



MEDICAL/FIRST AID POLICY

APPROVED	Chair of Governors / Headteacher
POLICY DATE	September 2023
REVIEW	September 2025

Introduction

ABSTRACT

At Grange Primary School, we are committed to embedding rigorous and robust procedures for pupils with medical conditions or injuries.

First Aid Policy

The purpose of this First Aid Policy is to enable the school to effectively meet the requirements of the Health and Safety (First Aid) Regulations 1981 and in doing so to:

- Provide for the immediate needs and requirements of staff and students who have sustained either a serious or a minor injury
- Ensure that adequate resources and arrangements are in place to deal with injuries/accidents as they arise
- Ensure lines of communication with parents/guardians are in place if required
- Activate a known plan of action with which all staff are familiar

The School shall inform employees of the first aid provisions made for staff, including the position of equipment, facilities and names of designated first aiders.

The treatment of minor illness by the administration of medicines and tablets falls outside of the definition of first aid in the Regulations and the School will not permit the presence of any such medication in designated first aid boxes. Please refer to the Medicines In School Policy for more information.

Definitions

'First aid' means medical treatment for an injured person for the purpose of preserving and stabilising life and minimising the consequences of injury or illness until further medical treatment can be administered.

'First aider' means: a person who holds a valid First Aid at Work Certificate or equivalent qualification.

Roles and Responsibilities

- The overall responsibility for the day-to-day management of school rests with the Head teacher.
- The class teacher is responsible for classroom supervision and all staff on break duty are directly responsible for the supervision of pupils at break time.
- The school's Health and Safety Administrator, is responsible for coordinating, implementing and overseeing company's employee safety at work.
- The Inclusion Manager/ CPD leader is responsible for ensuring training is up to date.

Assessment of First Aid Needs

The Head Teacher shall make an assessment of first aid needs appropriate to the circumstances of the school. The Head Teacher will need to assess what facilities and personnel are appropriate, and to justify the level of first aid provision. Where necessary and relevant, all staff will be trained on how to administer aspects of first aid e.g. epi-pens.

Where the first aid assessment identifies a need for employees to be trained as first aiders, the Head Teacher shall ensure they are provided in sufficient numbers at appropriate locations to enable first aid to be administered without delay should the occasion arise. All designated first aiders must re-qualify every 3 years. This means re-qualifying before the end of the third year when the certificate is no longer valid. It is the responsibility of the CPD leader to ensure they are booked onto the course before cancellation of the certificate.

Management of First Aid Equipment

It shall be the responsibility of the Ms Booty to ensure the provision of materials, equipment and facilities needed for the level of cover required. This will include ensuring that first aid equipment, suitably marked and easily accessible, is available in the agreed designated areas. Where additional or replacement material or equipment is required, staff should speak to the Finance Officer about ordering more items immediately. Ms Booty will ensure that all out of date items are discarded and replaced. These need to be checked on a regular basis i.e fortnightly.

Although the Welfare Assistant is responsible for maintaining and checking the first aid equipment, it is also expected that before going on duty/ on a school visit etc. teachers and teaching assistants in the class shall take responsibility for ensuring their first aid box contents are sufficient. Content list inside first aid kit.

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Fixed and Portable First-Aid Boxes

All school first-aid boxes are coloured green and are identified by a white cross on a green background. This conforms to the Safety Signs and Safety Signals Regulations.

Fixed first aid kits are sited in the following places:

- Main office
- Y3/4 corridor cupboards

Portable first aid kits are obtainable from:

- Y3/4 corridor cupboards

Eye wash facilities are located in the following places:

- Classrooms
- Toilets

The minimum first-aid provision for each site is:-

- A correctly stocked and labelled first-aid container
- Three qualified first aiders (to ensure that there is one duty when the establishment is open for normal activity)

The contents of first-aid boxes should be examined frequently and restocked as soon as possible after use. See below recommended minimum stocklist:

- 20 individually wrapped sterile adhesive dressings (Assorted sizes)
- 2 sterile eye pads
- 4 individually wrapped triangular bandages (preferably sterile)
- 6 safety pins
- 6 medium sized individually wrapped sterile unmedicated wound dressings
- 2 large sized individually wrapped sterile unmedicated wound dressings
- 1 pair of disposable gloves

The person responsible for checking and restocking: Ms Booty. (In case of absence, Mrs English)

The boxes should contain a sufficient quantity of suitable first aid materials. According to DFE guidance, as a minimum, First Aid Boxes should contain: micropore or plasters, scissors, triangular bandage, wound dressing, instant ice pack and gloves. No medicinal substance or materials are permitted within a first-aid box. This includes items such as antiseptic sprays, lotions, suntan oil, etc.

Individually wrapped sterile moist wipes, not impregnated with alcohol or antiseptic, may be used.

Blunt ended stainless steel scissors should be kept in the boxes in case there is the possibility that clothing may have to be cut away prior to first aid treatment.

Where tap water is not available for use as an eye wash only sterile water, sterile normal saline or sterile normal saline eye irrigation should be provided near the first-aid box. Eye baths/cups/refillable containers should not be used for eye irrigation.

Where medicines/inhalers have to be held for safety/security reasons, the separate lockable container must be used. This is in the Welfare Room. A register of contents must be kept up to date. Please see Medicines In Schools policy for more information.

No staff members are authorised to dispense medicines. Parents must administer medicines to children, or provide written authorisation for a pupil to administer their own medication under supervision of a staff member.

First Aid Treatment Area

The first aid area is in the Year 3/Year 4 corridor

First Aid Training

Paediatric Training Course one day face to face and one day online (12hrs minimum) valid for 3 years.

Person arranging CPD to ensure the paediatric training course is in line with Ofsted requirements for early years setting. The course training includes managing emergency situations or manage minor everyday occurrences when looking after children (defined as up to puberty).

The current EYFS statutory framework requires at least one person who has a current paediatric first aid certificate to be on the premises at all times when children are present, and accompany children on outings.

Emergency First Aiders at work one day training, valid for 3 years.

Person arranging course to ensure that the course meets the school's regulatory requirement.

Provision of First Aiders

There shall be adequate first aiders or paediatric first aiders within the school between 8:30 and 4.30pm.

Adequate first aiders will be on duty at playtimes and lunchtime.

Consideration must also be made to ensure first-aid cover during absences, such as annual leave and sickness.

This is the responsibility of the Health and Safety Officer and CPD lead.

Categories of Incidents and Procedures

Any pupil complaining of illness or who has been injured is sent to the Medical Room for the qualified first aider(s) to inspect and, where appropriate, treat. Constant supervision will be provided. Should the child be too ill to stay at school, parents should be contacted as soon as possible so that the child can be collected and taken home.

Minor Accidents and Injuries

The adult in charge initially looks after the injured party. If deemed necessary, a person other than the teacher will take the child to the 'First Aid Station', which is the Medical Room. No medicines are administered but cuts are cleaned with sterile un-medicated wipes and bandages are applied if deemed appropriate. The use of disposable plastic gloves is mandatory at all times. All accidents are recorded in the Accident Report Book by the first aider, and parents are contacted by telephone if the injury looks severe and a note (recording details of the incident/actions taken) is given to the pupil.

Minor Cuts and Bruises Method:

In all cases of injury it is understood that there is at least one adult present:

- A first aider should administer first aid if appropriate. If the first aider is not available, any member of staff may clean the wound.
- Class teacher is informed by the first aider.
- Teacher observation is maintained
- Children are advised to show/tell parents

Sprains/Bruises:

- A first aider should administer first aid if appropriate. If the first aider is not available, any member of staff may implement the process of rest, ice, compress and elevate
- If in doubt, parent/s are contacted
- Teacher observation is maintained

More Serious Accidents and Injuries

If considered safe to do so, the injured party is taken to the Medical room. Parents are immediately informed, particularly if there is a suspicion of broken bones/head or eye injuries. The child is kept under close observation until parents arrive, with the emphasis on making the child as comfortable and as settled as possible.

Stings/Bites:

- If the case is serious/ parent/s are contacted – no stings should be removed.

Faints and Shocks:

A first aider should administer first aid if appropriate. If the first aider is not available, any member of staff may implement the process of:

- Lie the casualty down
- Loosen any tight clothing
- Ensure there is fresh air
- Keep crowds away
- Reassure casualty when they recover
- Contact parents – the pupil should go home

Very Serious Injuries

In the event of a very serious injury, parents/guardians are immediately contacted. If the considered opinion of the staff is that immediate professional help is required, an ambulance is called.

On rare occasions the staff may agree that taking the child to Accident & Emergency in a private car is a more prudent option particularly in the case of rapid blood loss. This should be on a voluntary basis. In such cases staff should ensure they have specific cover from their insurance company.

Parents are kept informed of developing situations. Very serious injuries are considered to be:

- Severe Bleeding
- Burns/Scalds
- Unconsciousness
- Anaphylaxis reaction to a trigger e.g. allergy

The event is subsequently recorded in the accident report book and an accident / incident form is recorded on the Safety Cloud website by the Office Manager: the website address is: <https://identity.safetycloud.com>

The Education Space Head of School Support Services & Compliance Management is informed automatically by email once the school has completed the form online and will advise.

The First Aid Policy is based on collective teacher input. All staff automatically assist the teacher on break duty and the first aider in the case of a serious injury.

Ultimately, the trained First Aider makes the decision on what medical treatment, if any, is appropriate for the injury in question.

First Aid Record Keeping

It shall be the responsibility of the Head teacher, or other nominated officer, to ensure that procedures are in place for the immediate recording of any injury as required by the Social Security Act 1975 and the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

Details on the forms to be completed, time scales for completion and distribution and who is to be notified, are shown on the Health & Safety policy.

After administering treatment, first aiders will ensure they adhere to the school arrangements for record keeping and accident reporting, as detailed below. Each first aider must receive appropriate instruction to enable them to carry out this responsibility during first-aid training.

All incidents, injuries, head injuries, ailments and treatment are reported in the accident book, kept in the office.

The information recorded will include:

- date, time and place of incident;
- name and, where relevant, job title of the injured or ill person;
- details of the injury/illness and what first aid was given;
- what happened to the person immediately afterwards e.g. went home, went back to lessons, went to hospital, etc; and
- name and signature of the first aider or person dealing with the incident.

Parents are immediately informed of a head injury by telephone. Outlining the injury and symptoms to look out for.

Staff should complete the accident book if they sustain an injury at work.

An injured member of staff or other supervising adult should not continue to work if there is any possibility that further medical treatment is needed. The member of staff or other supervising adult concerned should seek medical advice without delay.

Duty to Inform Staff of First Aid Arrangements

All staff must be informed of the location of first aiders, appointed persons, equipment and facilities.

The Health and Safety Coordinator must ensure that a notice giving the names of first aiders, their location and the location of first aid boxes, is posted in each of the following locations:

- Staffroom
- Hall
- School Office
- EYFS
- KS1
- KS2

Notices will be inspected and kept up to date by the Office Manager as part of the regular health and safety inspection.

Medicine Policy

Aim

A clear policy that is understood and accepted by all staff, parents and children providing a sound basis for ensuring that children with medical needs receive proper care and support in school, and that for such children attendance is as regular as possible.

The policy is to include:

- Procedures for managing prescription medicines which need to be stored in school.
- Procedures for managing prescription medicines on outings and trips
- Roles and responsibilities of staff
- A clear statement of parental responsibilities in respect of medicines
- Written permissions from parents for medicines
- Circumstances in which children may take non-prescription medicines
- Assisting children with long term medical needs
- Staff training
- Record keeping

- Safe storage of medicines
- The school's emergency procedures
- Risk assessment and management procedures

Prescribed Medicines

Except for prescribed auto-injector pens, asthma inhalers and serious allergy medication, we do not administer any medicines to pupils in school, prescribed or otherwise. Provision for the administration of medication must be made by the parent/carer of a pupil. Every attempt must be made by parent/carers to ensure that the need to complete a course of medication does not disrupt a child's attendance at school.

Non-Prescription Drugs

Staff should never give non-prescription drugs to a child.

Long Term Medical Needs

Grange Primary School will be fully informed of the child's needs before admittance. It is essential to have sufficient information in order for the child's medical needs to be adequately supported. The SENCo then devises a care plan with the school nurse following DfE guidance.

All care plans and risk assessments are stored securely and records are retained until the child is removed from the school roll.

Individual healthcare plans

The headteacher has overall responsibility for the development of IHPs for pupils with medical conditions. This has been delegated to Ms James.

Plans will be reviewed at least annually, or earlier if there is evidence that the pupil's needs have changed.

Plans will be developed with the pupil's best interests in mind and will set out:

- What needs to be done
- When
- By whom

Not all pupils with a medical condition will require an IHP. It will be agreed with a healthcare professional and the parents when an IHP would be inappropriate or disproportionate. This will be based on evidence. If there is not a consensus, the headteacher will make the final decision.

Plans will be drawn up in partnership with the school, parents and a relevant healthcare professional, such as the school nurse, specialist or paediatrician, who can best advise on the pupil's specific needs. The pupil will be involved wherever appropriate.

IHPs will be linked to, or become part of, any statement of special educational needs (SEN) or education, health and care (EHC) plan. If a pupil has SEN but does not have EHC plan, the SEN will be mentioned in the IHP.

The level of detail in the plan will depend on the complexity of the child's condition and how much support is needed. The governing board and the headteacher/deputy headteacher will consider the following when deciding what information to record on IHPs:

- The medical condition, its triggers, signs, symptoms and treatments
- The pupil's resulting needs, including medication (dose, side effects and storage) and other treatments, time, facilities, equipment, testing, access to food and drink where this is used to manage their condition, dietary requirements and environmental issues, e.g. crowded corridors, travel time between lessons
- Specific support for the pupil's educational, social and emotional needs. For example, how absences will be managed, requirements for extra time to complete exams, use of rest periods or additional support in catching up with lessons, counselling sessions
- The level of support needed, including in emergencies. If a pupil is self-managing their medication, this will be clearly stated with appropriate arrangements for monitoring
- Who will provide this support, their training needs, expectations of their role and confirmation of proficiency to provide support for the pupil's medical condition from a healthcare professional, and cover arrangements for when they are unavailable
- Who in the school needs to be aware of the pupil's condition and the support required
- Arrangements for written permission from parents and the headteacher for medication to be administered by a member of staff, or self-administered by the pupil during school hours
- Separate arrangements or procedures required for school trips or other school activities outside of the normal school timetable that will ensure the pupil can participate, e.g. risk assessments
- Where confidentiality issues are raised by the parent/pupil, the designated individuals to be entrusted with information about the pupil's condition
- What to do in an emergency, including who to contact, and contingency arrangements

Food allergies

The kitchen staff is provided with an up to date list of children with allergies, which includes a photograph of the child.

The pupil medical/allergy list is shared with all staff.

Epi-Pens / asthma inhalers are stored in the classrooms. The school has also purchased additional Epi-pens and asthma inhalers in case of emergency.

Allergy information is also recorded on SIMs at the point of admission.

All inhalers/epipens are clearly labelled with the child's full name and class.

The school liaises with the school nurse annually (when available) to update asthma and anaphylaxis plans. The nurse will then issue action plans for the parent to read and sign and return to the school. This is then shared with the class teachers and SLT.

Data sheets are given to parents on an annual basis to update any details. It is the responsibility of the parents to keep the school informed of any medical updates.

Should an anaphylaxis reaction occur the following steps must be followed:

- Use an adrenaline auto-injector if the person has one – but make sure you know how to use it correctly first
- Call 999 for an ambulance immediately (even if they start to feel better) – mention that you think the person has anaphylaxis
- Remove any trigger if possible – for example, carefully remove any stinger stuck in the skin
- Lie the person down flat – unless they're unconscious, pregnant or having breathing difficulties
- Record on the box time epi-pen was administered
- Give another injection after 5-15 minutes if the symptoms do not improve and a second auto-injector is available

If you're having an anaphylactic reaction, you can follow these steps yourself if you feel able to.

Positioning and resuscitation

Someone experiencing anaphylaxis should be placed in a comfortable position. Most people should lie flat. Pregnant women should lie on their left side to avoid putting too much pressure on the large vein that leads to the heart. People having trouble breathing should sit up to help make breathing easier. People who are unconscious should be placed in the recovery position.

Administering Medicines

A record must be kept in a written form each time medicines are given. Records are kept in the medical room.

Self Management

Children who are able will be encouraged to manage their own medicines. This will generally apply to relief treatments for asthma.

Record Keeping

Parents should inform the school of the medicines their child needs. School will check that the medicine is in its original container and that the dispenser's instructions are clear.

Educational Visits

All medicines required by children on such undertakings will be part of the overall risk assessment for the visit. Medicines not self-managed by the pupils should be in the safe care of a nominated member of the support staff. This colleague should be one who is willing to carry this responsibility. Complex medical needs for a specific pupil may necessitate a Care Plan for the visit. If any member of staff is concerned they should seek advice from the school office.

Sporting Activities

Children who require medication and take part in after school sports should have a risk assessment of their medical needs. Asthma relievers not self-managed should be taken to the sports area and be supervised by a member of staff.

Head Injury

Children frequently sustain minor head injuries. This advice sheet gives details of what symptoms and signs should be looked for in children who have hit their head whilst at school and when medical advice should be sought.

If after a head injury a child remains unconscious or fits an ambulance should be called immediately and the parents contacted. If a child suffers from any of the following symptoms medical advice must be sought and if advised the child should be taken to see either their GP or to A&E by the parents or by school staff.

- Loss of consciousness
- Vomiting
- Sleepiness
- Fits or abnormal limb movements
- Persisting dizziness or difficulty walking
- Strange behaviour or confused speech

Children may appear well immediately after sustaining a head injury but show signs of complications later in the day. School staff must remain vigilant and take the appropriate action if the child develops a problem.

If a child sustains a head injury whilst at school, the following information should be recorded from any witness.

- Was the child behaving in an unusual way before the injury?
- What happened to cause the injury?
- If they fell, how far did they fall?
- What did they hit their head against?
- Did the child lose consciousness? If so, for how long?
- How did they appear afterwards?
- Did they vomit afterwards?
- Was the child observed to have any other problem after the injury?

Regardless of whether the school seek medical advice about the child, this information should be given to parents afterwards, where possible. It may be that the child becomes unwell after school and the information will be helpful to parents if they need to see a doctor.

In addition parents will be notified by phone following any minor head injury to their child and invited in to inspect the injury. Each head injury will also be recorded in the accident book and a slip advising of the injury sent home with the child (example below). Both will be completed by the person dealing initially with the accident.

If an accident occurs during break or lunchtime the duty staff must ensure that the class teacher is aware of the injury.

Supporting Children with Medical Conditions

This school is an inclusive community that supports and welcomes pupils with medical conditions. It provides children with medical conditions with the same opportunities and access to activities (both school-based and out-of-school) as other pupils. No child will be denied admission or prevented from taking up a place in this school because arrangements for their medical condition have not been made. Staff understand the medical conditions of pupils at this school and that they may be serious, adversely affect a child's quality of life and impact on their ability and confidence.

All staff understand their duty of care to children and young people and know what to do in the event of an emergency. This school understands that all children with the same medical condition will not have the same needs, our school will focus on the needs of each individual child. The school recognises its duties as detailed in Section 100 of the Children and Families Act 2014. (Other related legislation is referenced in DfE guidance p21). Some children with medical conditions may be considered to be disabled under the definition set out in the Equality Act 2010. Where this is the case, this school complies with their duties under that Act. Some may also have special educational needs (SEN) and may have a statement, or Education, Health and Care (EHC) plan which brings together health and social care needs, as well as their special educational provision. For children with SEN, this policy should be read in conjunction with the SEN policy.

All school staff, including temporary or supply staff, are aware of the medical conditions at this school and understand their duty of care to pupils in an emergency. All staff receive training in what to do in an emergency and this is refreshed at least once a year.

All children with medical conditions that are complex, long-term or where there is a high risk that emergency intervention will be required at this school have an individual healthcare plan which explains what help they need in an emergency. The IHP will accompany a pupil should they need to attend hospital. Parental permission will be sought and recorded in the IHP for sharing the IHP within emergency care settings.

This school makes sure that all staff providing support to a pupil have received suitable training and ongoing support to ensure that they have confidence to provide the necessary support and that they fulfil the requirements set out in the pupil's IHP. This should be provided by the specialist nurse/school nurse/other

suitably qualified healthcare professional and/or parent/carer. The school keeps an up to date record of all training undertaken and by whom.

All staff know what action to take in an emergency and receive updates at least yearly. First aid training includes training for common conditions eg asthma, allergies, epilepsy and diabetes. Specific extra training is provided for administration of epi-pens and asthma.

Grange Primary School uses an IHP to record the support an individual pupil needs around their medical condition. The IHP is developed with the pupil (where appropriate), parent/carer, designated named member of school staff, specialist nurse (where appropriate) and relevant healthcare services. Where a child has SEN but does not have a statement or EHC plan, their special educational needs are mentioned in their IHCP.

This school has a centralised register of IHPs, and an identified member of staff has the responsibility for this register. IHPs are regularly reviewed, at least every year or whenever the pupil's needs change. The pupil (where appropriate) parents/carers, specialist nurse (where appropriate) and relevant healthcare services hold a copy of the IHP. Other school staff are made aware of and have access to the IHP for the pupils in their care. We make sure that the pupil's confidentiality is protected, in accordance with GDPR regulations.

Grange Primary School ensures that the whole school environment is inclusive and favourable to pupils with medical conditions. This includes the physical environment, as well as social, sporting and educational activities.

This school is committed to providing a physical environment accessible to pupils with medical conditions and pupils are consulted to ensure this accessibility. This school is also committed to an accessible physical environment for out-of-school activities.

We make sure the needs of pupils with medical conditions are adequately considered to ensure their involvement in structured and unstructured activities, extended school activities and residential visits. All staff are aware of the potential social problems that pupils with medical conditions may experience and use this knowledge, alongside the school's anti bullying policy, to help prevent and deal with any problems.

The school understands the importance of all pupils taking part in off site visits and physical activity and that all relevant staff make reasonable and appropriate adjustments to such activities in order they are accessible to all pupils. This includes out-of-school clubs and team sports. Risk assessments will be conducted as part of the planning process to take account of any additional controls required for individual pupil needs.

Staff are aware that pupils should not be forced to take part in activities if they are unwell. They should also be aware of pupils who have been advised to avoid/take special precautions during activity, and the potential triggers for a pupil's medical condition when exercising and how to minimise these.

Grange Primary School makes sure that pupils have the appropriate medication/equipment/food with them during physical activity and offsite

visits.

We make sure that pupils with medical conditions can participate fully in all aspects of the curriculum and enjoy the same opportunities at school as any other child, and that appropriate adjustments and extra support are provided.

All school staff understand that frequent absences, or symptoms, such as limited concentration and frequent tiredness, may be due to a pupil's medical condition. We will not penalise pupils for their attendance if their absences relate to their medical condition and relevant medical proof has been provided. We will refer pupils with medical conditions who are finding it difficult to keep up educationally to the SENCO, who will liaise with the pupil (where appropriate), parent/carer and the pupil's healthcare professional. We make sure that a risk assessment is carried out before any out-of-school visit. The needs of pupils with medical conditions are considered during this process and plans are put in place for any additional medication, equipment or support that may be required.

Children With Health Needs Who Cannot Access School

Aims

We aim to ensure that all children, regardless of circumstance or setting receive a good education to enable them to shape their own futures. Where children are unable to attend school because of their health, the school will follow Department of Education Guidance and work with Newham Local Authority who have the responsibility to arrange suitable full-time education (or part-time when appropriate for the child's needs) for children who are unable to attend a mainstream or special school because of their health.

The Local Authority is responsible for arranging suitable full-time education for children who – because of illness or other reasons – would not receive suitable education without such provision. There will however, be a wide range of circumstances where a child has a health need but will receive suitable education that meets their needs without the intervention of the Local Authority, for example, where the child can still attend school with some support. Where the school has made arrangements to deliver suitable education outside of school for the child; or where arrangements have been made for the child to be educated in a hospital by an on-site hospital school, we would not expect the Local Authority to become involved in such arrangements unless it had reason to think that the education being provided to the child was not suitable or, while otherwise suitable, was not full-time or for the number of hours the child could benefit from without adversely affecting their health. This might be the case where, for example, the child can attend school but only intermittently.

Legislation and guidance

This policy has due regard to all relevant legislation and statutory guidance including, but not limited to, the following:

- Education Act 1996
- Equality Act 2010
- Data Protection Act 2018

- DfE (2013) 'Ensuring a good education for children who cannot attend school because of health needs'
- DfE (2014) 'Supporting pupils at school with medical conditions'

This policy operates in conjunction with the following school policies:

- Attendance Policy
- Child Protection and Safeguarding Policy
- Confidentiality Policy
- SEN/Inclusion Policy
- Remote Learning Policy

The responsibilities of the school

The governing board is responsible for:

- Ensuring arrangements for pupils who cannot attend school as a result of their medical needs are in place and are effectively implemented.
- Ensuring the termly review of the arrangements made for pupils who cannot attend school due to their medical needs.
- Ensuring the roles and responsibilities of those involved in the arrangements to support the needs of pupils are clear and understood by all.
- Ensuring robust systems are in place for dealing with health emergencies and critical incidents, for both on- and off-site activities.
- Ensuring staff with responsibility for supporting pupils with health needs are appropriately trained.

The headteacher is responsible for:

- Working with the governing board to ensure compliance with the relevant statutory duties when supporting pupils with health needs.
- Working collaboratively with parents and other professionals to develop arrangements to meet the best interests of children.
- Ensuring the arrangements put in place to meet pupils' health needs are fully understood by all those involved and acted upon.
- Appointing a named member of staff who is responsible for pupils with healthcare needs and liaises with parents, pupils, the LA, key workers and others involved in the pupil's care.
- Ensuring the support put in place focusses on and meets the needs of individual pupils.
- Arranging appropriate training for staff with responsibility for supporting pupils with health needs.
- Providing teachers who support pupils with health needs with suitable information relating to a pupil's health condition and the possible effect the condition and/or medication taken has on the pupil.
- Providing annual reports to the governing board on the effectiveness of the arrangements in place to meet the health needs of pupils.
- Notifying the LA when a pupil is likely to be away from the school for a significant period of time due to their health needs.

The Deputy Headteacher is responsible for:

- Dealing with pupils who are unable to attend school because of medical needs.
- Actively monitoring pupil progress and reintegration into school.
- Supplying pupils' education providers with information about the child's capabilities, progress and outcomes.
- Liaising with the headteacher, education providers and parents to determine pupils' programmes of study whilst they are absent from school.
- Keeping pupils informed about school events and encouraging communication with their peers.
- Providing a link between pupils and their parents, and the LA.

Teachers and support staff are responsible for:

- Understanding confidentiality in respect of pupils' health needs.
- Designing lessons and activities in a way that allows those with health needs to participate fully and ensuring pupils are not excluded from activities that they wish to take part in without a clear evidence-based reason.
- Understanding their role in supporting pupils with health needs and ensuring they attend the required training.
- Ensuring they are aware of the needs of their pupils through the appropriate and lawful sharing of the individual pupil's health needs.
- Ensuring they are aware of the signs, symptoms and triggers of common life-threatening medical conditions and know what to do in an emergency. Keeping parents informed of how their child's health needs are affecting them whilst in the school.

Parents are expected to:

- Ensure the regular and punctual attendance of their child at the school where possible
- Work in partnership with the school to ensure the best possible outcomes for their child.
- Notify the school of the reason for any of their child's absences without delay.
- Provide the school with sufficient and up-to-date information about their child's medical needs.
- Attend meetings to discuss how support for their child should be planned.

If the local authority makes arrangements**Expectations of the Local Authority**

- Where the Local Authority is involved in arranging provision, the expectation from the school is that the LA will Arrange suitable full-time education (or as much education as the child's health condition allows) for children of compulsory school age who, because of illness, would otherwise not receive suitable education.
- Provide such education as soon as it is clear that the child will be away from school for 15 days or more, whether consecutive or cumulative. They should liaise with appropriate medical professionals to ensure minimal delay in arranging appropriate provision for the child.

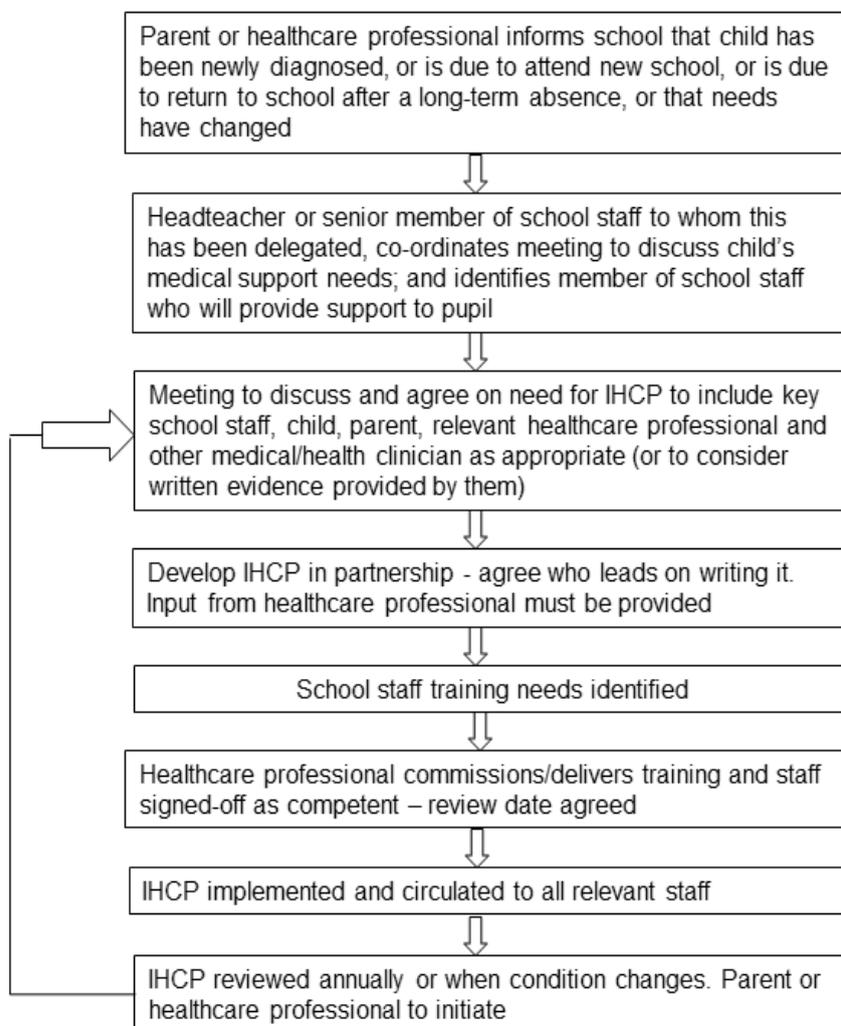
- Ensure that the education children receive is of good quality and allows them to take appropriate external tests, prevents them from slipping behind their peers in school and allows them to reintegrate successfully back into school as soon as possible.
- Address the needs of individual children in arranging provision. 'Hard and fast' rules are inappropriate: they may limit the offer of education to children with a given condition and prevent their access to the right level of educational support which they are well enough to receive. Strict rules that limit the offer of education a child receives may also breach statutory requirements.
- Where full-time education would not be in the best interests of a particular child because of reasons relating to their physical or mental health, provide part-time education on a basis they consider to be in the child's best interests. Full and part-time education should still aim to achieve good academic attainment particularly in English, Maths and Science. The nature of the provision must be responsive to the demands of what may be a changing health status.
- Where appropriate, use electronic media – such as 'virtual classrooms', learning platforms and so on – to provide access to a broader curriculum, but this should generally be used to complement face-to-face education, rather than as sole provision (though in some cases, the child's health needs may make it advisable to use only virtual education for a time).
- Ensure that teachers who provide education for children with health needs receive suitable training and support and are kept aware of curriculum developments. They should also be given suitable information relating to a child's health condition, and the possible effect the condition and/or medication taken has on the child.
- Set up a personal education plan, which should ensure that the school, the Local Authority, hospital school or other provider can work together.
- Ensure effective collaboration between all relevant services (LAs, CAMHS, NHS, schools and, where relevant, school nurses) in delivering effective education for children with additional health needs.

Monitoring arrangements

This policy will be reviewed by the governing board on an annual basis as part of the medical/first aid policy. Any changes to the policy will be clearly communicated to all members of staff involved in supporting pupils with additional health needs, and to parents and pupils themselves.

Appendix A

Model process for developing individual healthcare plans



Asthma Policy

Grange Primary School recognises that asthma is a widespread, serious but controllable condition affecting many pupils at the school. The school positively welcomes all pupils with asthma. This school encourages pupils with asthma to achieve their potential in all aspects of school life by having a clear policy that is understood by school staff and pupils. The policy is available to read on request.

The school's asthma lead is Ms Booty, Teaching Assistant.

Policy Principles

The school:

- Recognises that asthma is a widespread, serious but controllable condition and the school welcomes all pupils with asthma
- Ensures that pupils with asthma can do participate fully in all aspects of school life, including art lessons, PE, science, visits, outings or field trips and other out-of hours school activities
- Recognises that pupils with asthma need immediate access to reliever inhalers at all times
- Keeps a record of all pupils with asthma and the medicines they take.
- Ensures that the whole school environment, including the physical, social, sporting and educational environment, is favourable to pupils with asthma.
- Ensures that all pupils understand asthma.
- Ensures that all staff (including supply teachers and support staff) who come into contact with pupils with asthma know what to do in an asthma attack.
- Understands that pupils with asthma may experience bullying and has procedures in place to prevent this.
- Will work in partnership with all interested parties including the school's governing body, all school staff, school nurses, parents/carers, employers of school staff, doctors, nurses and pupils to ensure the policy is planned, implemented and maintained successfully.

Asthma medicines

- Immediate access to reliever medicines is essential. Reliever inhalers are stored in the classroom, with spare inhalers available from the school office. Care plans are in place for all pupils with asthma and are reviewed annually.
- All inhalers must be labelled with the child's name.

Record keeping

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

All parents/carers of children with asthma are consequently required to fill out an information sheet that is returned to school and school updates its medical records that are available to all school staff. Parents/carers are also asked to update school annually or when their medication or dosage changes.

All instances in which asthma inhalers are administered (whether self-administered, or administered by a member of staff) are recorded, and a slip given to the child to take home for their parents to be informed.

Exercise and activity – PE and games

Taking part in sports, games and activities is an essential part of the school life for all pupils. All teachers know which children in their class have asthma and all teachers at the school are aware of which pupils have asthma from the school's medical records.

Pupils with asthma are encouraged to participate fully in all PE lessons. Before PE, teachers will remind pupils whose asthma is triggered by exercise to take their reliever inhaler before the lesson, and to thoroughly warm up and down before and after the lesson. If a pupil needs to use their inhaler during the lesson they will be sent to the medical room. If a child is unable to do PE due to their asthma, the asthma lead, Mrs Roberts, will be informed by the class teacher or PE teacher, and this information will be recorded and a referral made to CHS 0-19.

Classroom teachers follow the same principles as described above for all games and activities involving physical activity.

Out-of-hours sport

The health benefits of exercise are well documented and this is also true for children and young people with asthma. At Grange Primary, pupils with asthma are encouraged as much as possible to participate in after school clubs.

Staff are aware of the potential triggers for pupils with asthma when exercising, tips to minimise these triggers and what to do in the event of an asthma attack. There is a first aider on-site with access to asthma medicines during out-of-hours activities

School environment

The school does all that it can to ensure the school environment is favourable to pupils with asthma. The school does not keep furry or feathery animals and has a definitive no-smoking policy. Should animals be coming into school for a workshop, parents are consulted. As far as possible the school does not use chemicals in science and art lessons that are potential triggers for pupils with asthma. Pupils with asthma are encouraged to leave the room briefly if particular fumes trigger their asthma.

When a pupil is falling behind in lessons

If a pupil is missing a lot of time at school or is always tired because their asthma is disturbing their sleep at night, the class teacher will initially talk to the parents/ carers to work out how to prevent their child from falling behind. If appropriate, the teacher will then talk to the school nurse and SEN co-ordinator about the pupil's needs.

The school recognises that it is possible for pupils with asthma to have special education needs due to their asthma.

Asthma attacks

All staff who come into contact with pupils with asthma know what to do in the event of an asthma attack.

In the event of an asthma attack the school follows the procedure outlined by Asthma UK in its School Asthma Pack. This procedure is visibly displayed in the staffroom and every classroom, and is included at the end of this policy.

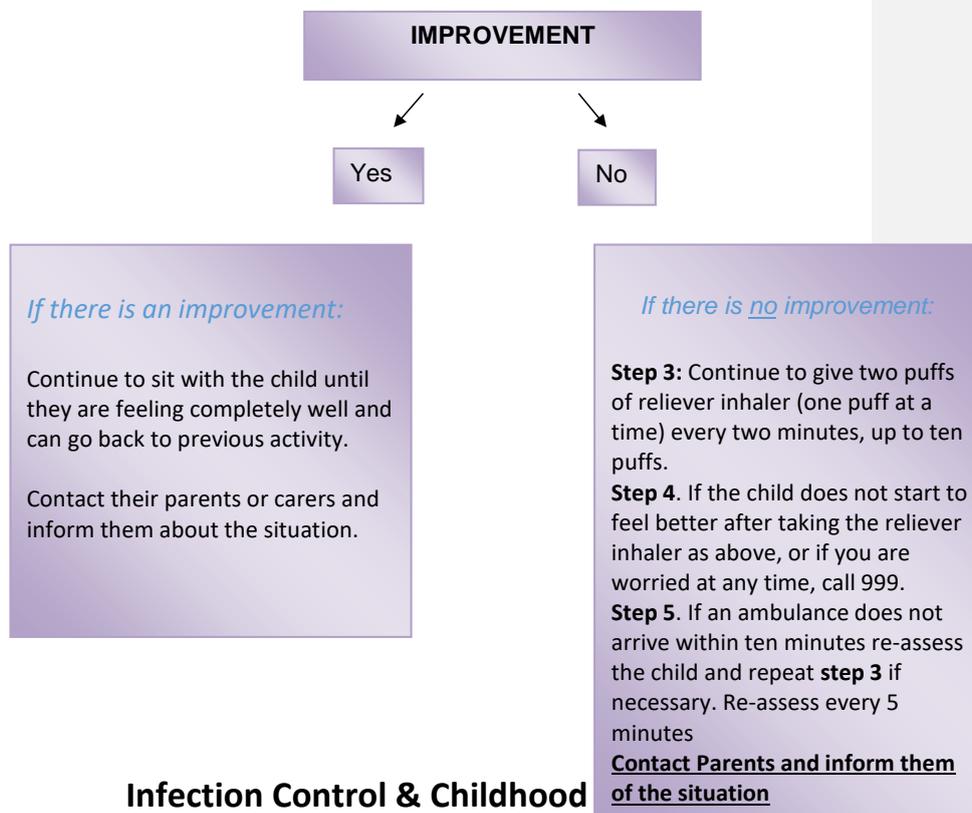
Asthma

If a child develops any of the following signs please follow the instructions below.

- COUGHING
- SHORTNESS OF BREATH
- WHEEZING
- TIGHTNESS IN THE CHEST, BEING UNUSUALLY QUIET
- DIFFICULTY SPEAKING IN FULL SENTENCES
- LIPS ARE BLUE.

Step 1: Help the child to take their usual dose of reliever inhaler immediately, preferably through a spacer.

Step 2: Sit the child upright.
Get them to take slow steady breaths.



Infection Control & Childhood

Chapter 1: introduction

Schools and nurseries are common sites for transmission of infections. Children are particularly susceptible because:

- they have immature immune systems
- have close contact with other children
- sometimes have no or incomplete vaccinations
- have a poor understanding of hygiene practices ¹

These guidelines aim to provide information for staff about managing a range of common and important childhood infections in settings including schools and nurseries.

The guidance is not intended to be used as a tool for diagnosing infectious disease but to help and direct staff about where and when to seek further advice. It can also be used as a tool to help develop local policy and training.

The way to prevent and manage infectious disease in your setting is to:

- promote immunisation
- promptly exclude the unwell child or member of staff
- check that effective handwashing is being carried out routinely

If you are notified of an outbreak of infectious disease in a pupil or staff member, please report it to your local [Health Protection Team \(HPT\)](#) as soon as possible as not all infections require exclusion. Your local team can also give you additional advice and support as needed.

Multiple cases of an infectious illness are reported via the form SP092 (see appendix below) to the school management support team, who will then advise on next steps

Chapter 2: infections in childcare settings

Micro-organisms such as bacteria, viruses and fungi are everywhere and commonly do not cause infection (and can even be beneficial). However, some do cause infection resulting in symptoms such as fever and sickness ². Infections in children are common. This is because a child's immune system is immature. Added to this, young children often have close contact with their friends, for example through play, and lack good hygiene habits, making it easier for infections to be passed on ³.

Many diseases can spread before the individual shows any symptoms at all (during the infectious period). For example a pupil with chickenpox is infectious to others 1 to 2 days before the rash appears.

Infection prevention and control measures aim to interrupt the cycle of infection by promoting the routine use of good standards of hygiene so that transmission of infection is reduced overall. This is usually through:

- immunisation of pupils and staff
- good hand washing
- making sure the environment is kept clean

Where a case of infection is known, measures aim to reduce or eliminate the risk of spread through information and prompt exclusion of a case.

How infections spread

Infections are spread in many different ways but the most important of these are through

Respiratory spread

Contact with cough or other secretions from an infected person, like influenza. This can happen by being near the infected person when they cough and then breathe in the organism; or by picking up the organism from an infected item, for example a used tissue or on an object in the environment, and then touching your nose or mouth.

Direct contact spread

By direct contact with the infecting organism, for example contact with skin during contact sports such as rugby and in gyms, like impetigo or staphylococcal infections.

Gastrointestinal spread

Resulting from contact with contaminated food or water (hepatitis A), contact with infected faeces or unwashed hands after using the toilet (typhoid fever).

Blood borne virus spread

By contact with infected blood or body fluids, for example while attending to a bleeding person or injury with a used needle (hepatitis B). Human mouths are inhabited by a wide variety of organisms, some of which can be transmitted by bites. Human bites resulting in puncture or breaking of the skin are potential sources of exposure to blood borne infections therefore it is essential that they are managed promptly.

There is a theoretical risk of transmission of hepatitis B from human bites, so the injured person should be offered vaccination. Although HIV can be detected in saliva of people who are HIV positive there is no documented evidence that the virus has been transmitted by bites.

Chapter 3: Prevention and Control

Exclusion

Prompt exclusion is essential to preventing the spread of infection in childhood settings. There should be a local policy for exclusion of staff and children while they are infectious and a procedure for contacting parents or carers when children become ill at school.

When pupils are suffering from infectious diseases they should be excluded from school on medical grounds for the minimum period recommended. Formal exclusion of pupils from school on medical grounds is enforceable by the Head Teacher only, acting on behalf of the local authority or the managers or governors of a school¹. In exceptional cases, when parents insist on the return of their child to school when the child still poses a risk to others, the local authority may, by serving notice on the child's parents or carers, require that they keep the child away from school until they no longer pose a risk to others¹.

Exposure to infectious disease is not normally a reason for medical exclusion. However, your local HPT can advise.

Handwashing

Hand washing is one of the most important ways of controlling the spread of infections, especially those that cause diarrhoea and vomiting and respiratory disease. Liquid soap, warm water and paper towels are recommended.

Advise all staff and pupils to wash their hands after using the toilet, before eating or handling food and after touching animals.

Cover all cuts and abrasions with a waterproof dressing.

Coughing and sneezing

Coughs and sneezes spread diseases. Children and adults should be encouraged to cover their mouth and nose with a disposable tissue and wash hands after using or disposing of tissues. Spitting should be discouraged.

Personal protective equipment (PPE)

Wear disposable gloves and plastic aprons if there is a risk of splashing or contamination with blood or body fluids during an activity. Gloves should be disposable, non-powdered vinyl or latex-free and CE marked. Wear goggles if there is a risk of splashing to the face.

Managing cuts, bites and nose bleeds

Staff should be aware of the school health and safety policy and manage situations such as cuts, bites and bleeds according to that policy. This includes the identification and training of nominated first aiders for the school.

If a bite does not break the skin:

1. Clean with soap and water.
2. No further action is needed.

If a bite breaks the skin:

1. Clean immediately with soap and running water.
2. Record incident in accident book.
3. Seek medical advice as soon as possible (on the same day):

- to treat potential infection
- to protect against hepatitis B
- for reassurance about HIV

Managing needle stick injuries

Occasionally children or staff may injure themselves with discarded used hypodermic needles which they have found. Dispose of the needle safely to avoid the same thing happening to someone else. This can be done by either contacting your local authority or school nurse. If someone pricks or scratches themselves with a used hypodermic needle:

- wash the wound thoroughly with soap and water
- cover it with a waterproof dressing
- record it in the accident book and complete the accident form
 - seek immediate medical attention from your local Accident and Emergency department

Cleaning blood and body fluid spills

All spillages of blood, faeces, saliva, vomit, nasal and eye discharges should be cleaned up immediately, wearing PPE.

Clean spillages using a product which combines detergent and disinfectant (and ensure it is effective against both bacteria and viruses). Always follow the manufacturer's instructions. Use disposable paper towels or cloths to clean up blood and body fluid spills, and dispose of after use. A spillage kit should be available for bodily fluids like blood, vomit and urine².

Sanitary facilities

Good hygiene practices depend on adequate facilities. A hand wash basin with warm running water along with a mild liquid soap, preferably wall mounted with disposable cartridges, should be available. Bar soap should not be used.

Place disposable paper towels next to basins in wall mounted dispensers, together with a nearby foot-operated waste paper bin.

Toilet paper should be available in each cubicle (it is not acceptable for toilet paper to be given out on request). If schools or nurseries experience problems with over-use, they could consider installing paper dispensers to manage this.

Suitable sanitary disposal facilities should be provided where there are female staff and pupils aged 9 or over (junior and senior age groups).

Managing nappies

Children in nappies must have a designated changing area, away from play facilities and from any area where food or drink is prepared or consumed. Hand washing facilities must be available in the room so that staff can wash and dry their hands after every nappy change, before handling another child or leaving the nappy changing room. Soiled nappies should be wrapped in a plastic bag before disposal in the general school waste.

Clean children's skin with a disposable wipe. Flannels should not be used to clean bottoms. Label nappy creams and lotions with the child's name and do not share with others.

Wipe changing mats with soapy water or a baby wipe after each use. Mats should be cleaned thoroughly with hot soapy water if visibly soiled and at the end of each day. Check weekly for tears and discard if the cover is damaged.

A designated sink for cleaning potties (not a hand wash basin) should be located in the area where potties are used. Wear household rubber gloves to flush contents down the toilet. The potty should be washed in hot soapy water, dried and stored upside down.

The rubber gloves should be washed whilst wearing them and then wash and dry hands after taking them off.

Nappy waste can sometimes be produced in large quantities in places such as nurseries. Although considered non-hazardous, in quantity it can be offensive and cause handling problems. Where the premises produce more than one standard bag or container of human hygiene waste over the usual collection interval, it is advised to package it separately from other waste streams. Organisations that produce significant amounts of used nappies should contact their local authority to discuss appropriate disposal arrangements.

Children with continence aids

Pupils who use continence aids (like continence pads, catheters) should be encouraged to be as independent as possible. The principles of basic hygiene should be applied by both pupils and staff involved in the management of these aids.

Continence pads should be changed in a designated area. Disposable powder-free non-sterile latex gloves and a disposable plastic apron should also be worn. Gloves and aprons should be changed after every pupil. Hand washing facilities should be readily available. Contact your school health team for further advice.

Laundry

There should be a designated area on site if there is a need for laundry facilities. This area should:

- be separate from any food preparation areas
- have appropriate hand washing facilities
- have a washing machine with a sluice or pre-wash cycle

Staff involved with laundry services should ensure that:

- manual sluicing of clothing is not carried out as this can subject the operator to inhale fine contaminated aerosol droplets; soiled articles of clothing should be rinsed through in the washing machine pre-wash cycle, prior to washing
- gloves and aprons are worn when handling soiled linen or clothing
 - hands are thoroughly washed after removing gloves

Dealing with contaminated clothing

Clothing of either the child or the first-aider may become contaminated with blood or body fluids. Clothing should be removed as soon as possible and placed in a plastic bag and sent home with the child with advice for the parent on how to launder the contaminated clothing. The clothing should be washed separately in a washing machine, using a pre-wash cycle, on the hottest temperature that the clothes will tolerate.

Vulnerable groups at particular risk from infection

Some children have impaired immune defence mechanisms in their bodies (known as immuno-compromised) and hence will be more likely to acquire infections. Also, the consequence of infection in the immuno-compromised is likely to be significantly more serious than in those with a properly functioning immune system (known as immuno-competent).

Impaired immunity can be caused by certain treatments such as those for leukaemia or other cancers, like cytotoxic therapy and radiotherapy. Other treatments such as

high doses of steroids, enteral feeding and others, may also have a similar effect. Children and carers will have been fully informed by their doctor.

There are also some rare diseases, which can reduce the ability of a person to fight off infection. Usually nurseries and schools are aware of such vulnerable children through information given by their parents or guardians.

If a vulnerable child is thought to have been exposed to a communicable disease, chickenpox or measles in the school setting, parents or guardians of that child should be informed promptly so that they can seek further medical advice from their GP or specialist, as appropriate.

It is important that these children are also made known to the school nurse on entry to the school.

Chapter 4: What To Do if You Suspect an Outbreak of Infection

Classification of an outbreak

An outbreak is defined as 2 or more linked cases with similar symptoms (or a notifiable disease) than would normally be expected, such as:

- 2 or more cases of diarrhoea or vomiting or both
- scabies
- scarlet fever
- impetigo

When to report

Head teachers and managers should contact their local health protection team as soon as they suspect an outbreak to discuss the situation and agree if any actions are needed. It is useful to have the information listed below available before this discussion as it will help to inform the size and nature of the outbreak:

- total numbers affected (staff and children)
- symptoms
- date(s) when symptoms started
- number of classes affected

If you suspect cases of infectious illness at your school but are unsure if it is an outbreak, please [call your local HPT](#).

How to report

Childcare settings are asked to telephone their local HPT as soon as possible to report any serious or unusual illness particularly for:

- Escherichia coli (VTEC) (also called E.coli 0157) or E coli VTEC infection
- food poisoning
- hepatitis
- measles, mumps, rubella (rubella is also called German measles)
- meningitis
- tuberculosis
- typhoid
- whooping cough (also called pertussis)

The [full list of notifiable diseases](#) was updated in 2010.

Your local HPT can also draft letters and provide factsheets for parents and carers to ensure the most up to date information is given.

Confidentiality

It is important to note that health protection teams are bound to manage personal case details in strict confidence. Therefore, information given to schools from the team for distribution during an outbreak will never name cases or give out any personal details. Organisations where cases are identified are also bound to manage personal case details in strict confidence.

Chapter 5: Immunisation

Immunisations should always be checked at school entry and at the time of any vaccination. Parents should be encouraged to have their child immunised and any immunisation missed or further catch-up doses required should be organised through the child's GP. The national schedule changes periodically so it is important to check the [NHS Choices website](#) for up to date details. Alternatively the school health service can advise on the latest national immunisation schedule.

Children who present with certain risk factors may require additional immunisations. Your local community NHS health team can provide further information if required.

Staff immunisation

It is important that all staff are up to date with the current immunisation schedule (see above). In addition to this, the following risk areas should be considered:

Hepatitis B

Hepatitis B vaccine is not recommended for routine school or nursery contacts of an infected child or adult. Hepatitis B vaccine is, however, recommended for staff who are involved in the care of children with severe learning disability or challenging behaviour, and for these children, if they live in an institutional accommodation¹. In such circumstances it is the responsibility of the employer to finance the vaccine programme².

Rubella

Women of childbearing age should check with their GP that they are immune to the rubella (German measles) virus. Those who are not immune should be immunised with MMR vaccine. The vaccine should not be given during pregnancy¹.

Chapter 6: Cleaning the Environment

Cleaning of the environment, including toys and equipment, is an important function for the control of infection in childcare settings. It is important that cleaning schedules clearly describe the activities needed, the frequency and who will carry them out. Cleaning standards should be monitored regularly by the school. Cleaning staff should be appropriately trained and have access to personal protective equipment.

Cleaning contract

Essential elements of a comprehensive cleaning contract include daily, weekly and periodic cleaning schedules, based on national guidance. A proper colour coding system is recommended by the Health and Safety Executive¹. Choosing to employ a colour system in your workplace can make cleaning easy, efficient and in turn, increase general hygiene and cleanliness.

Colour-coded equipment should be used in different areas with separate equipment for kitchen, toilet, classroom and office areas (red for toilets and wash rooms; yellow for hand wash basins and sinks; blue for general areas and green for kitchens). Cloths should be disposable (or if reusable, disinfected after use).

Cleaning solutions should be stored in accordance with Control of Substances of Hazardous to Health (COSHH), and cleaning equipment changed and decontaminated regularly². Consideration should be given to situations where additional cleaning will be required including during term time (for example in the event of an outbreak) and how the school might carry this out.

A nominated member of staff should be chosen to monitor cleaning standards and discuss any issues with cleaning staff.

Cleaning blood and body fluid spills

All spillages of blood, faeces, saliva and vomit should be cleaned up immediately, wearing personal protective equipment. Clean spillages using a product which combines detergent and disinfectant, and ensure it is effective against both bacteria and viruses. Always follow the manufacturer's instructions. Use disposable paper towels or cloths to cleaning up blood and body fluid spills, and dispose of after use. A spillage kit should be available for blood spills.

Toys and equipment

Toys can easily become contaminated with organisms from infected children so it is important that a written schedule is in place for regular cleaning. The cleaning schedule should identify who, what, when and how toys should be cleaned and be monitored.

If toys are shared, it is strongly recommended that only hard toys are made available because they can be wiped clean after play. The condition of toys and equipment should be part of the monitoring process and any damaged item that cannot be cleaned or repaired should be discarded.

Soft modelling and play dough should be replaced regularly or whenever they look dirty and should be included in the schedule.

Sandpits should be securely covered when not in use to protect from animals contaminating the sand. Sand should be changed regularly; 4 weekly for indoor sandpits and as soon as it becomes discoloured or malodorous for outdoor sandpits. Sand should be sieved (indoor) or raked (outdoor) regularly to keep it clean.

The tank should be washed with detergent and water, and dried before refilling with sand. Water play troughs or receptacles should be emptied, washed with detergent and hot water and dried and stored inverted when not in use. The water should be replenished either daily or twice daily when in use and it should always be covered when not in use.

Enhanced cleaning during an outbreak of infection

In the event of an outbreak of infection at your school, your local health protection team will recommend enhanced or more frequent cleaning, to help reduce transmission. Advice may be given to ensure twice daily cleaning of areas (with particular attention to door handles, toilet flushes and taps) and communal areas where surfaces can easily become contaminated such as handrails. Plans should be developed for such an event on how the school might carry this out which could also include during term time. Dedicated cleaning equipment must be colour coded according to area of use.

Chapter 7: staff health

Staff immunisation

All staff should undergo a full occupational health check before starting employment; this includes ensuring they are up to date with immunisations, including Measles, Mumps, Rubella (MMR).

Exclusion Staff employed in schools, nurseries and other childcare settings should have the same rules regarding exclusion applied to them as are applied to the children. They may return to work when they are no longer infectious, provided they feel well enough to do so.

Pregnant staff

It should be noted that the greatest risk to pregnant women from such infections comes from their own household rather than the workplace. However, if a pregnant woman develops a rash, or is in direct contact with someone with a rash who is

potentially infectious, she should consult her doctor or midwife.

Chickenpox

Chickenpox can affect the pregnancy if a woman has not already had the infection. The GP and midwife should be informed promptly. A blood test may be arranged to check immunity if it isn't already known. Shingles is caused by the same virus as chickenpox therefore anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.

Measles

Measles during pregnancy can result in early delivery or even loss of the baby. If a pregnant woman is exposed, the midwife should be informed immediately. All female staff under the age of 25 years, working with young children, should have evidence of 2 doses of MMR vaccine or a positive history of measles.

Rubella (German measles)

If a pregnant woman comes into contact with German measles she should inform her GP and midwife immediately. The infection may affect the developing baby if the woman is not immune and is exposed in early pregnancy.

All female staff under the age of 25 years, working with young children, should have evidence of 2 doses of MMR vaccine or a positive history of Rubella.

Slapped cheek disease (Parvovirus B19)

Slapped cheek disease (Parvovirus B19) can occasionally affect an unborn child if exposed early in pregnancy. The pregnant woman should inform their midwife promptly.

Food handling staff

Food handlers and catering staff may present a particular risk to the health of their pupils and staff if they become infected (or have close contact) with diseases that can be transmitted to others via the medium of food or drink. These diseases commonly affect the gastrointestinal system (stomach and bowel) and usually cause diarrhoea or vomiting, or both.

Food handling staff suffering from such diseases must be excluded from all food handling activity in the school or nursery setting until advised by the local Environmental Health Officer that they are clear to return to work. There are legal powers for the formal exclusion of such cases but usually voluntary exclusion will suffice with 'off work' certificates from the GP, as necessary.

All establishments should have a clear written policy for the exclusion of staff, particularly food handlers, in relation to gastro-enteric diseases. Staff and attenders should not be present at the establishment if they are currently suffering from diarrhoea or vomiting, or both. At the very least, persons suffering from gastrointestinal diseases should not return to work until 48 hours post recovery (no further diarrhoea or vomiting).

Employers should notify their local Environmental Health Department immediately that they are informed of a member of staff engaged in the handling of food has become aware that he or she is suffering from, or is the carrier of, any infection likely to cause food poisoning.

This policy should be made clear to the person in charge of the kitchen and all catering staff at the time of appointment¹. Food handlers are required by law to inform their employer immediately if they are suffering from:

- typhoid fever
- paratyphoid fever
- other salmonella infections
- dysentery

- shigellosis
- diarrhoea (cause of which has not been established)
- infective jaundice
- staphylococcal infections likely to cause food poisoning like impetigo, septic skin lesions, exposed infected wounds, boils
- E. coli VTEC infection

Chapter 8: Pets and animal contact

Pets and other animals in school can enhance the learning environment. However, contact with animals can pose a risk of infection including gastro-intestinal infection, fungal infections and parasites. Some people, such as pregnant women and those with a weakened immune system, are at greater risk of developing a severe infection. However, sensible measures can be taken to reduce the risk of infection to the children and to staff.

Only mature and toilet trained pets should be considered and the Head Teacher should ensure that a knowledgeable person is responsible for the animal. There should be a written agreement within the school detailing:

- the types of animals allowed in the school
- how to manage them and permitted behaviour whilst on the premises
- where they can go and where they cannot go when in the school
- any insurance liability of owners and handlers

Animals should always be supervised when in contact with the children and those handling animals advised to wash their hands immediately afterwards. Animals should have recommended treatments and immunisations, be regularly groomed (including claws trimmed) and checked for signs of infection. Bedding should be laundered regularly.

Cat litter trays should be cleaned daily wearing disposable gloves. It should not be placed near food preparation, storage or eating areas. Wash hands immediately after removing gloves but pregnant staff members should not carry out this task because of the risk of toxoplasmosis.

Feeding areas should be kept clean and their food stored away from human food. Food not consumed in 20 minutes should be taken away or covered to prevent attracting pests¹.

Visits to petting farms and zoos

There are a number of diseases that can be passed on to pupils and staff from infected farm animals such as campylobacter, salmonella and cryptosporidium. It is not possible to know which animals are carriers so a standard approach to reducing the risk of transmission of infection to children and staff should be taken.

Before you go

Emphasise the importance of hand hygiene during and after the visit and check that the farm has easily accessible hand washing facilities. Educate pupils not to eat, drink or put fingers in their mouths except when in designated eating areas and after they have washed their hands.

Check that the farm is well managed. Drinking taps should be clearly marked and sited in a clean area away from the animals.

During the visit

If children are allowed to handle or feed the animals, ask them not to put their faces against the animals or put their hands in their own mouths afterwards. Check that children wash and dry their hands thoroughly after contact with animals and particularly before eating and drinking. Younger children should be supervised.

Food should only be taken in the designated picnic areas. Children should be reminded not to eat anything which may have fallen on the ground. They should not eat or drink unpasteurised products like milk, cheese or ice-cream, or taste animal feed stuff such as silage and concentrates.

Manure or slurry presents a particular risk of infection and children should be warned against touching it. If they do, ensure hands are promptly washed and dried.

At the end of the visit

Ask all the children to wash and dry their hands before leaving. Ensure that they are as free as possible from faecal material².

School trips

Some school trips involve activities associated with a small risk of picking up an infection, particularly those involving water-based activities and visits to farms or animal parks.

Water based activities

There is a risk of infection associated with any water-based activity on rivers, canals and freshwater docks, and also with the collection of specimens from ditches, streams and ponds. Water-based activities should only be undertaken at education authority residential centres.

Exercises such as 'capsize drill' and 'rolling' should ideally be practised in swimming pools and never in stagnant or slow-moving natural bodies of water.

Children and staff should cover all cuts, scratches and abrasions with a waterproof dressing prior to the activity. Do not eat or drink immediately after water-based activities until after hands have been washed.

The use of appropriate footwear is recommended to reduce the risk of cuts to the feet. Pupils and staff should always wash or shower after canoeing or rowing.

Anyone taking part in water based activities who becomes ill within 3 to 4 weeks of the activity is advised to seek medical advice.

It should be made clear to parents and carers that if their child becomes ill following participation in outdoor or water-based activities, the treating doctor should be made aware of the child's participation in these activities.

Babies or children shouldn't swim in public swimming pools for 2 weeks after diarrhoea and vomiting has stopped³.

Chapter 9: Managing specific infectious diseases**Athlete's Foot**

Athlete's foot is a skin infection caused by a fungus which can also cause ringworm.

Symptoms

The person will have scaling or cracking of the skin, especially between the toes, or blisters containing fluid; it can be very itchy.

Spread

It is generally spread by prolonged direct or indirect contact with skin lesions on infected people or contaminated floors, shower stalls and other articles used by infected people.

Exclusion

No exclusion is necessary.

Do's

- Advise the case to visit their GP for advice and treatment.
- Take care to dry between the toes after bathing. Use a fungicidal dusting powder on the feet, between the toes and in the socks and shoes.
- Wear shoes that allow feet to breathe and change frequently.
- Cover the affected foot with a rubber sock when going swimming.

Don'ts

- Do not share towels, bath mats or footwear when infected.

Chicken pox (shingles)

Chickenpox and shingles are 2 separate infections caused by the same virus known as varicella-zoster virus (VZV). Life-long immunity develops after chickenpox infection. However, following chickenpox infection, the VZV virus can lay dormant in the body and later reactivate causing shingles in some people.

Chickenpox is usually a mild illness but can lead to complications in young babies, pregnant women and those with a weakened immune system.

Symptoms

Chickenpox has a sudden onset with fever, runny nose, cough and a generalised rash. The rash starts with blisters which then scab over. Several 'crops' of blisters occur so that at any one time there will be scabs in various stages of development.

The rash tends to be more noticeable on the trunk than on exposed parts of the body and may also appear inside the mouth and on the scalp. Some infections can be mild or without symptoms.

Shingles presents as a blistering rash in the area supplied by the affected nerve. Usually only one side of the body is affected and there is severe pain in the affected area. Most people recover fully without developing serious complications. There is often altered sensation before the rash appears, accompanied by 'flu like' symptoms.

Spread

Chickenpox is highly infectious and is spread by respiratory secretions or by direct contact with fluid from blisters.

Shingles is spread by direct contact with fluid from blisters. It cannot produce shingles in another person but the virus can spread to those who never had chickenpox from fluid in the blisters of a case.

Exclusion

Cases of chickenpox are infectious from up to 5 days but usually 2 days before the rash appears until the blisters are crusted over.

Children should be kept away from school for at least 5 days from onset of rash (and not developing new lesions). It is not necessary for all the spots to have healed or

crusted over before return to school as the risk of transmission to other children after 5 days is minimal.

A person with shingles is infectious to those who have not had chickenpox and should be excluded from school if the rash is weeping and cannot be covered or until the rash is dry and crusted over.

Do's

- Send the child home and advise parents to consult their GP.
- In cases of shingles, decision to exclude child will vary for each case of shingles and will be dependent on whether the rash is weeping and whether the rash can be covered.

Don'ts

- Don't allow the child back to school until at least 5 days after the appearance of the chickenpox rash (blisters).

Cold sores

Cold sores are caused by a virus called herpes simplex and usually appear on lips and around nostrils but can spread more widely over the face. It is estimated that 50 to 90% of the population are carriers of the virus but they do not all suffer from cold sores.

It is usually a mild self-limiting disease. Most people who already suffer from cold sores will have been infected very early in life.

Symptoms

First signs are tingling, burning or itching in the area where it is going to appear. This phase may last for as little as 24 hours. There is reddening and swelling of the infected area resulting in a fluid filled blister, or sometimes a group of them, which can be very painful and uncomfortable. They break down to form ulcers, which weep and crack. They then dry up and crust over.

The virus can be reactivated by various trigger factors such as stress or sunlight.

Spread

The virus is spread by direct contact.

Exclusion

None needed.

Do's

- Advise the case (and their carers) to avoid spread by not touching the cold sore or breaking or picking the blisters.
- Avoid kissing people, especially children when they have a blister and not to share things like cups, towels and facecloths.

Don'ts

- Cases should not touch their eyes and adults should take extra care when applying or removing make-up.

Conjunctivitis

Conjunctivitis is an inflammation of the outer lining of the eye and eyelid causing an itchy red eye with a sticky or watery discharge. It can be caused by bacteria or viruses or due to an allergy.

Conjunctivitis can be caused by a bacteria or a virus and is treated with eye drops. Spread is by direct or indirect contact with discharge from the eyes. Prompt treatment and good hand washing helps to prevent spread especially after contact with infectious secretions.

Symptoms

The eye(s) becomes reddened and swollen and there may be a sticky yellow or green discharge. Eyes usually feel itchy and 'gritty'. Topical ointment can be obtained from the doctor or pharmacy to treat the infection.

Spread

Conjunctivitis can be spread by contact with discharge from the eye which gets onto the hands or towel when the child rubs their eyes.

Exclusion

None needed.

Do's

- Advise parents to seek advice.
- Encourage children not to rub their eyes and to wash their hand frequently.
- Contact your local Health Protection Team if an outbreak or cluster occurs.

Food poisoning

Food poisoning is a general term for gastrointestinal infections caused by consuming contaminated food or drink. Person to person spread of these infections is unusual.

Symptoms

Symptoms of food poisoning usually begin within 1 to 2 days of eating contaminated food, although they may start at any point between a few hours and several weeks later. The main symptoms include feeling sick (nausea), vomiting, diarrhoea, stomach cramps and fever.

Spread

Infection can be caused by a variety of bacteria, viruses or parasites; most commonly reported are Salmonella and Campylobacter. They can cause sudden large outbreaks of diarrhoea if a large number of people eat the same contaminated food.

Exclusion

Children and adults with diarrhoea should be excluded until 48 hours after the diarrhoea and vomiting has stopped and they are well enough to return.

For some infections, longer periods of exclusion from school are required and there may be a need to obtain microbiological clearance. For these groups your local

Health Protection Team will advise. All outbreaks of food poisoning need to be investigated in order to identify their cause.

Do's

- Exclude the pupil or staff member until 48 hours after the symptoms have stopped.
- Inform your local Health Protection Team if 2 or more cases with similar symptoms are reported to you.

Giardia

This parasitic disease is spread from those with the infection to others by the faecal-oral route. It may also be spread by drinking water contaminated with faeces. Infection with giardia may not cause any symptoms. The incubation period is between 5 and 25 days.

When symptoms do occur, they may include abdominal pain, bloating, fatigue and pale, loose stools. Cases need to be treated with antibiotics.

Exclusion

Cases should be excluded until 48 hours after symptoms have stopped.

Do's

- Exclude the pupil or staff member until 48 hours after the symptoms have stopped.
- Inform your local Health Protection Team if 2 or more cases with similar symptoms are reported to you.

Salmonella

Salmonella is caused by eating contaminated food, particularly poultry or eggs. It can also be spread directly from person to person by the faecal-oral route. Symptoms include diarrhoea, headache, fever and sometimes vomiting. Infection can be more serious in the very young and very old. The incubation period can be from as little as 6 hours up to 72 hours (most commonly 12 to 36 hours).

Exclusion

Cases should be excluded until 48 hours after symptoms have stopped.

Do's

- Exclude the pupil or staff member until 48 hours after the symptoms have stopped.
- Inform your local Health Protection Team if 2 or more cases with similar symptoms are reported to you.

Typhoid and Paratyphoid fever

These are less common but serious illnesses. They are spread by consuming food or water contaminated by the faeces or urine of someone with the illness or someone without symptoms who may be excreting the organism. These infections are most commonly acquired abroad.

Symptoms of typhoid fever are tiredness, fever and constipation, whereas those of paratyphoid fever are fever, diarrhoea and vomiting. The severity of the illness and length of the incubation period (typhoid 1 to 3 weeks, paratyphoid 1 to 10 days), are related to the number of infecting organisms ingested.

Exclusion

Environmental health officers or your local Health Protection Team will advise.

Do's

- Encourage staff and children to always practice good personal hygiene.
- Encourage staff and children to wash their hands especially after using the toilet and before eating or preparing food. Young children may need supervision to ensure that adequate hand washing takes place
- Always ensure high standards of environmental cleaning (especially frequently touched areas, like flush handles, toilet seats, taps, toilet door handles). Please refer to the infection control section on cleaning.
- Use liquid soap and disposable paper towels for hand washing.
- Report immediately to the Health Protection Team (HPT).
- Observe exclusion period – whilst symptomatic and for 48 hours after symptoms have resolved, or longer if advised by the HPT or Environmental Health Officer (EHO).
- Consider sending out the travel health advice information prior to the main travel periods to raise awareness of the need for pre-travel health advice and vaccinations.

E. coli (verocytotoxigenic or VTEC)

Escherichia coli (E. coli) are bacteria that live in the gut of humans and animals, particularly cattle and sheep. A few strains of E. coli, such as VTEC can produce toxins that lead to more serious and potentially fatal illness.

Spread is by eating contaminated food, direct contact with animals and by faecal-oral route from an infected person as a result of sharing towels and food. Spread by contaminated drinking has also been reported.

Symptoms

Symptoms vary depending on the severity of the infection but include diarrhoea, abdominal cramps, headache and bloody diarrhoea. The incubation period is 1 to 10 days and cases are infectious as long as bacteria are present in the faeces.

Spread

Spread is mainly by contaminated water and food and contact with animals. Person to person spread is by direct contact and can happen within families and child care settings. Outbreaks and sporadic cases have also been linked with handling animals. Therefore, adults should supervise children while washing their hands during visits to petting zoos and farm centres. Read chapter 8: pet and animal contact.

Exclusion

The standard exclusion period is until 48 hours after symptoms have resolved. However, some people pose a greater risk to others and may be excluded until they have a negative stool sample(s) for example pre-school infants, food handlers, and care staff working with vulnerable people. The HPT will advise in these instances.

Do's

- Follow healthcare professional's exclusion advice.
- Promote good hand washing to children visiting to farms or petting zoos, especially after handling animals and prior to eating or drinking (see chapter 8: pet and animal contact).

Gastroenteritis (causes of)

Diarrhoea and vomiting

Diarrhoea has numerous causes but diarrhoea caused by an infection in the gut can be easily passed to others.

Symptoms

Diarrhoea is defined as 3 or more liquid or semi-liquid stools in a 24 hour period.

Spread

These infections are spread when organisms enter the gut by the mouth or when contaminated hands or objects are put in the mouth or after eating contaminated food or drinks. Also, infection can be spread to contacts when the affected person vomits. This is because aerosols can spread the organism directly to others and contaminate the environment. A person will be infectious while symptoms remain.

Exclusion

Children and adults with diarrhoea or vomiting should be excluded until 48 hours after symptoms have stopped and they are well enough to return. If medication is prescribed, ensure that the full course is completed and there is no further diarrhoea or vomiting for 48 hours after the course is completed.

For some gastrointestinal infections, longer periods of exclusion from school are required and there may be a need to obtain microbiological clearance. For these groups, your local HPT, school health advisor or environmental health officer will advise.

Cases should be excluded from swimming for 2 weeks following last episode of diarrhoea.

Do's

- Ensure the case is excluded.
- Do encourage staff and children to practice good hand hygiene at all times.
- Notify your local Health Protection Team if there are more cases than normally expected.

Bacillary Dysentery (Shigella)

This disease is passed directly from person to person by the faecal-oral route or by contaminated food. It is usually spread from those with diarrhoea but can be spread from those recovering from the illness even if they do not have symptoms.

Symptoms

Symptoms can include bloody diarrhoea, vomiting, abdominal pain and fever lasting on average from 4-7 days but can last for several weeks. The incubation period is 12 to 96 hours.

Exclusion

Microbiological clearance is required for some types of shigella species prior to the child or food handler returning to school (age of child and infectious agent).

Campylobacter

It is spread between people and animals by the faecal-oral route. Bacteria are present in the faeces of adults and children with diarrhoea, and spread to the mouths of other people directly on their hands or by food or objects. Campylobacter can be present in raw meat, especially chicken, and can contaminate other foods, surfaces and utensils. The disease usually lasts 3 to 5 days and has an incubation period of between 1 and 10 days but most commonly 3 to 5 days.

Exclusion

Cases should be excluded until 48 hours after symptoms have stopped.

Cryptosporidiosis

Cryptosporidiosis is spread from those with the infection to others by the faecal-oral route. It can also be spread by direct contact with farm animals particularly cattle and sheep. Spread by contaminated or untreated water and milk has also been reported. Symptoms include abdominal pain, diarrhoea and occasionally vomiting. The incubation period is between 1 and 12 days.

Exclusion

Cases should be excluded until 48 hours after symptoms have stopped.

Glandular fever

Glandular fever is caused by the Epstein-Barr virus.

Symptoms

Symptoms present as severe tiredness, aching muscles and sore throat, fever, swollen glands and occasionally jaundice (yellowing of the skin and eyes). In children, the disease is generally mild and difficult to recognise. The incubation period is 4 to 6 weeks but the infectious period is not accurately known.

Duration of the illness is from 1 to several weeks or months.

Spread

Spread is by direct contact with saliva and by indirect contact with hands or contaminated objects from cases. The incubation period is between 4 to 6 weeks.

Exclusion

Exclusion is not required and children can return once they feel well.

Do's

- Promote hand hygiene to reduce the risk of spread and ensure that used tissues are disposed of or washed straight away.
- Remember the child may feel unwell for some months.

Don'ts

- There is no specific treatment only symptom management.

Hand, foot and mouth disease

Hand, foot and mouth disease is a common childhood illness. It is generally a mild illness caused by an enterovirus.

Symptoms

The child develops a fever and a rash with blisters on their cheeks, hands and feet. Not all cases have symptoms. The incubation period is 3 to 5 days.

Spread

Spread is by direct contact with the secretions of the infected person (including faeces) and by coughing and sneezing. Younger children are more at risk because they tend to play closely with peers. Promote good hand washing to reduce the risk of transmission.

Exclusion

Exclusion of a well pupil is not required

Do's

- Do ensure that any tissues used to for nose and throat are disposed of or washed immediately.
- Promote hand washing.

Don'ts

- Don't confuse with foot and mouth disease in animals.

Head lice

Head lice are tiny insects that live only on humans, feeding on blood. Eggs are grey or brown and about the size of a pinhead; are glued to the hair, close to the scalp and hatch in 7 to 10 days. Empty egg shells (nits) are white and shiny and are found further along the hair shaft as they grow out.

Spread

Head lice are spread by direct head-to-head contact and therefore tend to be more common in children because of the way they play. They cannot jump, fly or swim. When newly infected, cases have no symptoms. Itching and scratching on the scalp occurs 2 to 3 weeks after infection. There is no incubation period.

Treatment is only needed if live lice are seen. Dimeticone, a silicone oil (like Hedrin) or malathion, an insecticide are recommended treatments. Alternatively, lice can be physically removed by combing through hair that has been lubricated with a conditioner using a fine-toothed detector comb.

Exclusion

No exclusion is needed.

Do's

- Treatment is needed only when live lice are seen.

Don'ts

- Exclusion is not required.

Hepatitis A

Hepatitis A is a viral infection affecting the liver. The severity of the disease varies from a mild illness lasting 1 to 2 weeks to a severely disabling disease lasting several months. Children under 5 years may not have any symptoms.

Symptoms

Symptoms include abdominal pain, loss of appetite, nausea, fever and tiredness, followed by jaundice (yellowing of the skin and eyes), dark urine and pale faeces. Symptoms are usually much milder or not noticed in younger children and jaundice is not common in children under 5 years.

The illness in children usually lasts 1 to 2 weeks but be longer and more severe in adults.

Spread

Hepatitis A is spread from person to person through the faecal-oral route, most commonly when food and hands are contaminated. As some children may not have symptoms at all, they may readily spread the infection to others unless good personal hygiene measures are routinely taken.

Exclusion

Exclude cases from school while unwell or until 7 days after the onset of jaundice (or onset of symptoms if no jaundice or if under 5 or where hygiene is poor. There is no need to exclude well, older children with good hygiene who will have been much more infectious prior to diagnosis.

Do's

- Promote good hand washing to reduce the risk of spread.
- Take care to wash hand before handling food and after going to the toilet.
- Clean kitchen and toilet areas regularly.
- Household contacts of cases will be offered a hepatitis A vaccine if they are not immune.

Hepatitis B

Hepatitis B infection is not a common viral infection in young children.

Symptoms

The incubation period varies between 4 to 160 days. Symptoms can vary and include general tiredness, nausea and vomiting, loss of appetite, fever, dark urine and older children and adults may develop jaundice (a yellowing of the eyes and skin).

Spread

Spread is by contact with infected blood and body fluids entering the bloodstream through broken skin or the mucous membranes, for example through a bite which breaks the skin or if the skin is pierced by an object which has been in contact with someone else's body fluids.

All blood and body fluids should be considered potentially infectious and spills should be cleared wearing protective clothing and using a spills kit.

Exclusion

Acute cases of hepatitis B will be too ill to attend school and their doctors will advise when they can return. Do not exclude chronic cases of hepatitis B or restrict their activities. Similarly, do not exclude staff with chronic hepatitis B infection. Contact your local health protection team for more advice if required.

Do's

- Take a standard approach to cleaning all spillages of blood and body fluids.
- Always complete the accident book with details of injuries or adverse events.

Don'ts

- Individuals with chronic hepatitis B infection should not be excluded or have their activities restricted.

Hepatitis C

- Hepatitis C is not a common infection in children.

Symptoms

Hepatitis C virus (HCV) is a blood borne virus affecting the liver. Symptoms of hepatitis C infection can often be vague and include loss of appetite, fatigue, nausea and abdominal pain. Jaundice (yellowing of the skin and eyes) occurs less commonly than in hepatitis B infection. Up to 80% of those infected may be carriers of the virus and can pass it on to others.

Spread

HCV is present in blood and other body fluids and tissues and is spread in the same way as hepatitis B virus. Hepatitis C, like Hepatitis B, cannot be spread through casual contact.

Exclusion

No exclusion is needed

Do's

- Take a standard approach to cleaning all spillages of blood and body fluids.
- Always complete the accident book with details of injuries or adverse events.

Don'ts

- Individuals with chronic hepatitis C infection should not be excluded or have their activities restricted.

Impetigo

Impetigo is an infectious bacterial skin disease and may be a primary infection or a complication of an existing skin condition such as eczema, scabies or insect bites. Impetigo is common in children, particularly during warm weather.

Symptoms

The infection can develop anywhere on the body but lesions tend to occur on the face, flexures and limbs not covered by clothing.

Spread

Spread is by direct contact with discharges from the scabs of an infected person. The bacteria invade skin through minor abrasions and then spread to other sites by scratching. Infection is spread mainly on hands, but indirect spread via toys, clothing, equipment and the environment may occur. The incubation period is between 4 to 10 days.

Exclusion

The child should be excluded from school until the lesions are crusted and healed or 48 hours after commencing antibiotic treatment.

Do's

- Promote hand hygiene to reduce the risk of spread.
- Towels and facecloths or eating utensils should not be shared by pupils.
- Ensure that toys and play equipment are thoroughly cleaned.

Don'ts

The child should not return to school until lesions are crusted over or 48 hours after starting antibiotic treatment.

Influenza

Influenza, commonly known as flu, is caused by a virus, usually influenza A or B. The illness is very infectious and easily spreads in crowded populations and in enclosed spaces. Flu viruses are always changing so this winter's flu strains will be slightly different from last winter's.

Annual vaccination is recommended for certain groups of people. Currently all children between the ages of 2, 3 or 4 years and children in year groups 1, 2 and 3 are recommended to have vaccination against influenza.

This programme will include more year groups in the future, your school health team will be able to advise you on this Influenza vaccine is also recommended for pregnant women. For further details see national immunisation schedule.

Symptoms

Influenza is a respiratory illness and commonly has a sudden onset. Symptoms include headache, fever, cough, sore throat, aching muscles and joints and tiredness. Cases are infectious 1 day before to 3 to 5 days after symptoms appear.

Spread

By breathing in droplets coughed out into the air by infected people or by the droplets landing on mucous membranes. Transmission may also occur by direct or indirect contact with respiratory secretions for example via soiled tissues, surfaces.

Incubation period is between 1 to 3 days.

Exclusion

There is no precise exclusion period. Adults and children with symptoms of influenza are advised to remain at home until recovered.

Do's

- Encourage those in risk groups to have the influenza vaccine.
- Encourage children and staff with flu-like symptoms to stay at home until recovered.
- Ask children to cover their noses and mouths with a tissue when coughing or sneezing and discard tissues after use.
- Ensure regular hand washing with soap and water, especially after coughing or sneezing.

Don'ts

Do not allow children under 16 years old to have aspirin as it is associated with Reye's syndrome (a neurological disorder).

Measles

Measles is a highly infectious viral infection. The mumps, measles-rubella (MMR) immunisation campaign carried out in the UK 1994 resulted in a dramatic reduction in cases of measles. However, there has recently been a sharp rise in the number of cases reported in unvaccinated individuals in London.

Symptoms

Symptoms include a runny nose; cough; conjunctivitis (sticky eye); high fever and small white spots (Koplik spots) inside the cheeks. Around day 3 of the illness, a rash of flat red or brown blotches appear, beginning on the face and spreading over the body. The incubation period is between 7 to 18 days.

Spread

Measles is highly infectious. The virus is transmitted through airborne droplet spread, and direct contact with nasal or throat secretions.

Exclusion

Cases are infectious from 4 days before onset of rash to 4 days after so it is important to ensure cases are excluded from school during this period.

Do's

Encourage all children over the age of 1 to have MMR immunisations as per the national schedule.

Staff should be up to date with their MMR vaccinations.

Don'ts

Children and adults with a weak immune system, pregnant women and children under 12 months who come into contact with measles should contact their GP immediately for advice.

Meningitis

Meningitis is a general term that describes an inflammation of the membranes covering the brain and spinal cord. It can be caused by a range of bacteria or viruses. Bacterial meningitis is less common but more serious than viral meningitis and needs urgent antibiotic treatment. In some cases, bacterial meningitis can lead to septicaemia (blood poisoning). If you suspect meningitis, get medical help urgently.

Symptoms

Common signs and symptoms of meningitis and septicaemia include fever, severe headache, photophobia, neck stiffness, non-blanching rash (see glass test box below), vomiting, drowsiness.

The incubation period varies with the organism causing the infection. Bacterial meningitis incubation is between 2 and 10 days.

Glass test

If a glass tumbler is pressed firmly against a septicaemic rash, the rash will not fade. You will be able to see the rash through the glass. If this happens get medical help immediately. Note that the rash is a late symptom - if any of the other symptoms have already occurred seek medical advice immediately.

The routine childhood immunisation schedule provides protection against meningitis caused by mumps, polio, Haemophilus influenzae type b (Hib), pneumococcus and Neisseria meningitidis group A,B,C,W and Y. There is no vaccination for some types of meningitis. Pupils should be encouraged to be up to date with their vaccinations.

There is no effective medication the treatment of viral meningitis but symptoms are usually much milder.

Exclusion

Once the child has been treated (if necessary) and has recovered, they can return to school. No exclusion is needed.

Meningitis is a notifiable disease.

Meningococcal meningitis and meningitis septicaemia

Meningitis and septicaemia require immediate medical attention.

The bacteria Neisseria meningitidis is responsible for meningococcal meningitis and meningococcal septicaemia (known collectively as 'meningococcal infection'). There are 13 known groups of the bacteria, the most common worldwide are A, B, C, W135 and Y. In the UK, groups B and C are the most common. Meningococcal infection is a rare but serious disease and is fatal in around 1 in 10 people with the illness. About 15% of those that recover have long-term complications.

Symptoms

Symptoms include fever, severe headache, photophobia, drowsiness, non-blanching rash (see glass test box). Not all the symptoms will be present and cases can have symptoms of meningitis and septicaemia.

Glass test:

If a glass tumbler is pressed firmly against a septicaemic rash, the rash will not fade. You will be able to see the rash through the glass. If this happens get medical help immediately. Note that the rash is a late symptom - if any of the other symptoms have already occurred seek medical advice immediately.

Spread

Spread is from person to person through respiratory droplets and direct contact with nose and throat secretions. About 10% of us carry the bacteria harmlessly in our nose and throat without and only a very small proportion of people develop meningitis or septicaemia if they come into contact with it.

Close and prolonged contact is needed to pass the bacteria to others (such as contacts in a household setting or intimate kissing). For this reason, only people that have had significant close contact with the case in the previous 7 days will be offered antibiotics.

The case is considered non-infectious 24 hours after taking appropriate antibiotic treatment to clear the bacteria from their nose and throat.

If the child has been treated and has recovered, they can return to school. The HPT will have carried out a risk assessment and organised antibiotics for household and other close contacts. Exclusion is not necessary for household or close contacts unless they have symptoms suggestive of meningococcal infection.

Do's

- Seek medical advice immediately if meningitis is suspected.
- Inform HPT and school health advisor of a case of meningococcal disease in your school.
- Respect confidentiality of the patient.
- Inform the HPT if 2 cases of meningococcal disease occur in the school within 4 weeks.

Meningitis (viral)

The symptoms of meningitis (inflammation of the linings surrounding the brain) can be caused by a number of different viruses.

Symptoms

Symptoms include headache, fever, gastrointestinal or upper respiratory tract involvement and in some cases a rash. Active illness seldom lasts more than 10 days.

Spread

How the disease is spread will depend on the virus causing the illness. Transmission may be through droplet spread or direct contact with nose and throat discharges or faeces of infected individuals.

Exclusion

No exclusion is required. Once the child is well the risk of infection is minimal. There is no reason to exclude siblings and other close contacts of a case.

Do's

- Encourage high standards of basic hygiene.
- Encourage the prompt disposal of soiled tissues.
- Recommend a consultation with the GP.
- Seek advice from Health Protection Team if more than one case occurs.

Meticillin resistant Staphylococcus aureus (MRSA)

MRSA (meticillin resistant Staphylococcus aureus) is a bacteria that has developed resistance to methicillin (a type of penicillin) and some other antibiotics that are used to treat infections.

Symptoms

Staphylococcus aureus is commonly found on the skin and in the nostrils of about 25 to 30% of the population. Most people do not even realise they are carrying it because it does not harm them and they have no symptoms, or only experience minor problems such as skin infections or boils. It can occasionally cause serious infection.

Spread

Spread is mainly by direct contact with contaminated hands and objects.

Exclusion

None advised.

Do's

- Staff should ensure good infection control principles are in place, in particular good hand washing, to reduce the risk of transmission.
- All infected wounds should be covered.

Mumps

Symptoms

Mumps is a viral infection. The first symptoms of mumps are usually a raised temperature and general malaise. Following this there is stiffness or pain in the jaws or neck. Then the glands in the cheeks and under the jaw swell up and cause pain. The swelling can be one sided or affect both sides. Mumps is usually fairly mild in young children, but can cause swelling of the testicles and rarely, infertility in males over the age of puberty.

Spread

The mumps virus is highly infectious and can be spread by droplets from the nose and throat and by saliva.

Exclusion

Infected children can return to school 5 days after the onset of swelling, if well.

Do's

- Encourage staff and children to practice good hygiene at all times.
- Send the child home if unwell.
- Advise the parents to see their GP.
- Encourage parents to have their children immunised against mumps.

Ringworm

Symptoms

Ringworm, also known as tinea, is a fungal infection of the skin, hair or nails. It is caused by various types of fungi and infections are named after the parts of the body that are affected, namely face, groin, foot, hand, scalp, beard area and nail. Scalp ringworm in children is becoming more common in the UK, particularly in urban areas. Until recently this was usually spread from infected animals but now spread between humans within families and in schools is more common.

Ringworm of the scalp

Infection with animal ringworm starts as a small red spot which spreads leaving a scaly bald patch. The hair becomes brittle and breaks easily. The picture with human scalp ringworm varies from lightly flaky areas, often indistinguishable from dandruff, to small patches of hair loss on the scalp. There may be affected areas on the face, neck and trunk.

Ringworm of the body

Infected areas are found on the trunk or legs and have a prominent red margin with a central scaly area.

Athlete's foot

Affects the feet, particularly the toes, in between the toes and soles.

Nail ringworm

Infection of the nails often with infection of the adjacent skin. There is thickening and discolouration of the nail.

Spread

Spread is by direct skin to skin contact with an infected person or animal and with athlete's foot, by indirect contact with contaminated surfaces.

Exclusion

No exclusion needed. Once treatment has started for infections of the skin and scalp children can return to school. Scalp ringworm needs to be treated with oral anti-fungal agents. An anti-fungal cream is used to treat ringworm of the skin and feet.

Do's

- Wash and dry feet well in cases of athlete's foot.
- Keep towels separate in all cases.
- Ensure the child with ringworm of the feet is wearing socks and trainers. The child should have his or her feet covered for physical education.

Rotavirus

Symptoms

Rotavirus infection is the most common cause of gastroenteritis (inflammation of the intestines) in children under 5 years of age worldwide. Rotavirus is a highly infectious virus and can cause severe diarrhoea, stomach cramps, vomiting, dehydration and mild fever. These symptoms usually last from 3 to 8 days.

Spread

Rotavirus is highly contagious and is mainly transmitted by the faecal-oral route, although respiratory transmission may also occur.

Apart from vaccination, good hygiene is the most important way of preventing the spread of rotavirus.

Exclusion

Until 48 hours after the symptoms have subsided.

Do's

- Encourage staff and children to practice good hygiene at all times.
- Send the child home if unwell advise the parents to see their GP.
- Use PPE when handling blood or body substances.

Rubella (German Measles)

Rubella is a viral infection. The infection is mild but can cause congenital rubella syndrome. When a pregnant woman who is not immune gets a rubella infection it can cause damage including deafness, cataracts and brain damage.

In the UK, the introduction of the MMR vaccine has resulted in the infection being virtually eliminated, although due to the decline in the uptake of the measles, mumps and rubella vaccine has resulted in some cases within the UK.

Symptoms

The symptoms of rubella are mild. Usually the rash is the first indication, although there may be mild catarrh, headache or vomiting at the start.

The rash takes the form of small pink spots all over the body. There may be a slight fever and some tenderness in the neck, armpits or groin and there may be joint pains. The rash lasts for only 1 or 2 days, and the spots remain distinct, unlike measles.

Spread

Spread is by the respiratory route.

Exclusion

Exclude from school for 6 days from the appearance of the rash.

Do's

- Promote 2 MMR vaccinations for all pupils.
- Female staff should have 2 MMR vaccinations or show a history of measles infection.

Scabies

Scabies is a skin infection caused by tiny mites that burrow in the skin. The pregnant female mite burrows into the top layer of the skin and lays about 2 to 3 eggs per day before dying after 4 to 5 weeks. The burrows may be several centimetres long but they are very close to the surface of the skin. The eggs hatch after 3 to 4 days into larvae which move to hair follicles where they develop into adults.

Symptoms

The appearance of the rash varies but tiny pimples and nodules are characteristic. Secondary infection can occur if the rash has been scratched. The scabies mites are attracted to folded skin such as the webs of the fingers. Burrows may also be seen on the wrists, palms elbows, genitalia and buttocks.

Spread

Spread is most commonly by direct contact with the affected skin.

Occasionally if there is impaired immunity or altered skin sensation, large numbers of mites occur and the skin thickens and becomes very scaly.

Exclusion

Yes. The infected child or staff member should be excluded until after the first treatment has been carried out.

Do's

- The child can return after the first treatment has been completed.
- It is important that the second treatment is not missed and this should be carried out 1 week after the first treatment.
- All household contacts and any other very close contacts should have 1 treatment at the same time as the second treatment of the case.

Scarlet Fever

A wide variety of bacteria and viruses can cause tonsillitis and other throat infections. Most are caused by viruses but streptococci bacteria account for 25 to 30% of cases. Certain strains of streptococcus bacteria produce a toxin which causes scarlet fever in susceptible people.

Symptoms

There is acute inflammation extending over the pharynx or tonsils. The tonsils may be deep red in colour and partially covered with a thick yellowish exudate. The illness symptoms vary but in severe cases there may be high fever, difficulty in swallowing and tender enlarged lymph nodes.

A rash develops on the first day of fever, it is red, generalised, pinhead in size and gives the skin a sandpaper-like texture and the tongue has a strawberry-like appearance. The fever lasts 24 to 48 hours. Scarlet fever is now usually a mild illness but is rarely complicated by ear infections, rheumatic fever which affects the heart, and kidney problems.

Spread

Spread is by the respiratory route through inhaling or ingesting respiratory droplets or by direct contact with nose and throat discharges especially during sneezing and coughing.

Exclusion

Yes. Children can return to school 24 hours after commencing appropriate antibiotic treatment. If no antibiotics have been administered the person will be infectious for 2 to 3 weeks. If there is an outbreak of scarlet fever at the school or nursery, the HPT will assist with letters and factsheet to send to parents or carers and staff.

Do's

- Ensure that particular attention is paid to hand washing at all times.
 - Send the child home from school if unwell.
 - Advise parents to take the child to their GP.
-
- Inform the HPT if there is an outbreak.

Slapped cheek syndrome, Parvovirus B19, Fifth's Disease

Symptoms

The illness may only consist of a mild feverish illness which escapes notice but in others a rash appears after a few days. The rose-red rash makes the cheeks appear bright red, hence the name 'slapped cheek syndrome'. The rash may spread to the rest of the body but unlike many other rashes it only rarely involves the palms and soles.

The child begins to feel better as the rash appears. The rash usually peaks after a week and then fades. The rash is unusual in that for some months afterwards, a warm bath, sunlight, heat or fever will trigger a recurrence of the bright red cheeks and the rash itself. Most children recover and need no specific treatment. In adults the virus may cause acute arthritis.

The virus can affect an unborn baby in the first 20 weeks of pregnancy. If a woman is exposed early in pregnancy (before 20 weeks) she should seek prompt advice from whoever is giving her antenatal care.

Spread

Spread is by the respiratory route and a person is infectious 3 to 5 days before the appearance of the rash. Children are no longer infectious once the rash appears. There is no specific treatment.

Exclusion

None. The child need not be excluded from school because he or she is no longer infectious by the time the rash occurs.

Do's

- Do advise a visit to the GP.
- Do request that parents inform the school of a diagnosis of fifth disease.

Threadworm

Threadworm infection is an intestinal infection and is very common childhood infection.

Symptoms

Adult worms live in the small intestine. Mature female worms migrate through the anus and lay thousands of eggs on the perianal skin causing itching, particularly at night. Infective embryos develop within 5 to 6 hours and these are transferred to the mouth on fingers as a result of scratching. Larvae emerge from the eggs in the small intestine and develop into adult worms.

Spread

Re-infection is common and infectious eggs are also spread to others directly on fingers or indirectly on bedding, clothing and environmental dust.

Exclusion

None needed.

Do's

- Do encourage high standards of basic hygiene.
- Do recommend a consultation with the GP or pharmacist.
- Do be aware that transmission is uncommon in schools.

Don'ts

- Don't forget that threadworm infection can lead to lack of sleep, irritability and loss of concentration.

Tuberculosis (TB)

TB is a bacterial infection that can infect any part of the body, including the lungs. It can affect people of all ages, classes and ethnic background.

Symptoms

People with TB might have all or some of the following symptoms; cough, loss of appetite, loss of weight, fever, sweating particularly at night, breathlessness and pains in the chest. TB in a part of the body other than the lungs may produce a lump or swelling which can be painful.

Spread

Some (but not all) people who develop TB of the lung (pulmonary TB) are infectious to others. Spread happens when these infectious cases pass TB in their sputum to someone else by inhalation. This happens if the person had a lot of close contact

with the case (especially if the case has been coughing). The incubation period is 4 to 12 weeks.

Exclusion

Yes. Pupils and staff with infectious TB can return to school after 2 weeks of treatment if well enough to do so and as long as they have responded to anti-TB therapy. Pupils and staff with non-pulmonary TB do not require exclusion and can return to school as soon as they are well enough.

Do's

- Do inform and discuss with the Health Protection Team, TB nurses or school health advisor before taking any action.
- Do maintain confidentiality of persons with suspected TB.
- Do exclude pupils whilst they are infectious, following taking advice from TB nurses or the Health Protection Team.

Don'ts

Don't exclude children or staff with non- pulmonary TB or those with pulmonary TB who have effectively completed at least 2 weeks of treatment as confirmed by the TB nurses.

Whooping Cough (pertussis)

Whooping cough (pertussis) is a bacterial chest infection caused by *Bordetella pertussis*. The national immunisation schedule recommends that women 16 to 32 weeks pregnant should be immunised to maximise the likelihood that the baby will be protected from birth. Infants receive 3 doses of vaccination by their 16th week and an additional pre-school booster.

Symptoms

The early stages of whooping cough, which may last a week or so, can be very like a heavy cold with a temperature and persistent cough. The cough becomes worse and usually the characteristic 'whoop' develops. Coughing spasms are frequently worse at night and may be associated with vomiting. The whole illness may last several months.

The disease is usually more serious in children of pre-school age. Antibiotics rarely affect the course of the illness, but may reduce the period the child is infectious.

Spread

Whooping cough spreads by direct contact with airborne particles of discharges from the nose and throat.

Exclusion

Yes. A child or staff member should not return to school until they have had 48 hours of appropriate treatment with antibiotics and they feel well enough to do so or 21 days from onset of illness if no antibiotic treatment.

Children should be immunised against whooping cough in their first year of life.

Do's

- Do advise parent to see GP.

- Do allow the child to return to school after exclusion period even if they are still coughing.
- Do encourage parents to have their children immunised against whooping cough.

Health Protection for schools, nurseries and other childcare facilities

Exclusion table

Infection	Exclusion period	Comments
Athlete's foot	None	Athlete's foot is not a serious condition. Treatment is recommended.

Chickenpox	Five days from onset of rash	Blisters on the rash must be dry and crusted over
Cold sores (herpes simplex)	None	Avoid kissing and contact with the sores. Cold sores are generally mild and heal without treatment
Conjunctivitis	None	If an outbreak/cluster occurs, consult your local HPT
Diarrhoea and vomiting	Whilst symptomatic and 48 hours after the last symptoms.	See section in chapter 9
Diphtheria *	Exclusion is essential. Always consult with your local HPT	Preventable by vaccination. Family contacts must be excluded until cleared to return by your local HPT
Flu (influenza)	Until recovered	Report outbreaks to your local HPT.
Glandular fever	None	
Hand foot and mouth	None	Contact your local HPT if large numbers of children are affected. Exclusion may be considered in some circumstances
Head lice	None	Treatment recommended only when live lice seen
Impetigo	Until lesions are crusted /healed or 48 hours after starting antibiotic treatment	Antibiotic treatment speeds healing and reduces the infectious period.
Measles*	Four days from onset of rash and recovered	Preventable by vaccination (2 doses of MMR). Promote MMR for all pupils and staff. Pregnant staff contacts should seek prompt advice from their GP or midwife
Hepatitis A*	Exclude until seven days after onset of jaundice (or 7 days after symptom onset if no jaundice)	In an outbreak of hepatitis A, your local HPT will advise on control measures
Hepatitis B*, C*, HIV	None	Hepatitis B and C and HIV are blood borne viruses that are not infectious through casual contact. Contact your local HPT for more advice
Meningococcal meningitis*/septicaemia*	Until recovered	Meningitis ACWY and B are preventable by vaccination (see national schedule @ www.nhs.uk). Your local HPT will advise on any action needed
Meningitis* due to other bacteria	Until recovered	Hib and pneumococcal meningitis are preventable by vaccination (see national schedule @ www.nhs.uk) Your local HPT will advise on any action needed
Meningitis viral*	None	Milder illness than bacterial meningitis. Siblings and other close contacts of a case need not be excluded.
MRSA	None	Good hygiene, in particular handwashing and environmental cleaning, are important to minimise spread. Contact your local HPT for more information
Mumps*	Five days after onset of swelling	Preventable by vaccination with 2 doses of MMR (see national schedule @ www.nhs.uk). Promote MMR for all pupils and staff.

Infection	Exclusion period	Comments
Ringworm	Not usually required.	Treatment is needed.
Rubella (German measles)	Four days from onset of rash	Preventable by vaccination with 2 doses of MMR (see national schedule @ www.nhs.uk). Promote MMR for all pupils and staff. Pregnant staff contacts should seek prompt advice from their GP or midwife
Scarlet fever	Exclude until 24hrs of appropriate antibiotic treatment completed	A person is infectious for 2-3 weeks if antibiotics are not administered. In the event of two or more suspected cases, please contact local health protection
Scabies	Can return after first treatment	Household and close contacts require treatment at the same time.
Slapped cheek /Fifth disease/Parvo virus B19	None (once rash has developed)	Pregnant contacts of case should consult with their GP or midwife.
Threadworms	None	Treatment recommended for child & household
Tonsillitis	None	There are many causes, but most cases are due to viruses and do not need an antibiotic treatment
Tuberculosis (TB)	Always consult your local HPT BEFORE disseminating information to staff/parents/carers	Only pulmonary (lung) TB is infectious to others. Needs close, prolonged contact to spread
Warts and verrucae	None	Verrucae should be covered in swimming pools, gyms and changing rooms
Whooping cough (pertussis)*	Two days from starting antibiotic treatment, or 21 days from onset of symptoms if no antibiotics	Preventable by vaccination. After treatment, non- infectious coughing may continue for many weeks. Your local HPT will organise any contact tracing

*denotes a notifiable disease. It is a statutory requirement that doctors report a notifiable disease to the proper officer of the local authority (usually a consultant in communicable disease control).

Health Protection Agency (2010) Guidance on Infection Control in Schools and other Child Care Settings. HPA: London.

Appendix 1

Reporting of Communicable Diseases and Illnesses in Schools

The illnesses shown in **Table 1** below must be reported to Geetha Unnithan, Head of Compliance, NPW, Francis House, 760 Barking Road, London, E13 9PJ (School Management Support) and the Infectious Diseases Officer, Public Protection, Newham Dockside, 1000 Dockside Road, London, E16 2QU. A confirmed case is a diagnosis by a GP or other medical practitioner.

TABLE 1: COMMUNICABLE ILLNESSES TO BE REPORTED:

Diphtheria		Dysentery (Shigella)		Diarrhoea or Gastro-enteritis	
Tuberculosis		Food poisoning		Jaundice/Hepatitis A, B and C	
Poliomyelitis		Typhoid/ Paratyphoid			
Leptospirosis		Meningitis or Encephalitis			

The infectious illnesses shown in **Table 2** below, which occur in Schools and other educational establishments, must be reported for each week when there is a cluster of cases. A confirmed case is a diagnosis given by a GP or other medical practitioner.

Schools can use the form below, which when completed, must be sent to the School Management Team and Infectious Diseases Officer.

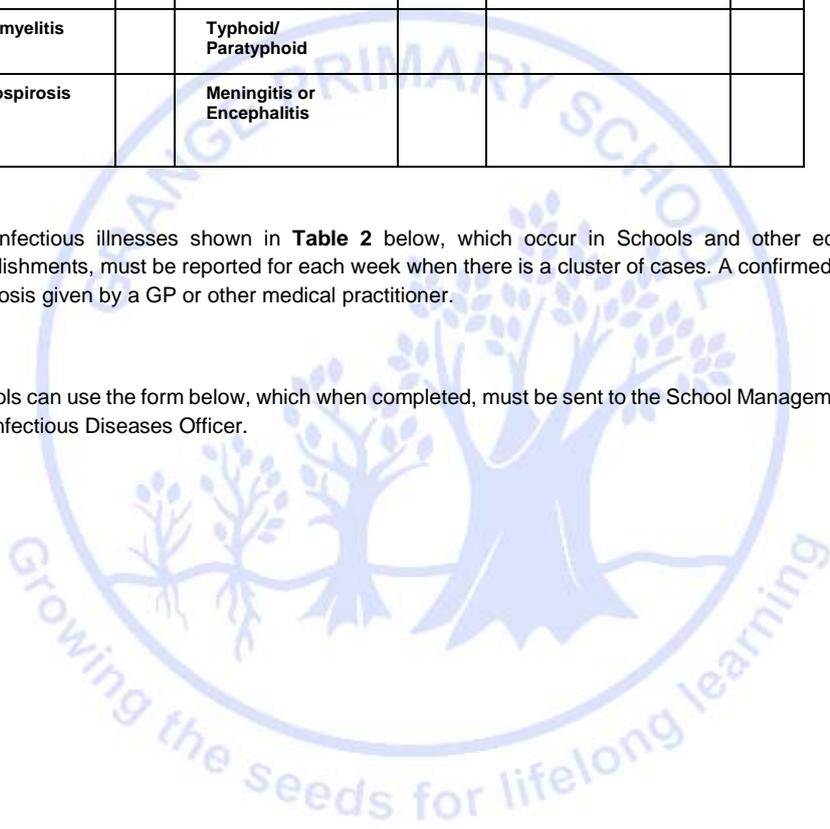


TABLE 2: CLUSTERS OF COMMON ILLNESSES TO BE REPORTED

<u>Disease</u>	<u>Total</u>	<u>Disease</u>	<u>Total</u>
Chickenpox		Pneumonia	
Conjunctivitis and Ophthalmia		Ringworm (Scalp)	
Erysipelas		Ringworm (Body)	
Fifth Disease		Rubella (German Measles)	
Impetigo		Scabies	
Influenza		Scarlet Fever	
Malaria		Sore Throat/Tonsillitis	
Measles		Whooping Cough	
Mumps			

SCHOOL NAME:.....

SIGNED BY:.....

DATE:.....