediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) are uncommon acute-onset conditions that can cause a sudden deterioration in emotional, cognitive and functional abilities. Symptoms such as abrupt obsessive-compulsive behaviours, tics, restricted eating, severe anxiety, tics, sensory sensitivities and slowed processing can lead to the acute onset of SEND, with immediate impact on learning, wellbeing, participation and attendance. Early recognition and a prompt, supportive response from education settings are vital, especially as "flares" can make some children too unwell to attend school or tolerate typical classroom demands.

Flexible, low-demand approaches such as reduced cognitive load, rest breaks, alternatives to handwriting, quiet spaces and paced expectations may be required to support access to education. For some children and young people, periods of part-time attendance or home-based learning may be needed. Where the level of support required amounts to special educational provision, it may be appropriate to request an Education, Health and Care (EHC) needs assessment.

Further information about UK clinical guidelines endorsed by the Royal College of Paediatrics and Child Health (RCPCH) and Local Authority Advisory Principles of Support is available at the PANS PANDAS UK Steering Group website. Further information can be found at PANS PANDAS UK.

Postural tachycardia syndrome (PoTS)

Postural Tachycardia Syndrome (PoTS) is a chronic autonomic condition characterised by an abnormal increase in heart rate upon standing, accompanied by a range of debilitating symptoms. The condition is variable and fluctuating in nature. Symptom severity may change significantly over time and from day to day, and may be exacerbated by intercurrent illness, temperature, dehydration, stress, or prolonged upright posture. It is common for people with PoTS to have other associated medical conditions that compounds their disability. PoTS is often under diagnosed and misdiagnosed. There are estimates that it affects up to 1 in 100 children and young people. Over half of children and young people with PoTS have lost over three months of schooling.

PoTS has a number of impacts which can have a significant effect on a child or young person's ability to participate in education. These include:

- *Orthostatic intolerance*: Prolonged standing (e.g. assemblies, queues, practical lessons) may provoke dizziness, pre-syncope, or syncope. Sudden positional changes can trigger symptom escalation.
- *Severe and fluctuating fatigue*: Fatigue may be disproportionate to activity levels and can significantly impair both physical stamina and cognitive function. Some children and

young people experience more severe symptoms in the morning, while others deteriorate as the day progresses.

- *Cognitive dysfunction ("brain fog")*: Reduced processing speed, impaired working memory, word-finding difficulty, and reduced concentration are frequently reported. Academic performance may fluctuate accordingly.
- *Autonomic symptoms*: Palpitations, chest discomfort, nausea, abdominal pain, headache, visual disturbance, tremor and temperature dysregulation may affect classroom participation. These physiological symptoms may be misinterpreted as anxiety.
- *Attendance*: Symptom flares, recovery following illness and frequent medical appointments may impact attendance.
- *Wellbeing*: Unpredictable symptoms and fear of fainting in public settings may contribute to distress or social withdrawal.

Children and young people with PoTS need appropriate recognition and reasonable adjustments to ensure they can participate as well as possible in education. These arrangements should be set out in an Individual Healthcare Plan, which should also set out emergency response procedures. Appropriate adjustments may include:

- Provision of seating as an alternative to activities involving prolonged standing;
- Access to fluids (including electrolyte supplementation) and snacks during the school day;
- Access to rest spaces to allow symptom stabilisation when required;
- Flexible timetabling, including consideration of reduced or phased attendance during periods of instability;
- Environmental adjustments to reduce heat exposure and overcrowding where possible and uniform adjustments to avoid overheating;
- Adjusted expectations regarding written output, processing speed, and deadlines during symptomatic periods;
- Access to lesson materials in alternative formats (e.g. digital resources, recorded content) to mitigate the impact of cognitive fatigue or absence;
- Training for staff to improve understanding of autonomic conditions and reduce misinterpretation of symptoms as behavioural or anxiety-related issues. Education of peers should also be considered, where appropriate.

Further information can be found at Managing PoTS.

Appendix B: Over the counter medications stocked in school

AFTER SUN	Topically as required	For sunburn
AQUEOUS CREAM	Topically as required	For dry skin
Loperamide	**Child 8–11 years** 2 mg 4 times a day for up to 5 days. **Child 12–17 years** Initially 4 mg, followed by 2 mg for up to 5 days, dose to be taken after each loose stool; usual dose 6–8 mg daily; maximum 16 mg per day. **Adult** Initially 4 mg, followed by 2 mg for up to 5 days, dose to be taken after each loose stool; usual dose 6–8 mg daily; maximum 16 mg per day	Diarrhoea
Ibuleve Gel	Topical	Contains Ibuprofen
ARNICA CREAM	Topically as required	For bruises
BONJELA TEETHING GEL	Topically as required, every 3 hours if required	For mouth ulcers
DEEP HEAT	Topically as required	For muscular and rheumatic pain, lumbago, fibrosis's, sprains and strains, sciatica and stiffness
ELECTROLYTE REPLACEMENT	Follow instructions on leaflet enclosed	For diarrhoea and upset stomachs
PIRITON (Held at the Prep)	Adults 4mg (1 tablet) every 4-6 hours (Max 6 tablets daily) 6-12 years 2mg or 5mls every 4-6 hours (Max 6 half tablets daily 2-6 years 2.5mls every 4-6 hours)	Hay fever, some allergic skin reactions, insect bites and allergic conjunctivitis
STUGERON 15	Travel sickness	**Over 12 year olds** –2 x tablets 2 hours before travel
SUDAFED CONGESTION RELIEF	**Over 12 year olds.** 1 x capsule up to 4 times a day	Clears stuffy noses associated with colds and hay fever

SUNCREAM **(Prep children to bring in their own)**	Apply generously to exposed skin	Protect against sunburn
VASELINE	Topically as required	For chapped lips or skin barrier
IPUPROFEN TABLETS **200MGS (Held at the Prep for staff only)** **IBUPROFEN LIQUID**	**Under 12's do not give.** Over 12 one or two tablets to be taken 3 times a day after food. 100mg/5mls of liquid 3 times a day.	For headaches, period pains, toothache and muscular aches and sprains
OLBAS OIL	Use via a tissue or as a skin rub	For nasal congestion
PARACETAMOL 500MGS. (At the Prep for staff only) **PARACETAMOLSOLUBLE 500MGS** **Liquid Paracetamol (2+ months or 6+ Years held at the Prep)**	Under 16, 500-750mgs Over 16 years 500-1000mgs to be taken 4-6 hourly (not more than 8 in 24 hours). 2+ months – 5mls 6+ years – 5/7.5mls	For headaches, period pains and reducing raised temperatures.
Lemsip Max/Beechams all in		Contains Paracetamol. Cold and flu remedy
EURAX CREAM	Topically as required, 2-3 times daily	To stop itchy dermatitis, allergic rashes, hives and nettle rash, insect bites and stings
Strepsils		Sore throat
Loratidine	**Child 2–11 years (body-weight up to 31 kg)** 5 mg once daily. **Child 2–11 years (body-weight 31 kg and above)** 10 mg once daily. **Child 12–17 years** 10 mg once daily. **Adult** 10 mg once daily.	

CETIRIZINE	10 mgs once daily	Allergic reactions
BUSCOPAN	10-20 mgs four times a day	Stomach cramps
GENERIC VENTOLIN AND ADRENALIN PEN (Both at Prep and Senior School)		Asthma or Anaphylaxis

Appendix C: Locations of first aid boxes

At Senior School:

Biology x 5

Chemistry x 4

Physics x 6

Mini buses and school car x 16

Porters lodge x 1

Sports Hall x 1

PE Department x 1

Maintenance x 1

Art x 1

D.T. x 2

Domestics x 1

Laundry x 1

College House x 1

Mannamead House x 1

6th Form Centre x 1

Outdoor Ed x 8

Whiteworks (outward bound house) x 1

Delgany (sports field) x 1

School office x 1

At Prep School:

Minibus

Pre School

Trip bag (held in reception)

Art room

Preschool classroom

Appendix D: how to recognise and respond to an asthma attack

The signs of an asthma attack are:

• Persistent cough (when at rest)
• A wheezing sound coming from the chest (when at rest)
• Difficulty breathing (the child could be breathing fast and with effort, using all accessory muscles in the upper body)
• Nasal flaring
• Unable to talk or complete sentences. Some children will go very quiet.
• May try to tell you that their chest 'feels tight' (younger children may express this as tummy ache)

CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD
• Appears exhausted
• Has a blue/white tinge around lips
• Is going blue
• Has collapsed

WHAT TO DO IN THE EVENT OF AN ASTHMA ATTACK

• Keep calm and reassure the child
• Encourage the child to sit up and slightly forward
• 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 two separate puffs of salbutamol via the spacer
• If there is no immediate improvement, continue to give two puffs at a time every two minutes, up to a maximum of 10 puffs
• Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better
• If the child does not feel better or you are worried at ANYTIME before you have reached 10 puffs, CALL 999 FOR AN AMBULANCE
• If an ambulance does not arrive in 10 minutes give another 10 puffs in the same way

Appendix E: Guidance for using an AED

1. **Ensure it is safe to approach** the victim.
2. **Assess responsiveness and breathing**: Is the person unconscious? Are they breathing normally?
    - If not breathing normally or unresponsive, **suspect cardiac arrest**, even if seizure-like activity is present.
3. **Call 999** for an ambulance. If possible, send someone else to make the call.
4. **Start CPR immediately** and **send for an AED**.
    - If trained and able, combine chest compressions and rescue breaths, otherwise provide compression-only CPR
5. **When AED arrives**:
    - Turn it on and follow its spoken instructions.
    - **Do not stop CPR** while attaching pads.
    - **Pad placement**:
    a. **Adults and children over 8 years/25kg**: one pad on the upper right chest, the other on the left side below the armpit.
    b. **Children under 8 years/25kg**: one pad on the centre of the chest, the other on the back.
6. **Do not stop CPR** unless:
    - The person shows signs of recovery and begins breathing normally.
    - A healthcare professional instructs you to stop.

Appendix F: Paediatric Life Support