WREKIN PREP

FIRST AID POLICY

2024 - 2025

Last review: September 2024 (Nick Rothwell)

Date for next review: September 2025

First Aid Policy 2024

Introduction

At The Old Hall School, we are committed to ensuring that every pupil (including EYFS), the staff and visitors, will be provided with adequate First Aid, in the event of an accident or illness.
The School is also committed to enabling all pupils to have full access to the curriculum, including those who have both short and long term medical needs. To this end, we are committed to ensuring that the impact of their medical difficulties upon their life in school is minimised as far as possible. All staff who work with such pupils should understand the nature of their difficulties and how best to support them.

While there is no legal or contractual duty on teachers to administer medicines or supervise pupils taking their medicines, we would wish to support our pupils where we can. This policy has been drawn up using the DFE guidance on First Aid for schools. The Health and Safety (First Aid) Regulations 1981 relate only to employees, recommending one qualified First Aider for every 50 employees. However, under common law, employers and employees have a duty to look after the children in their care and administer First Aid where necessary.

Key Personnel

Between the hours of 7.30am and 5.45pm First Aid will normally be administered by the two school Matrons who are based in the Matron's Room. They hold certificates of competence in First Aid at Work, Paediatric First Aid and Safer Handling of Medication. The Old Hall School and Wrekin College will always have at least one qualified first aider on the site when children are present.

In the EYFS setting provision is made for at least one person, on the premises, or on school outings, to have a current paediatric first aid certificate. (minimum of 12 hours training)
First aid training is coordinated by The School Matrons, who keep copies of certificates and make sure that qualifications are kept up to date.

If First Aid is required when Matron is not available, the School Office should be notified and the nearest First Aider will be contacted. An up-to-date list of the many trained First Aiders on the school staff is available outside Matron's Room. Lists are also around the school, in the school office, the staff room and above each first aid box.

Medical staff are also available at the Wrekin College Medical Centre until 6.30pm.
(See appendix A)

First Aid Equipment and Information.

A fully stocked and suitable first aid room is situated on the ground floor (Matron's Room) and is supervised by the school Matrons. The Matrons are responsible for checking first aid boxes each term and replenishing them as needed. First Aid boxes, (marked with a white cross on a green background) can also be found in the following places;

- The Early Years Foundation Stage cloakroom.
- Outside Matron's room.
- The Science room, (eye wash station).
- The Design and Technology room & (Eye wash station).
- The Games changing rooms.
- The kitchen & (Eye wash station).
- The Upper School landing (near Evacuchair)

School minibuses

The school's minibuses are shared with Wrekin College. They each have a prominently marked First Aid box on board, which is readily available for use and is maintained by Wrekin College staff.

Hygiene and infection control when dealing with a medical incident

Common sense infection control measures (such as hand washing and the use of disposable gloves and aprons when dealing with blood or bodily fluids) must be followed by all staff when dealing with medical incidents.
Hand washing facilities are available throughout the school.

Single use, disposable, gloves, are to be found in all medical boxes around the school. Matron also has a supply of disposable gloves, aprons and yellow clinical waste bags.
Matron should always be called to deal with the clearing up of bodily fluids. Items that are contaminated must be disposed of in a yellow clinical waste bag and placed in a separate clinical waste bin, situated in Matron's room. Clinical waste is taken to the Wrekin College Medical Centre to be disposed of by a specialist waste company.

The Old Hall School uses Guidance provided by Public Health England on infection control and infectious illnesses.
(See appendix B)

Pupils with known medical conditions

The matrons provide a confidential list of pupils, with known medical and dietary conditions, to each form teacher. A list of pupils with special dietary needs, and /or nut allergies is kept in the kitchen, staff room, and Matron's room. Photographs of children at risk of anaphylaxis are also displayed in those places.
A list of asthmatic children is displayed both in the girls' and boys' changing rooms, and Matron's room. This list is also emailed to staff annually or following any changes.
See separate sections for asthmatics, epilepsy, diabetes and anaphylaxis.

Accident recording and record keeping

Where there is an accident or medical emergency and first aid assistance has been provided **the person who has administered First Aid must record the incident** according to procedures set out below.

In line with statutory requirements, all accidents/incidents as described in the Health and Safety policy are recorded in an accident book and are readily accessible from the Matrons room for a minimum of seven years. Once an accident or incident report has been completed a copy of the form must be sent to the deputy bursar, at the Wrekin College.

First Aid Treatment

In the event of minor incidents resulting in bruises, cuts and grazes, pupils will be sent or escorted to Matron's Room for assessment and treatment as necessary.

- An online record either on ISAM's of first aid treatment is kept by Matron and must include:
- Date time and place of incident
- Full name of injured/ill person
- Detail of the injury/illness and what first aid treatment was given.
- Any review of the person's condition.
- Name of the first aider dealing with the incident.

The matrons will be responsible for ensuring that parents are notified of a significant accident or injury sustained such as a potential concussion by a child, at the earliest opportunity on the same day, initially by phone, with a follow-up email.

Children with minor injuries, will be sent an email at the discretion of the Matron and the severity of the injury. This will state the date and time of the injury, treatment received, and by whom. Matron will also contact parents, when she feels necessary, to seek information, inform them of any concerns, or arrange for a child to be collected due to illness.

In the case of vomiting or diarrhoea we ask that the child does not return to school until 48 hours after the last bout of sickness /diarrhoea.

Head Lice

If a case of head lice is reported, a standard head lice email/note will be sent to all parents of children in that year group.

Informing the HSE or RIDDOR
Statutory requirements and Notifiable Incidents and Diseases.
In regard to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, (RIDDOR) some accidents must be reported to the HSE.

Helena Hyde, Operations and Health and Safety Manager, and the Head, Anna Karacan, are responsible for notifying serious accidents, illness or serious injury to, or death of, any pupil whilst in our care, and the action taken in respect of it.

For EYFS pupils, Ofsted will also be notified and will also be notified of any instance, in connection to medicines, which leads to such an event. A pupil's GP has the responsibility of reporting Notifiable Diseases and ensuring that a pupil is safe to return to school and does not cause public health problems from infections. However, the school may also seek advice from the Health Protection (Notifications) Regulations 2010 **(see Appendix C).** For children in EYFS, notification will be made to Ofsted as soon as reasonably practicable, but in any event within 14 days of the incident.

Procedure in the event of an accident or injury.
If an accident occurs, then the nearest available adult should assess the situation, and decide on the next course of action. This may involve calling for an ambulance immediately. Matron or a First Aider should also be called for as soon as possible. Helena Hyde, Operations and Health and Safety Manager, should be notified at the earliest opportunity.
The member of staff who witnessed the incident/accident must electronically record this through the new Assurity Portal: https://portal.assurityplus.co.uk/compliance/help/woht-maintain

Ambulances
Any person who believes that a situation requires it may telephone an ambulance. After an ambulance has been requested, Matron should be informed and the office should also be notified.
Parents will be informed as soon as is practicable. Another member of staff should await the arrival of the emergency services and direct them appropriately.
Should a child require hospitalisation, they will be accompanied to the hospital by their parents and/or Matron, or in her absence, a member of staff.

Head Injuries

Head injuries, however minor, should be reported to Matron and the child assessed by the Matron who will follow the guidelines. Refer to separate **Head Injury Policy (appendix H).**

School Trips

Every precaution is taken with regard to safety on school visits.
At least one Paediatric First Aider is present on every trip throughout the school and the EYFS.
First Aid kits, medical and dietary information and parent emergency contact details are sent on all trips.
Spare asthma inhalers are sent with asthmatic children and Epipens with children who are prescribed them**. (See separate Appendices D and G)**
Children with diabetes are accompanied by a First Aider trained in the supervision of insulin injections. **(See Appendix E)**

Administration of Medicines/Medication in School.

From time to time, parents request that the school administers medicines/medication. These requests fall into two categories:

1 Children who are suffering from minor ailments (coughs, colds etc).
2 Children who require medication on a long-term basis.

1 Minor Ailments

For minor ailments it is often possible for doses of medicine/medication to be given outside school hours. However, should the child need to be in school and receive medicine/medication, parents must put this request in writing by completing a medicine consent form, available from Matron.

The **consent form** will state:

- The name of the child
- The child's form
- Name of medicine/medication
- Reason for medicine/medication
- Date (s) to be given
- The time (s) to be given
- Parent's signature
- Date

All medicine/medication in school must be clearly labelled and in the original bottle.
All medicine/medication that is brought into school (except asthma relievers and Epipens) must be taken to Matron by a parent/guardian and a consent form signed. If Matron is unavailable, the medicine/medication must be taken to the School Office and a consent form signed. The medicine/medication will then be administered in accordance with the instructions by Matron or, in her absence, by a member of staff. The person administering this medicine/medication (as per written parental instructions) takes no responsibility for any adverse reaction the child may suffer. Permission for Calpol, throat soother, 4Head menthol stick (for headache,) cough syrup, Piriton and sore mouth gel is obtained when the child first enters school. If a child requires Calpol or Piriton whilst in school, the child's parents will be telephoned by Matron to inform them of her action and a note sent home.

2 Long-Term Medication

(With the exception of Asthmatics and Anaphylactics, who have specific consent forms and registers agreed with the school)

If a child has to take medicine/medication in school, each individual case will be considered and the Head will make the final decision. For the school to agree to assist in long-term dispensing of medicine/medication, several safeguards need to be in place, including, but not solely, the following:
Parents must complete a medicine consent form as stated above.

If the reason for the medicine/medication could result in an emergency needing an ambulance to be called, the school will require specific guidance on what to do for the child while awaiting paramedic assistance.

Refusing Medication
If a pupil refuses to take medication, Matron will not force the pupil to take it. The school will inform the parents as soon as possible if this occurs.

Asthmatics in school. See Asthma Policy (Appendix D)

Diabetics in school. See Diabetic Policy (Appendix E)

Epileptics in school. See Epilepsy Policy (Appendix F)

Anaphylaxis in school. See Anaphylactic policy (Appendix G)

Head Injuries/ Concussion in school. See Head Injury Policy (Appendix H)

Policy and Appendices updated Feb 2024 - NR

Appendix A – Qualified First-Aiders

QUALIFIED FIRST AID PERSONNEL
(Updated 04.10.2024)

Matrons ext.729
Sarah Barton

Teaching and Support Staff

Helen Aston	Jennifer Griffiths	Ellie Smith
Kayleigh Barton	Alison Hartland-Griffiths	Mike Sturrock
Sarah Barton	Charlotte Hill	Dave Tatton
Sarah Borrett	Lisa Lamb	Anneli Twiselton
Laura Cox	Stefan Lowes	Kate Ward
Zoe Clennell	Kathryn Mcgarry	Aimee Williams
Rebecca Davies	Chelsea Norton	Sue Wyatt
Elizabeth Devey	Stacey Paskin	
Tesni-Jayne Edwards	Niall Price	
Gemma Everson	Tegan Ransom	
Holly Farthing	Charlotte Richards	
Alan Grant	Nick Rothwell	
Helen Grant	Shina Sandhu	

Medical staff are also available at Wrekin College Medical Centre until 6.30pm each day.

Telephone extension 654, Direct line 265654

Appendix B Infection control in schools

Infection or complaint	Recommended period to be kept away from school	Comments
Rashes and skin infections		
Chicken pox	Until all vesicles have crusted over	See vulnerable children and Female staff pregnancy.
Cold sores (Herpes simplex)	None	Avoid kissing and contact with the sores. Cold sores are generally mild and self limiting.
German measles *	Four days from the onset of the rash.	Preventable by immunisation (see female staff pregnancy)
Hand foot and mouth	None	Contact your local HPT if a large number of children are affected. Exclusion may be considered in some circumstances.
Impetigo	Until lesions are crusted and healed, or 48 hours after starting antibiotic treatment.	Antibiotic treatment speeds healing and reduces the infectious period.
Measles *	Four days from the onset of the rash.	Preventable by vaccination .See vulnerable children and Female staff pregnancy.
Molluscum contagiosum	None	A self limiting condition.
Ringworm	Exclusion not usually required.	Treatment is required.
Scabies	Child can return after first treatment	Household and close contacts require treatment.
Scarlet fever *	Child can return 24 hours after starting appropriate antibiotic treatment.	Antibiotic treatment is recommended for the affected child.
Slapped cheek/fifth disease Parvovirus B19	None (once rash has developed)	See Vulnerable children and Female staff pregnancy.
Shingles	Exclude only if rash is weeping and cannot be covered.	Can cause chickenpox in those who are not immune, ie have not had chickenpox. It is spread by very close contact and touch. If further information is required contact your local PHE centre. See vulnerable children and Female staff pregnancy.
Warts and verrucas	None	Verrucae should be covered in swimming pools gymnasiums and changing rooms.
Diarrhoea and vomiting illness		
Diarrhoea and /or vomiting	48 hours from the last episode of diarrhoea or vomiting.	
Respiratory infections		
Flu (influenza)	Until recovered	See vulnerable children

Whooping cough *	48hrs from starting antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment.	Preventable by vaccination. After treatment non- infectious coughing may continue for many weeks .Your local PHE centre will organise any contact tracing necessary.
Other infections		
Conjunctivitis	None	If an outbreak/cluster occurs consult your local PHE centre
Glandular fever	None	
Head lice	None	Treatment is recommended only in cases where live lice have been seen.
MRSA	None	Good hygiene, in particular hand washing and environmental cleaning are important to minimise any danger of spread. If further information is required contact your local PHE centre.
Mumps *	Exclude child for 5 days after onset of swelling	Preventable by vaccination.
Threadworms	None	Treatment is recommended for the child and household contacts.
Tonsillitis	None	There are many causes but most cases are due to viruses and do not need an antibiotic.

Reference: HSC- Public Health Agency (March 2017)- Guidance on Infection Control in schools and other childcare settings.

*Denotes a Notifiable disease

Vulnerable children

Some medical conditions make children vulnerable to infections that would rarely be serious in most children, these include those being treated for leukaemia or other cancers, those on high doses of steroids and with conditions that seriously reduce immunity. Schools will normally have been made aware of such children. These children are particularly vulnerable to chickenpox, measles or parvovirus B19 and if exposed to either of these, the parent/carer should be informed promptly and further medical advice sought. It may be advisable for these children to have additional immunisations, for example pneumococcal and influenza.

Protecting pregnant workers and new mothers

Ref: https://www.hse.gov.uk/mothers/employer/index.htm

Employers are responsible for providing a safe working environment while effectively managing risks to the health and safety of all workers, including women of a childbearing age.

You must carry out an individual risk assessment for pregnant workers and new mothers. This applies to workers who:

- are pregnant
- have given birth in the last 6 months, or
- are currently breastfeeding
- Some working conditions and processes can potentially harm them and/or their child so you must assess and control the risks posed in each case.

This guidance applies to all new and expectant mothers. It's important for employers to support them all equally. The legal protections outlined also apply to some transgender men, non-binary people and people with variations in sex characteristics, or who are intersex.
This page sets out some of the most common risks from working conditions for pregnant workers and new mothers. It is not a complete list – you must think about the specific hazards and controls your business needs.

Posture and position
Pregnant workers and new mothers could be more prone to injury, which may not become apparent until after birth.

Postural problems can occur at different stages of pregnancy, and on returning to work, depending on the individual and their working conditions.

Pregnant workers and new mothers should no be:

- sitting or standing for long periods
- lifting or carrying heavy loads
- using a workstation that causes posture issues
- HSE provides general guidance on managing musculoskeletal disorders at work.

Working conditions
Long hours, shift work and night work can have a significant effect on the health of pregnant workers, new mothers and their children. They may also be particularly vulnerable to work-related stressors.

Not all workers will be affected in the same way, but mental and physical fatigue generally increase during pregnancy and following birth.

Risks should be assessed for:

- work-related stress
- temperature
- noise
- Risk of physical injury
- Some work carries the risk of physical injury, and the consequences for pregnant workers and new mothers can be more serious.

Check should look to provide extra control measures, for example to protect them when:

- working at height
- working alone
- at risk of work-related violence
- exposed to vibration
- Exposure to harmful substances
- Many chemical and biological agents can cause harm to pregnant workers or new mothers. They can also be passed on to their child during pregnancy or breastfeeding.

These could include:

- lead
- radioactive material
- toxic chemicals like mercury and pesticides
- infectious diseases
- antimitotic (cytotoxic) drugs

Appendix C - **RIDDOR Notifiable illnesses and Diseases**

- Acute encephalitis
- Acute infectious hepatitis
- Acute meningitis
- Acute poliomyelitis
- Anthrax
- Botulism
- Brucellosis
- Cholera
- Covid-19
- Diphtheria
- Enteric fever (typhoid or paratyphoid fever)
- Food Poisoning
- Haemolytic uraemic syndrome (HUS)
- Infectious bloody Diarrhoea
- Invasive group A streptococcal disease
- Legionnaires Disease
- Leprosy
- Malaria
- Measles
- Meningococcal septicaemia
- Monkey Pox
- Mumps
- Plague
- Rabies
- Rubella
- SARS
- Scarlet fever
- Smallpox
- Tetanus
- Tuberculosis
- Typhus
- Viral haemorrhagic fever (VHF)
- Whooping cough
- Yellow fever

(Check Updated- 31.05.2023)

Appendix D

Asthma Policy

This policy has been written with advice from The National Asthma Campaign, the Local Education Authority and the School Health Service, the Governing Body and pupils.

Background
The Old Hall 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. We encourage 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.

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

Asthma medicines
Immediate access to reliever medicines is essential.

As our children take part in physical activities over at the Wrekin College site, and the sports hall, swimming pool and playing fields are some distance from us, every asthmatic child should have an inhaler with them.

Option A
All children in LS and US who are asthmatic, should have two inhalers in school (parents to ensure that they are replaced if lost, run out or go past date of usage). One inhaler will be kept in a coloured bag (for their class) and be held in the Sports Dept Room by the changing rooms. Sports staff will take the child's inhaler with them from there for swimming/PE/Games lessons (onsite) or fixtures (offsite). Form teachers will also collect these bags when a child is on a school trip or going to chapel.

Inhalers will always be with the accompanying member of staff for any sports activities onsite or offsite, this will include co-curricular activities that take place at the Wrekin Sports Hall and Swimming Pool. It is imperative that asthma inhalers are taken when children are at a sporting fixture/swimming or are away from Old Hall School or Wrekin College. It is the responsibility of the teacher organising sports fixtures or residential educational visits to make sure that asthmatic children have their inhalers with them. For non-residential educational visits, Matron will pack the spare asthma inhalers needed for lower and upper school children. Teachers will then take responsibility for them during the visit.

The other inhaler will be kept with Matron for emergencies. Both inhalers will be labelled and Matron will make a note of when the inhalers go past their use by date and inform parents when a replacement is needed. These will be used if the child needs urgent access and is closer to the Matron's office than the Sports Dept Room or if a child loses their first inhaler.

Option B
Should a child have a more severe asthmatic need then the child will carry their own inhaler bag which is taken from classroom to classroom by each teacher and hung on the inhaler peg in the current room they are taught in. It is the responsibility of the Form Teacher/Sports Staff to ensure that this bag will also be taken down to any sporting activities and any offsite trip or fixtures.

Parents will be asked to complete a Google Form whereby they can choose which open they would like their child to follow based on their child's needs. Matrons will also call parents and discuss with them at the start of every year on which option they would like their child to follow (eg A or B).

Should a child have a period of worsening asthma that requires them to carry at all times then the parents should let Matron know that they would like their child to follow Option B until their symptoms improve.

If a child does not have an asthma inhaler in school they will not be allowed to attend educational visits or offsite sporting fixtures.

School staff are not required to administer asthma medicines to pupils (except in an emergency), however the Matrons and many of the staff are happy to do this. All school staff will let pupils take their own medicines when they need to.

From 1st October 2014 Human Medicines Regulations will allow schools to keep a (blue) Salbutamol inhaler, if they wish, for use in emergencies .This is for any pupil with asthma, or who has been prescribed an inhaler as reliever medication. The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty).

Schools are advised to hold an inhaler. However the school now has a clearly marked blue Emergency Salbutamol Inhaler Kit in Matron's room.

The emergency Salbutamol inhaler should only be used by children: who have been diagnosed with asthma, and prescribed a reliever inhaler; - OR who have been prescribed a reliever inhaler; AND for whom written parental consent for use of the emergency inhaler has been given. This consent has now been obtained for every child on the school Asthma Register.

This information should be recorded in a child's individual healthcare plan.

A child may be prescribed an inhaler for their asthma which contains an alternative reliever medication to Salbutamol (such as terbutaline). The Salbutamol inhaler should still be used by these children if their own inhaler is not accessible – it will still help to relieve their asthma and could save their life.

Records

Parents of every asthmatic child admitted to the school are asked to complete an asthma card, even if the child has seasonal or mild asthma. Cards are updated annually (at the start of every academic year). Asthma inhalers will only be administered with a completed and signed card.

A register is kept in the Matron's room of every asthmatic child and asthmatic staff. This records likely asthma triggers, the type of inhaler used (in or out of school), the dosage, and the expiry date of the spare inhaler kept with Matron. Matron will be responsible for checking the expiry dates of inhalers kept with her, and will notify the parents before expiry.

Matron will record on the pupil's health record card when use of the inhaler is needed. Staff with asthma and parents of an asthmatic child, are responsible for informing the school about all aspects of their asthma.

Arrangements for the supply, storage, care and disposal of the inhaler

https://assets.publishing.service.gov.uk/media/5a74eb55ed915d3c7d528f98/emergency_inhalers_in_schools.pdf

Supply

Schools can buy inhalers and spacers (these are enclosed plastic vessels which make it easier to deliver asthma medicine to the lungs) from a pharmaceutical supplier, such as a local pharmacy, without a prescription, provided the general advice relating to these transactions are observed. Schools can buy inhalers in small quantities provided it is done on an occasional basis and the school does not intend to profit from it. Please note that pharmacies are not required to provide inhalers or spacers free of charge to schools: the school must pay for them as a retail item.

A supplier will need a request signed by the principal or head teacher (ideally on appropriately headed paper) stating:

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

Schools may wish to discuss with their community pharmacist the different plastic spacers available and what is most appropriate for the age-group in the school. Community pharmacists can also provide advice on use of the inhaler.

The emergency kit

An emergency asthma inhaler kit should include:

- a salbutamol metered dose inhaler;
- at least two plastic spacers compatible with the inhaler;
- instructions on using the inhaler and spacer;
- instructions on cleaning and storing the inhaler;
- manufacturer's information;
- a checklist of inhalers, identified by their batch number and expiry date, with monthly checks recorded;
- a note of the arrangements for replacing the inhaler and spacers (see below);
- Guidance on the use of emergency salbutamol inhalers in schools
- a list of children permitted to use the emergency inhaler (see section 4) as detailed in their individual healthcare plans;
- a record of administration (i.e. when the inhaler has been used).

Schools should consider keeping more than one emergency asthma kit, especially if covering more than one site, to ensure that all children within the school environment are close to a kit. The experience of some respondents to the consultation on this guidance suggested a stock of 5 spacers would be adequate for a typical school.

Salbutamol

Salbutamol is a relatively safe medicine, particularly if inhaled, but all medicines can have some adverse effects. Those of inhaled salbutamol are well known, tend to be mild and temporary and are not likely to cause serious harm. The child may feel a bit shaky or may tremble, or they may say that they feel their heart is beating faster.

The main risk of allowing schools to hold a salbutamol inhaler for emergency use is that it may be administered inappropriately to a breathless child who does not have asthma. It is essential therefore that schools ensure that the inhaler is only used by children who have asthma or who have been prescribed a reliever inhaler, and for whom written parental consent has been given. Section 5 provides essential information on the safe use of an inhaler.

Storage and care of the inhaler

A school's asthma policy should include staff responsibilities for maintaining the emergency inhaler kit. It is recommended that at least two named volunteers amongst school staff should have responsibility for ensuring that:

- on a monthly basis the inhaler and spacers are present and in working order, and the inhaler has sufficient number of doses available;
- that replacement inhalers are obtained when expiry dates approach;
- replacement spacers are available following use;

- the plastic inhaler housing (which holds the canister) has been cleaned, dried andreturned to storage following use, or that replacements are available if necessary.
- Schools will wish to ensure that the inhaler and spacers are kept in a safe and suitably central location in the school, such as the school office, or staffroom, which is known to all staff, and to which all staff have access at all times, but in which the inhaler is out of the reach and sight of children. The inhaler and spacer should not be locked away.

The inhaler should be stored at the appropriate temperature (in line with manufacturer's guidelines), usually below 30C, protected from direct sunlight and extremes of temperature. The inhaler and spacers should be kept separate from any child's inhaler which is stored in a nearby location and the emergency inhaler should be clearly labelled to avoid confusion with a child's inhaler. An inhaler should be primed when first used (e.g. spray two puffs). As it can become blocked again when not used over a period of time, it should be regularly primed by spraying two puffs.

To avoid possible risk of cross-infection, the plastic spacer should not be reused. It can be given to the child to take home for future personal use. Guidance on the use of emergency salbutamol inhalers in schools

The inhaler itself however can usually be reused, provided it is cleaned after use. The inhaler canister should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place The canister should be returned to the housing when it is dry, and the cap replaced, and the inhaler returned to the designated storage place. However, if there is any risk of contamination with blood (for example if the inhaler has been used without a spacer), it should also not be re-used but disposed of.6

Disposal

Manufacturers' guidelines usually recommend that spent inhalers are returned to the pharmacy to be recycled, rather than being thrown away. Schools should be aware that to do this legally, they should register as a lower-tier waste carrier, as a spent inhaler counts as waste for disposal. Registration only takes a few minutes online, and is free, and does not usually need to be renewed in future years.
https://www.gov.uk/waste-carrier-or-broker-registration

Appendix E

The Old Hall School

Diabetic Policy

The incidence of diabetes amongst children and young people is increasing. Within Europe, the UK has the highest number of children diagnosed with diabetes and the lowest number of children achieving good diabetes control (DOH 2007).

Diabetes management can affect daily activities such as school attendance, participation in co-curricular activities, social inclusion and family life, having an impact on the child's mental health, emotional wellbeing and development (DOH 2007).

It has been shown however, that improved management and control of diabetes in children can improve academic performance and school attendance, reduce hospital admissions, and reduce the chances of developing long term complications of diabetes (DCCT 1993).

The Department of Health (2007) therefore recommends that children and young people be offered a range of diabetes management options and support which has the potential to improve control and encourage/enable self management, and hence lessen the impact diabetes has on their lives.

What does this mean for school?

Diabetes management can be in the form of multiple daily injections or a small computerised pump (Continuous subcutaneous insulin infusion). Staff should be aware of which therapy the child is receiving.

Schools should try to provide good levels of support which enable parents to work rather than having to attend school to test blood glucose levels, administer insulin or deal with concerns regarding the pump. They should provide an appropriate environment for these activities and allow children with diabetes to take part in the full range of school activities (DOH 2007).

This requires:

- Completion of a Medical Management Plan.
- Storage of blood glucose monitoring equipment, insulin pen and insulin, and hypoglycemia treatments in accordance with school policy on the safe storage of medicines in school.
- Maintenance of consumables needed for diabetes management in school via student's parents/guardian.
- Safe storage of used sharps in an approved container – provided and disposed of by parents.
- Record of diabetes related activities performed by/on behalf of the student.

Due to the layout of our school, diabetic children will carry their blood glucose monitor and fast acting glucose with them to enable the rapid detection and treatment of hypoglycaemia. This will not only encourage and support self-management and reduce time spent out of class but also reduce delays in hypoglycemia treatment.

Treatment of hypoglycaemia (low blood sugar):

Wash hands and check blood glucose. If below 4mmols/l, give 10-20 grams of fast acting carbohydrate to eat or drink eg. 3-6 glucose tablets, Fruit Pastilles, Starburst sweets or 100-200mls squash (non-diet). Wait 15 mins then re-check blood glucose levels. If still below 4 mmols/l, give more sugary food as above.
If blood glucose is still below 4mmols/l refer to the child's specific care plan for next steps. Once levels are above 4 mmols/l, then give some starchy food such as 2 biscuits, packet of crisps, cereal bar or next meal if due.

If the child is unconscious, having a seizure (convulsion), or unable to swallow effectively, place in the recovery position and call an ambulance (999 or 112). Do not give anything by mouth.

Treatment of hyperglycemia (high blood sugar):

Allow easy access to drinks and toilet facilities. Be aware that concentration levels, energy levels and mood will probably be affected by high blood glucose levels. If unwell in any way, e.g. headache, nausea, vomiting, lethargy, contact parents.

Appendix F

The Old Hall School

Epilepsy Policy

Epileptics

Epilepsy is a tendency to brief disruption in the normal electrochemical activity of the brain, which can affect people of all ages, backgrounds, and levels of intelligence. It is not a disease or an illness, but it may be a symptom of some physical disorder. However its cause especially in the young may have no precise medical explanation.

Tonic Clonic Seizures (arinal mal)

The person may make a strange cry and fall suddenly. Muscles first stiffen and then relax, and jerking or convulsive movements begin which can be quite vigorous. Saliva may appear around the mouth and the person may be incontinent.

Complex and partial seizures (temporal lobe seizures)

These occur when only a portion of the brain is affected by excessive electrical discharge. There may be involuntary movements, such as twitching, plucking at clothing or lip smacking. The person appears conscious but may be unable to speak or respond during this form of seizure. Ensure safety of the person, gently guide them away from dangers and speak calmly to the person and stay with them until they recover.

Absence (petit mal)

This can easily pass unnoticed .The person may appear to daydream or stare blankly. There are very few signs of an absence/petit mal seizure. This can lead to serious learning problems as the seizures may be frequent and the person does not receive any visual or aural messages during those few seconds. Therefore it is so important to be understanding, note any petit mals and inform parents.
Teachers can play an important role in the recognition of epilepsy and in the recognition of changing patterns or an increased rate of seizures.

Procedure for an epileptic seizure

Total seizure (total clonic)

- Keep calm**-** pupils will tend to follow your example! Let the seizure follow its own course. It cannot be stopped or altered.
- Ask the other pupils to leave the room and ask a responsible pupil to fetch another adult.
- Call or send for help from the school matron (located in her room and on ext 729)
- If the school matron is not available, call for a First Aider contact the school office and they will let you know the location of the nearest first aider.
- Note the time
- Refer to the pupils individual health care plan
- If the pupil has emergency medication ask a member of staff to collect it from the matron's room.
- Administer the prescribed medication as per instruction kept with the emergency medication according to the individual health care plan.
- Protect the pupil from harm. Only move the pupil during the seizure if you have to for their protection. If possible move any objects that may hurt them, rather than move them from dangerous objects.
- As soon as possible (normally post seizure) place the pupil on their side; this does not have to be a true recovery position just so that the tongue falls forward so that any saliva can drain out of the mouth easily.
- Put something under their head to protect them from facial abrasions if at all possible.
- Try not to leave the pupil alone if at all possible. If you need to leave the pupil make sure there is something behind their back to try to maintain a sideward's position.
- Talk quietly to the pupil to reassure them but do not try to restrain any convulsive movements.
- Do not place anything in their mouths.
- Minimise any embarrassment as during the fit the pupil may be incontinent, cover them with a blanket to keep warm.
- Once recovered, move them to the matron's room.
- If possible ask other pupils to leave matrons room
- Allow the pupil to sleep on their side. Do not leave them alone as the seizure may be the first of a cluster, leave with the matron or First Aider.
- Call the pupil's parent or guardian and request the pupil to be collected from school so that they can sleep as long as they need to. If the seizure occurs in the morning they may even be able to return to school in the afternoon. This is a very individual decision and will be up to the parents to decide.
- If the seizure lasts five minutes or longer, call an ambulance immediately.
- If a seizure lasts that long it is likely to last longer. It is very important that the pupil goes to hospital and gets the proper treatment within one hour of the beginning of the seizure. If you are concerned or the pupil has received an injury e.g. due to a fall, call an ambulance. We are advised it is better not to call an ambulance if the seizure lasts less than 5 minutes as they are better off left in peace and quiet.
- When the ambulance arrives, report to the paramedic details of the seizure, especially how long it has lasted. If the parent arrives, report the details of the seizure to them.

- An appropriate member of staff must accompany the pupil in the ambulance and stay with them until the parents arrive.
- Ensure that any pupils who were present during the seizure have a chance to talk it over with the school matron or another appropriate member of staff.

Policy

Old Hall School recognises its responsibility in dealing with pupils with epilepsy appropriately

- Old Hall School understands the importance of ensuring the pupils feel safe and secure.
- Old Hall School recognises that epilepsy is a common condition affecting many pupils and welcomes pupils with epilepsy.
- Old Hall School encourages, helps and supports pupils with epilepsy to achieve their potential and to participate fully in aspects of school life.
- Pupils with epilepsy will have an individual health care plan.
- All Old Hall School staff through reading this document should have a clear understanding of the condition epilepsy and what to do in the event of a pupil having an epileptic seizure.
- Some pupils may have emergency medication but it is not carried by the pupil so it is vital that all staff know this is kept in the matron's room.
- The school Matron provides training for all staff on the use of epileptic emergency medication.
- Pupils are encouraged through the schools PSHE programme to understand their condition so that they can support their friends.
- Old Hall School advises pupils with epilepsy to provide spare clothing to be kept in school, especially underwear and socks.
- All staff teaching and non-teaching will be informed of pupils with epilepsy by the school matron.
- A printout of pupil's medical conditions and individual health care plans is available to all staff and is kept confidentially and are available from the school matron.
- Advice and further information is available from the school matron.

Old Hall School is committed to working in partnership with all parties to ensure the policy is implemented and maintained and to ensure effective communication of the policy.

Appendix G

The Old Hall School

Anaphylactic Shock Policy

This policy has been written with advice from The Anaphylaxis Campaign, Shropshire's Acute and Community Children's Services, the Governing Body and pupils.

Background

Anaphylaxis (reaction to a particular substance e.g. nuts, peanuts, eggs, wasp stings, bee stings) is a serious, potentially life threatening, condition affecting an increasing number of people. The Old Hall School positively welcomes all children with anaphylaxis. We encourage pupils who suffer from anaphylaxis to achieve their potential in all aspects of school life, by having a clear policy that is understood by school staff and pupils.

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

The school environment must be favourable to children with anaphylaxis.

Teaching and catering staff are notified of **all** children with food allergies. At meal times, children requiring a special diet use a grey tray to reinforce this. No nuts are used in the menu or allowed in the school. Whenever the planned curriculum involves cookery and experiments with food items, known to cause an allergic reaction, suitable alternatives and measures will be taken.

Records

All new parents are sent an Anaphylaxis Card in their enrolment packs and are requested to complete it if their child suffers from any allergy requiring the prescribed use of an Epipen. Parents of children on the NHS Anaphylactic Register must also send a copy of their care plan to Matron. Cards are updated annually. Epipens and antihistamines will only be administered following completion of an Anaphylaxis Card.

The card is used to maintain an Anaphylaxis Register, which is kept in Matron's room. This records likely causes of an anaphylactic reaction, foods to be excluded from the child's diet and the signs and symptoms of which to be aware. This information is also stored on the child's medical record.

A copy of the Anaphylaxis Card will be kept with the child's spare Epipen and with the class teacher.

Each child with an allergy of this severity has a notice, with their photograph. This details their allergies and where their Epipen is located. These are kept in Matron's room and the staff room. These records are also accessible to all staff on the school server.

Epipens (Auto-injector)

Immediate access to a child's auto-injector is essential. Matron will be responsible for checking the expiry date of any Epipens kept with her, and will notify the parents before expiry. Parents will be responsible for providing the school with an "in-date" Epipen and updating the school about all aspects of their child's anaphylaxis.

Lower School Children

Two auto-injectors for our younger children will be kept in a labelled, unlocked cupboard, in Matron's room. One Auto-injectors will be kept as a spare or as a second dose if needed in an emergency.

On educational visits the auto-injector must be taken. Matron will pack the Epipen along with the asthma inhalers needed for the trip. The class teacher must ensure that the Epipen is taken and take responsibility for it.

If a child does not have an auto-injector in school, they will not be allowed to attend and must either remain in school or be collected by a parent.

Upper School Children

Two auto-injectors for our Upper School children will be kept in a labelled, unlocked cupboard, in Matron's room. One Epipen will be kept as a spare or as a second dose if needed in an emergency.

On educational visits and sports fixtures the Epipen must be taken. It is the responsibility of the teacher organising visits and sports fixtures, to make sure that the child has an Epipen with them. The teacher should then take responsibility for it.

Transfer of Medical Skills
A qualified instructor will give training sessions regularly, to members of staff who wish to receive it. No member of staff **has** to administer an Epipen; but do so on a purely voluntary basis.
Training will detail symptoms of anaphylactic reaction and the stages and procedures for administration of medication.

Staff Indemnity and Training
The Old Hall School fully indemnifies its staff against claims for negligence, providing they are acting within the scope of their employment, have been suitably trained and are following The Old Hall guidelines. For the purposes of indemnity, the administration of medicines falls within this definition and hence staff can be assured about the protection their employer provides.
The indemnity would cover the consequences that might arise where an incorrect dose was inadvertently given or where the administration was overlooked.
Staff training will occur on an annual basis (at the start of the academic year) and all new staff that join will go through this as part of their induction.

Common Allergens
Bee/wasp stings; drugs; foods such as nuts, especially peanuts; eggs; shellfish and cows milk.

IN THE EVENT OF A MILD ALLERGY:

Common signs of an attack may include:

Mild-moderate allergy
- Feeling unwell
- Restlessness
- Itching/sneezing
- Metallic taste in the mouth
- Urticarial rash (nettle)
- Flushed face and neck
- Nausea/vomiting

IN THE EVENT OF A SEVERE ALLERGY:
Severe allergy
- Difficulty in swallowing
- Difficulty in breathing
- Unable to talk
- Blue lips
- Pale and clammy
- Weakness
- Collapse

Symptoms can appear in a few seconds or up to a couple of hours after exposure.
Not all of these symptoms may be present at the same time.

Triggers may vary depending on Individual plans. Matrons will have information on all those students who have allergies and a list will be available to all staff at the beginning of term, whilst the catering team will also be informed prior to any child starting at the school.

EMERGENCY TREATMENT

Two adults present

1st adult phone ambulance 999 or 112 (if no reception from a mobile). Stating <u>Anaphylaxis reaction giving adrenaline.</u>

Second adult – give auto-injector
- Remove cap from end.

- Place on the upper outer side of the thigh.
- Press until click is heard – **hold down** for a count of 10.
- Give a used auto-injector to the ambulance crew.
- Remain with the child and check breathing and pulse.
- If no improvement give a second auto-injectorEpipen, if available after 5 minutes.
- Head and parents to be informed at the earliest opportunity after the incident.

Children in the school are taught about anaphylaxis in a sensible manner. This is done during PSHE lessons.

The Old Hall School works in partnership with all interested parties, including staff, parents, Governors, doctors and children to ensure this policy is implemented and maintained successfully.

Appendix G

The Old Hall School

Head Injury & Concussion Policy 2024

Introduction:

Old Hall School takes any injury or knock to the head very seriously. We understand that in most cases children do not suffer any concussion but unless they are closely monitored it can be easy to miss symptoms or have delayed concussion.

Despite many precautions being taken, risks being assessed, activities carefully planned and close supervision; children can still knock their heads.

Head injuries most commonly occur:

1. In the classrooms in day to day lessons.
2. On the playground and on play apparatus
3. During sporting activities (practices and matches)

Head injuries do tend to occur more in contact sports such as Rugby and Hockey. Therefore Old Hall and Wrekin College follow the International Rugby Board Graduated ReturnTo Play (GRTP) programme across all sports/activities within the school setting, which have been adopted by the Rugby Football Union (RFU) and England Hockey for use by all schools and clubs.

We believe the benefits that sport brings to a pupil far outweigh the risks involved. However, it is important to recognise and mitigate those risks by implementing strategies and managing them effectively.

Concussion is one of the possible risks associated with sports and pupil welfare is the priority when managing any case of concussion. We trust and implore pupils, parents,staff and external coaches to collaborate with the school and be honest about reporting any issue with concussion that has either occurred in or out of school hours.

Research shows the significantly increased risk to children/adolescents if concussion is not managed appropriately as their brains are still developing. Repeat concussions before a full recovery has been made could significantly interfere with academic performance and have potential to result in permanent neurological impairment.

Head Injury/Concussion Protocol at Old Hall

1. If a student receives a knock on the head, or shows obvious signs and symptoms of concussion, the teacher will stop the child from taking part in their activity and will either:

A, (If on school premises) Take the child immediately to the School Matron for an initial assessment and receive appropriate first aid treatment
B, (If Off-site) Be assessed by the dedicated first-aider from Old Hall and receive appropriate first aid treatment

2. In all instances, the child will be given a red band to wear on their wrist to highlight to parents, carers, other teachers and students that they have had a head knock that day and the parents will be contacted by phone. If the Matron and parents are happy that the child has not sustained any obvious injury ,then they may be able to continue with activities but still wearing the wristband. The child will be monitored and Games staff/ Form teacher made aware by the Matron or accompanying member of staff.

3. If Matrons deem after an initial assessment that the child has suspected concussion then the school Matron/First -Aider will be advising the parent to take the child to A&E or to see a GP that day. Child to stay and rest with matron until collected or until child feels better, with observation checklist (see symptoms above) carried out every 15 minutes.

4.We would also insist on the child not taking part in any sporting activities for 48hrs if they have sustained bruising, are cut or marked and have taken a substantial blow to the head..

5. Any child playing sport with suspected concussion, must be removed from play – the decision should not be left to the player as they are usually not thinking correctly. "**IF IN DOUBT SIT THEM OUT**"

What is Concussion?

A common misbelief is that concussion involves a loss of consciousness. This is only the case in 10% of concussions and actually the various symptoms of concussion can be far more subtle and harder to spot.

Concussion is a complex process caused by trauma that transmits force to the brain either directly or indirectly and results in temporary impairment of brain function. Its development and resolution are rapid and spontaneous. Concussion is associated with a graded set of clinical signs and symptoms that resolve sequentially. Concussion reflects a functional rather than structural injury and standard neuro-imaging is typically normal.

Common early signs and Symptoms of concussion

Onset of Symptoms

It should be noted that the symptoms of concussion can first present at any time (but typically in the first 24 – 48 hours) after the incident which caused the suspected concussion.

Symptoms	Evidence
Physical signs	Headache, dizziness,"feeling in a fog", loss of consciousness, vacant expression,stomach ache, vomiting, inappropriate playing behaviour, unsteady on legs,slowed reactions
Visual disturbances	Headache, dizziness,"feeling in a fog", Loss of consciousness, vacant expression, inappropriate

	playing behaviour, unsteady on legs,slowed reactionsVisual disturbances such as blurred or "fuzzy" vision. Not feeling 'right'.
Behavioural changes	Inappropriate emotions, irritability, feeling nervous or anxious Sleep disturbance Drowsiness

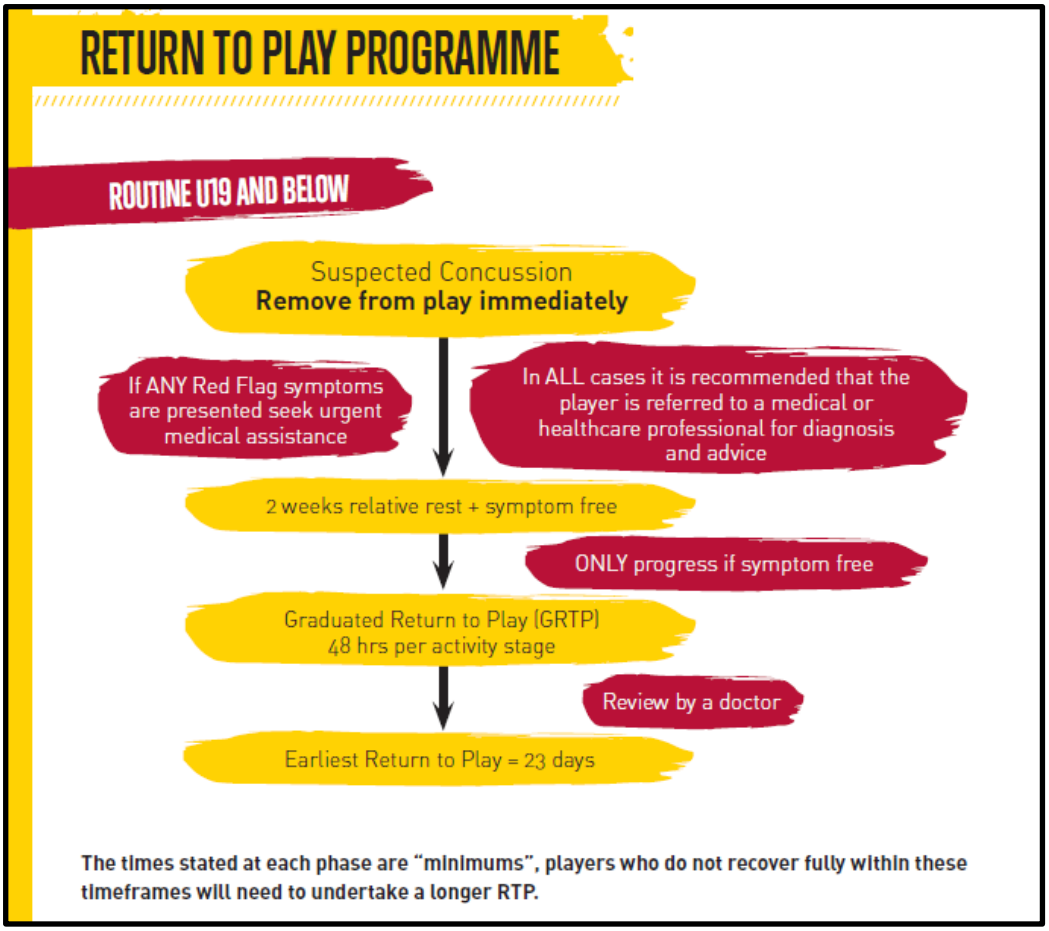
If a pupil is suspected of concussion they will rest and if symptom free, progress in the Graduated Return To Play protocol (GRTP) stated below as recommended for ages U19 and below.

Summary Principles

a. All staff involved in games and sporting activities MUST complete the RFU online course. b. Concussion must be taken extremely seriously to safeguard the long-term welfare of players.
c. Players suspected of having concussion must be removed from play and must not resume play in the match.
d. Players suspected of having concussion must be medically assessed.
e. Players suspected of having concussion or diagnosed with concussion must go through a graduated return to play protocol (GRTP).
f. The minimum period it takes for a player to return to matches following concussion is 23 days.
g. Players must receive medical clearance from their GP before returning to full training and play.

What should players do to return back to playing full contact rugby?

The routine Return to Play Pathway is shown in the diagram below following a diagnosed or suspected concussion.
(according to RFU Guidelines):



The GRTP follows 6 stages that a player must go through every 24hrs before they can return to full contact rugby.

Players should not be forced or be pressured to return to play until they have completed their GRTP. Concussion is taken seriously and can have a huge effect on a person short and long term.

Below is the **GRTP** Six-Stage Process:

Stage	Rehabilitation Stage	Exercise Allowed	Objective
1	Rest	Complete physical and cognitive rest without symptoms	Recovery
2	Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity, <70% maximum predicted heart rate. No resistance training.	Increase heart rate and assess recovery
3	Sport-specific exercise	Running drills. No head impact activities.	Add movement and assess recovery
4	Non-contact training drills	Progression to more complex training drills, e.g. passing drills. May start progressive resistance training.	Add exercise + coordination, and cognitive load. Assess recovery
5	Full Contact Practice	Normal training activities	Restore confidence and assess functional skills by coaching staff. Assess recovery
6	Return to Play	Player rehabilitated	Safe return to play once fully recovered.

Rest

Individuals should avoid the following initially and then gradually re-introduce them:

- Reading
- TV
- Computer games

It is reasonable for a pupil to miss a day or two of academic studies but extended absence is uncommon. Start Graduated Return To Play (GRTP) once all symptoms have resolved and cleared to do so by a doctor.

As part of the process it is also prudent that the child's form tutor consult with the academic teacher(s) to ensure that their academic performance has returned to normal prior to commencing their GRTP.

We also ask parents to inform any club or external team for which a pupil plays, in order for the pupil to be managed appropriately in accordance with the GRTP protocol. Vice-Versa, if a child suffers a head injury or symptoms of concussion at the weekend then they must inform school as a duty of care for their child.

It must be emphasised that these are minimum return to play times and players who do not recover fully within these timeframes will need to longer.

Under the GRTP protocol:

1. The player can proceed to the next Stage if no symptoms of concussion are shown at the current Stage (that is, both the periods of rest and exercise during that 48-hour period).

2. Where the player completes each Stage successfully without any symptoms, the player would take 23 days to complete their rehabilitation (this includes the 14-day rest period).

3. If any symptoms occur while progressing through the GRTP protocol, the player must return to the previous Stage and attempt to progress again after a minimum 24-hour period of rest has passed without the appearance of any symptoms.

4. After Stage 4 the player resumes full contact practice. Full contact practice equates to return to play for the purposes of concussion.

5. However,return to play itself shall not occur until Stage 6.

6. The player must see their Doctor in order to proceed to Stage 5 and the School Matron prior to being selected for matches.

Please see useful links in relation to Rugby and Concussion:

HEADCASE_Essential-Guide_Aug_2023.pdf (keepyourbootson.co.uk)

Concussion Guidance | World Rugby

UK-Grassroots-Concussion-Guidelines-April-2023.pdf (keepyourbootson.co.uk)

Head injury and concussion - NHS (www.nhs.uk)

Head Bump Policy

Any child who has a bump to the head, however minor, must be seen and checked by Matron or a qualified first aider.

Bump to the head

A bump to the head is common in children. If a child is asymptomatic i.e. there is no bruising swelling, abrasion, mark of any kind or symptoms, such as dizziness, headache, confusion, nausea or vomiting and the child appears well this incident will be treated as a bump rather than an injury .

In this instance:

- The child will be given a wristband clearly stating head bump, parents will be sent a head bump email (see below).
- Teachers will be made aware that the child has had a head bump and to keep an eye on them.
- This will be recorded on the child's individual ISAMS medical record.

OLD HALL

Your child suffered a slight head bump today.

A cold compress has been applied and your child was fully alert. We have also kept a close eye on your child and there have been no further problems.

Occasionally other symptoms can occur after some delay. These could include dizziness, nausea, headache, blurred vision or unusual drowsiness. In these circumstances, we would advise you to seek medical advice.

Regards,
Matron

Minor head injury

A minor head injury often just causes lumps or bruises on the exterior of the head. Other symptoms include:

- Nausea
- Mild headache
- Tender bruising or mild swelling of the scalp
- Mild dizziness

In these circumstances:

- **Head Injury Alert – Name of Pupil**
  Please be aware that this pupil has suffered a head injury today. They have been monitored and assessed to be fit to remain in school. Please be alert to any changes in their condition and notify Matron asap if you have any concerns.

- This will be recorded on the child's individual ISAMS record. If the injury was caused by an accident, the accident book should be filled in by whoever witnessed the incident.
- Head injury advice sheet will be emailed to parents (appendix I).

Severe head injury

A severe head injury will usually be indicated by the following

- Unconsciousness briefly or longer
- Difficulty in staying awake
- Seizure
- Slurred speech
- Visual problems including blurred or double vision
- Difficulty in understanding what people are saying /disorientated/confused
- Balance problems
- Loss of power in arms/legs/feet
- Pins and needles
- Amnesia
- Leakage of clear fluid from nose or ears
- Bruising around eyes/behind ears
- Vomiting
- Neck pain

Severe Head Injury Protocol:

- If unconscious, you should suspect a neck injury and do not move the child
- Call 999 for an ambulance
- Contact parents asap
- If the ambulance service assesses over the phone and determines that an ambulance is not needed, the child is to be sent home.
- Parents to be given appropriate advice when collecting their child (and given appendix I).

- Incident to be reported on Child's individual ISAMS record and if the injury was caused by an accident the accident book to be filled in by witness.

Return to school:

Matron to liaise with parents to determine the nature of activities to be allowed in school, upon the child's return to school. Matron also liaises with the PE/Games department. It is ultimately the parents' responsibility to give permission for the child to return to PE/sports activities.

Appendix I

ADVICE TO PARENTS AND CARERS CONCERNING CHILDREN WITH HEAD INJURIES

Your child has sustained a head injury and, following a thorough assessment, we are satisfied that the injury does not appear to be serious.

Please refer to NHS Head Injury Advice Sheet: https://what0-18.nhs.uk/professionals/gp-primary-care-staff/safety-nettingdocuments-parents/head-injury

If you are concerned, please CONTACT YOUR DOCTOR, NHS 111 OR CONTACT THE ACCIDENT AND EMERGENCY DEPARTMENT.

In addition:

- Do expect the child to feel 'off colour'.
- Do not force them to eat, but make sure they have enough to drink.
- Do expect the child to be more tired than usual. Allow them to sleep if they want to. Check on them every 2 hours in the first 24 hours. Do not be confused between normal sleep and unconsciousness – someone who is unconscious cannot be woken up – you need to be satisfied they are reacting normally to you.
- Do expect the child to have a slight headache.
- Do keep the child quiet and resting as much as possible. Keep them away from school, discourage active games, watching TV and reading until the symptoms subside.

These symptoms should improve steadily and the child should be back to normal within a few days. Even after a minor injury, complications may occur, but they are rare.

If the symptoms worsen, or if you notice the following signs:

- Difficulty in waking from sleep
- Appears confused or not understanding what is said to them
- Vomiting
- Complaining of severe headache, or trouble with their eyesight
- Become irritable
- Has any kind of attack which you think is a fit

Then you are advised to:

CONTACT YOUR DOCTOR, NHS 111 OR CONTACT THE ACCIDENT AND EMERGENCY DEPARTMENT WITHOUT DELAY.