

# Specific Medical Conditions

The medical conditions that most commonly cause concern in schools/settings are:

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This supporting document provides some basic information about these conditions but it is beyond its scope to provide more detailed medical advice and it is important that the needs of children/young people are assessed on an individual basis.

## Diabetes

Diabetes UK Careline      0345 123 2399 (Mon-Fri: 9am - 6pm)

[www.diabetes.org.uk](http://www.diabetes.org.uk)

### What is Diabetes?

Diabetes is a condition where the level of glucose in the blood rises due to a lack of insulin (Type 1 diabetes) or because there is insufficient insulin for the child/young person's needs or the insulin is not working properly (Type 2 diabetes).

About one in 550 school-age children have diabetes. The majority of children/young people have Type 1 diabetes. They normally need to have daily insulin injections, to monitor their blood glucose level and to eat regularly according to their personal dietary plan. Children with Type 2 diabetes are usually treated by diet and exercise alone.

Each child/young person may experience different symptoms and this should be discussed when drawing up the individual healthcare plan. Greater than usual need to go to the toilet or to drink, tiredness and weight loss may indicate poor diabetic control and staff will naturally wish to draw any such signs to the parents' attention.

### Medicine and Control

The diabetes of the majority of children/young people is controlled by injections of insulin each day. Most children will be on a once a day regime of a longer acting insulin and it is unlikely that this will need to be given during school/setting hours, although for those who do it may be necessary for an adult to administer the injection. Young people may be on multiple injections and others may be controlled on an insulin pump. Most children/young people can manage their own injections, but if doses are required at school/setting supervision will be required along with a suitable, private place to carry it out.

Increasingly, young people are taught to count their carbohydrate intake and adjust their insulin accordingly. This means that they have a daily dose of long acting insulin at home; usually before bedtime; and then insulin with breakfast, lunch and the evening meal, and before substantial snacks. The child/young person is taught how much insulin to give with each meal, depending on the amount of carbohydrate eaten.

They may or may not need to test blood sugar prior to the meal and to decide how much insulin to give. Diabetic specialists would only implement this regime when they were confident that the child/young person was competent.

The child/young person is then responsible for the injections and the regime would be set out in the individual healthcare plan.

Children/young people with diabetes need to ensure that their blood glucose levels remain stable and may check their levels by taking a small sample of blood and using a small monitor at regular intervals. They may need to do this during the school/setting lunch break, before PE or more regularly if their insulin needs adjusting. Young people will be able to do this themselves and will simply need a suitable place to do so. However, young children may need adult supervision to carry out the test and/or interpret test results.

When staff agree to administer blood glucose tests or insulin injections, they should be trained by an appropriate healthcare professional.

Continuous glucose monitoring (CGM) is a system being used more and more and allows blood sugar levels to be checked without having to prick a finger. CGM gives information about glucose levels every few minutes, allowing the user to see a graph of glucose levels rather than just a single measurement at a given point in time. The user (or parent/guardian) inserts a sensor that measures the glucose level in the tissue just below the skin. The CGM sensor connects to a transmitter that beams the glucose data to a receiver, which can be either a handheld device or an insulin pump. The sensor is worn for six or more days and then replaced with a new one.

Children/young people with diabetes need to be allowed to eat regularly during the day. This may include eating snacks during class time or prior to exercise. Special arrangements for children/young people with diabetes will need to be made if the school/setting has staggered lunchtimes. If a meal or snack is missed, or after strenuous activity, the child/young person may experience a hypoglycaemic episode (a hypo) during which blood glucose level fall too low. Staff in charge of physical education or other physical activity should be aware of the need for a child/young person with diabetes to have glucose tablets or a sugary drink to hand.

Staff should be aware that the following symptoms, either individually or combined, may be indicators of low blood sugar - a **hypoglycaemic reaction** (hypo) in a child/young person with diabetes:

- hunger
- sweating
- drowsiness
- pallor
- glazed eyes
- shaking or trembling
- lack of concentration
- irritability
- headache
- mood changes, especially angry or aggressive behaviour.

Each child/young person may experience different symptoms and this should be discussed when drawing up the individual healthcare plan.

If a child/young person has a hypo, it is very important that the child/young person is not left alone and that a fast acting sugar, such as glucose tablets, a glucose rich gel or a sugary drink to brought to the child/young person and given immediately. Slower acting starchy food, such as a sandwich or two biscuits and a glass of milk, should be given once the child/young person has recovered, some 10 - 15 minutes later.

An ambulance should be called if:

- the child/young person's recovery takes longer that 10 - 15 minutes
- the child/young person becomes unconscious.

Some children/young people may experience **hyperglycaemia** (high glucose level) and have a greater than usual need to go to the toilet or to drink. Tiredness and weight loss may indicate poor diabetic control and staff will naturally wish to draw any such signs to the parents' attention. If the child/young person is unwell, vomiting or has diarrhoea this can lead to dehydration. If the child/young person is giving off a smell of pear drops or acetone this may be a sign of ketosis and dehydration and the child/young person will need urgent medical attention.

Such information should be an integral part of the school/setting's emergency procedures as highlighted in the Supporting Pupils with Medical Conditions Policy but also relate specifically to the child/young person's individual healthcare plan.

## Procedures

When a child/young person has been identified as being at risk of a **hypoglycaemia** or **hyperglycaemia** episode, the school/setting need to take steps to ensure that prompt and efficient action will be taken in accordance with medical advice and guidance. An emergency procedure and protocol should be developed and agreed by the parents, the school/setting and the child's doctor.

The protocol includes:

- emergency procedure
- medication, if agreed
- staff training
- precautionary measures
- consent and agreement.

A protocol forms an agreement that the best possible support is in place for both the child/young person and staff. It may be necessary that child/young persons in secondary schools/settings wear a form of identification of their medical condition as teachers may not be familiar with the child/young person's medical needs, e.g. medi bracelet to alert staff of ill health risk.

An example of a protocol is available on Webshop.

All staff should be informed of the protocol and advised of their responsibilities in case of ill health.

***Once an agreement has been made to administer medication the school/setting will have a responsibility to do so if hypoglycaemia or hyperglycaemia episode occurs***

## Training

All staff responsible for administering the medication named in the protocol must be trained. This can be organised by contacting the healthcare professional. The medication should be kept in school/setting and be easily accessible. It is recommended that several key members of staff are trained to administer the medication.

As in all cases of administering medication, a parental consent form should be completed and kept in school/setting. An example of a consent form is available on Webshop. A record of staff who have received training in the administration of this medicine must be kept and an example of this form is available on Webshop.

When an offsite activity or educational visit takes place, a member of staff trained in administering the medication should attend with the medication, e.g. class teacher/parent.

### What is Epilepsy?

Children/young people with epilepsy have repeated seizures that start in the brain. An epileptic seizure, sometimes called a fit, turn or blackout can happen to anyone at any time. Seizures can happen for many reasons. At least one in 200 children have epilepsy and around 80% attend mainstream school/setting. Most children/young people with diagnosed epilepsy never have a seizure during the school/setting day. Epilepsy is a very individual condition.

Seizures can take many different forms and a wide range of terms may be used to describe the particular seizure pattern for the individual child/young person. Parents and health care professionals should provide information to schools/settings, to be incorporated into the individual healthcare plan, setting the particular pattern of an individual child/young person's epilepsy. If a child/young person does experience a seizure during the school/setting day, details should be recorded and communicated to parents including:

- any factors which might possibly have acted as a trigger to the seizure e.g. visual/auditory stimulation, emotion (anxiety, upset)
- any unusual 'feelings' reported by the child/young person prior to the seizure
- parts of the body demonstrating seizure activity e.g. limbs, facial muscles
- the timing of the seizure - when it happened and how long it lasted
- whether the child/young person lost consciousness
- whether the child/young person was incontinent.

This will help parents to give more accurate information on seizures and seizure frequency to the child/young person's specialist.

What the child/young person experiences depends on whether all or which part of the brain is affected. Not all seizures involve a loss of consciousness. When only a part of the brain is affected, a child/young person will remain conscious with symptoms ranging from the twitching or jerking of a limb to experiencing strange tastes or sensations such as pins and needles. Where consciousness is affected, the child/young person may appear confused, wander around and be unaware of their surroundings. They could also behave in unusual ways such as plucking at clothes, fiddling with objects or making mumbling noises and chewing movements. They may not respond if spoken to. Afterwards they may have little or no memory of the seizure. In some cases, such seizures go on to affect all of the brain and the child/young person loses consciousness. Such seizures might start with the child/young person crying out, then the muscles becoming stiff and rigid. The child/young person may fall down. Then there are jerking movements as muscles relax and tighten rhythmically. During a seizure breathing may become difficult and the child/young person's colour may change to a pale blue or grey colour around the mouth. Some children/young persons may bite their tongue or cheek and/or lose control of their bladder and/or bowels.

After a seizure a child/young person may feel tired, be confused, have a headache and need time to rest or sleep for several hours.

Another type of seizure affecting all of the brain involves a loss of consciousness for a few seconds. A child/young person may appear 'blank' or 'staring' sometimes with fluttering of the eyelids. Such absence seizures can be so subtle that they may go unnoticed. They might be mistaken for daydreaming or not paying attention in class. If such seizures happen frequently they could be a cause of deteriorating academic performance.

## Medicine and Control

Most children/young people with epilepsy take anti-epileptic medicines to stop or reduce their seizures. Regular medicine should not need to be given during school/setting hours.

Triggers such as anxiety, stress, tiredness or being unwell may increase a child/young person's chance of having a seizure. Flashing or flickering lights and some geometric shapes or patterns can also trigger seizures. This is called photosensitivity and it is very rare. Most children/young people with epilepsy can use computers and watch television without any problem.

A child/young person with epilepsy should be included in all activities. Extra care may be needed in some areas such as swimming or working in science laboratories. Concerns about safety should be discussed with the child/young person and their parents as part of the individual healthcare plan.

During a seizure it is important to make sure that the child/young person is in a safe position, not to restrict a child/young person's movements and to allow the seizure to take its course. In a convulsive seizure putting something soft under a child/young person's head will help to protect it. Nothing should be placed in their mouth. After a convulsive seizure has stopped, the child/young person should be placed in the recovery position and stayed with, until they are fully recovered.

An ambulance should be called during a convulsive seizure if:

- it is the child/young person's first seizure
- the child/young person has injured themselves badly
- they have problems breathing after a seizure
- a seizure lasts longer than the period set out in the child/young person's individual healthcare plan
- a seizure lasts for five minutes - if you do not know how long they usually last for a particular child/young person
- there are repeated seizures - unless this is usual for the child/young person, as set out in their individual healthcare plan.

Such information should be an integral part of the emergency procedures and also relate specifically to the child/young person's individual healthcare plan. The individual healthcare plan should clearly identify the type or types of seizures, including seizure descriptions, possible triggers and whether emergency intervention may be required.

Most seizures last for a few seconds and minutes and stop of their own accord. Where a child/young person has longer seizures, a liquid solution midazolam, given into the buccal cavity of the mouth or intra-nasally, may be prescribed. Training in the preparation and administration of buccal midazolam is needed and will be available from healthcare professionals.

Some child/young persons who have longer seizures may be prescribed diazepam for rectal administration. This is an effective emergency treatment for prolonged seizures. The epilepsy nurse or a paediatrician should provide guidance as to when to administer it and why. Training in the administration of rectal diazepam is needed and will be available from healthcare professionals. Staying with the child/young person afterwards is important as diazepam may cause drowsiness.

Children/young people requiring rectal diazepam will vary in age, background and ethnicity and will have differing levels of need, ability and communication skills. It is strongly recommended that arrangements are made for two adults, at least one of the same gender as the child/young person, to be present for such treatment, this minimises the potential for accusations of abuse. Two adults can also often ease practical administration of treatment. Staff should protect the dignity of the child/young person as far as possible, even in emergencies.

## Procedures

When a child/young person has been identified as being at risk of epilepsy, the school/setting needs to take steps to ensure that prompt and efficient action will be taken in accordance with medical advice and guidance. A protocol should be developed and agreed by the parents, the school/setting and the child's doctor/paediatrician.

The protocol includes:

- emergency procedure
- medication, if agreed
- staff training
- precautionary measures
- consent and agreement.

A protocol forms an agreement to ensure that the best possible support is in place for both the child/young person and staff. It may be necessary that children/young people in secondary schools wear a form of identification of their medical condition as teachers may not be familiar with the child/young person's medical needs, e.g. medi bracelet to alert staff of severe ill health risk.

An example of a protocol is available on Webshop.

All staff should be informed of the protocol and advised of their responsibilities in case of ill health.

*Once an agreement has been made to administer medication, the school/setting will have a responsibility to do so if epileptic seizure occurs*

## Training

All staff responsible for administering the medication named in the protocol must be trained. This can be organised by contacting the healthcare professional. The medication should be kept in school/setting and be easily accessible. It is recommended that several key members of staff are trained to administer the medication

As in all cases of administering medication, a parental consent form should be completed and kept in school/setting. An example of a consent form is available on Webshop. A record of staff who have received training in the administration of this medicine must be kept. An example of this form is available on Webshop.

When an offsite activity or educational visit takes place, a member of staff trained in administering the medication should attend with the medication, e.g. class teacher/parent.

## Asthma

Asthma UK Helpline      0300 222 5800 (Mon-Fri: 9am - 5pm)      [www.asthma.org.uk](http://www.asthma.org.uk)

### What is Asthma?

Asthma is common and appears to be increasingly prevalent in children and young people. One in ten children has asthma in the UK.

The most common symptoms of asthma are coughing, wheezing or whistling noise in the chest, tight feelings in the chest or getting short of breath. Younger children may verbalise this by saying that their tummy hurts or that it feels like someone is sitting on their chest. Not everyone will have all of these symptoms, and some children/young people may only have symptoms from time to time.

However, in early years settings, staff may not be able to rely on children being able to identify or verbalise when their symptoms are getting worse, or what medicines they should take and when. It is therefore imperative that early years settings and primary school/setting staff, who have younger children in their classes, know how to identify when symptoms are getting worse and what to do for child/young persons with asthma when this happens. This should be supported by written asthma plans, asthma school/setting cards provided by parents and regular training and support for staff. Children/young people with significant asthma should have an individual healthcare plan.

### Medicine and Control

There are two main types of medicines used to treat asthma, relievers and preventers. Usually a child/young person will only need a reliever during the school/setting day. **Relievers** (blue inhalers) are medicines inhaled immediately to relieve asthma symptoms and are used during an asthma attack. They are sometimes used before exercise. Whilst **preventers** (brown, red, orange inhalers, sometimes tablets) are usually taken out of school/setting hours.

Children/young people with asthma need to have immediate access to their reliever inhalers when they need them. Inhaler devices usually deliver asthma medicines. A spacer device is used with most inhalers and the child/young person may need some help to do this. It is good practice to support children/young people with asthma to take charge of and use their inhaler from an early age and many do.

Children/young people who are able to use their inhalers themselves should be allowed to carry them with them. If the child/young person is too young or immature to take personal responsibility for their inhaler, staff should make sure that it is stored in a safe by readily accessible place, and clearly marked with the child/young person's name. Inhalers should always be available during PE, sports activities and educational visits.

For a child/young person with severe asthma, the health care professional may prescribe a spare inhaler to be kept in school/setting.

The signs of an asthma attack include:

- coughing
- being short of breath
- wheezy breathing
- feeling of tight chest
- being unusually quiet.

When a child/young person has an attack they should be treated according to their individual healthcare plan or asthma card as previously agreed. An ambulance should be called if:

- the symptoms do not improve sufficiently in 5 - 10 minutes
- the child/young person is too breathless to speak
- the child/young person is becoming exhausted
- the child/young person looks blue.

It is important to agree with the parents how to recognise when the child/young person's asthma gets worse and what action will be taken. An asthma school/setting card (available from Asthma UK) is a useful way to store written information about the child/young person's asthma and should include details about asthma medicines, triggers, individual symptoms and emergency contact numbers for the parent and child/young person's healthcare professional.

A child/young person should have a regular asthma review with their healthcare professional. Parents should arrange the review and make sure that a copy of the child/young person's management plan is available in school/setting.

Children/young people with asthma should participate in all aspects of the schools/settings day including physical activities. They need to take their reliever inhaler with them on all offsite activities. Physical activity benefits children/young people with asthma in the same way as other children/young people. Swimming is particularly beneficial, although endurance work should be avoided. Some children/young people may need to take their reliever asthma medicines before any physical exertion. Warm-up activities are essential before any sudden activity especially in cold weather. Particular care may be necessary in cold or wet weather.

Reluctance to participate in physical activities should be discussed with parents, staff and the child/young person. However, children/young people with asthma should not be forced to take part if they feel unwell. Children/young people should be encouraged to recognise when their symptoms inhibit their ability to participate.

Children/young people with asthma may not attend on some days due to their condition and may also at times have some sleep disturbance due to night symptoms. This may affect their concentration. Such issues should be discussed with the parents or attendance officers as appropriate.

All staff, particularly PE teachers, should have training to be provided with information about asthma once per year. This should support them to feel confident about recognising worsening symptoms of asthma, knowing about asthma medicines and their delivery and what to do if a child/young person has an asthma attack.

## **Procedures**

When a child/young person has been identified as being at risk of asthma, the school/setting needs to take steps to ensure that prompt and efficient action will be taken in accordance with medical advice and guidance. An example of an individual healthcare plan that could be used to record the severity of the child/young person's asthma, individual symptoms and allergies, details of medication to be taken and any assistance or emergency action which may be necessary for staff to implement is available on Webshop.

As in all cases of medication in schools/settings, a parental consent form should be completed and kept in school/setting. An example of a consent form is available on Webshop.

## *Anaphylaxis*

The Anaphylaxis Campaign	01252 542029	<a href="http://www.anaphylaxis.org.uk">www.anaphylaxis.org.uk</a>
Allergy UK Helpline	01322 619898	<a href="http://www.allergyuk.org">www.allergyuk.org</a>
Kids' Allergies		<a href="http://www.kidsallergies.co.uk">www.kidsallergies.co.uk</a>

### **What is Anaphylaxis?**

Anaphylaxis is an acute, severe allergic reaction requiring immediate medical attention. It usually occurs within seconds or minutes of exposure to a certain food or substance but on rare occasions may happen after a few hours.

Common triggers include peanuts, tree nuts, sesame, eggs, cow's milk, fish, certain fruits such as kiwi fruit and also penicillin, latex and the venom of stinging insects such as bees, wasps or hornets.

The most severe form of allergic reaction is anaphylactic shock, when the blood pressure falls dramatically and the patient loses consciousness. Fortunately this is rare among young children below teenage years. More commonly among children there may be swelling in the throat, which can restrict the air supply or severe asthma. Any symptoms affecting the breathing are serious.

Less severe symptoms may include tingling or itching in the mouth, hives anywhere on the body, generalised flushing of the skin or abdominal cramps, nausea and vomiting. Even where mild symptoms are present, the child/young person should be watched carefully. They may be heralding the start of a more serious reaction.

### **Medicine and Control**

The treatment for a severe allergic reaction is an injection of adrenaline (also known as epinephrine). Preloaded injection devices containing one measured dose of adrenaline are available on prescription. The devices are available in two strengths - adult and junior.

Should a severe allergic reaction occur, the adrenaline injection should be administered into the muscle of the upper outer thigh. **An ambulance should always be called.**

Staff trained in the use of these devices can be reassured that they are simple to administer. Adrenaline injectors, given in accordance with the manufacturer instructions, are a well understood and safe delivery mechanism. It is not possible to give too large a dose using this device. The needle is not seen until after it has been withdrawn from the child/young person's leg. In cases of doubt it is better to give the injection than to hold back.

The decision on how many adrenaline devices the school/setting should hold and where to store them has to be decided on an individual basis between the headteacher, parents and the healthcare professionals.

Where children/young people are considered sufficiently responsible to carry their emergency treatment on their person, there should always be a spare set kept safely which is not locked away and is accessible to all staff. In large schools/settings or split sites, it is often quicker for staff to use an injector that is with the child/young person rather than taking time to collect one from a central location.

Studies have shown that the risks for allergic reaction are reduced where an individual healthcare plan is in place. Reactions become rarer and when they occur they are mostly mild. The plan will need to be agreed by the parents, the school/setting and the treating doctor.

Important issues specific to anaphylaxis to be covered include:

- anaphylaxis - what may trigger it
- what to do in an emergency
- prescribed medication
- food management
- precautionary measures.

Once staff have agreed to administer medicine to an allergic child/young person in an emergency, a training session will need to be provided by the school/setting health service. Staff should have the opportunity to practice with trainer injection devices.

Day to day policy measures are needed for food management, awareness of the child/young person's needs in relation to the menu, individual meal requirements and snacks in school/setting. When kitchen staff are employed by a separate organisation, it is important to ensure that the catering supervisor is fully aware of the child/young person's particular requirements.

Parents often ask for the headteacher/manager to exclude from the premises the food to which their child is allergic. This is not always feasible, although appropriate steps to minimise any risk to allergic child/young persons should be taken.

Children/young people who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children/young people in every respect - except that if they come into contact with certain foods or substances, they may become unwell. It is important that these children/young people are not stigmatised or made to feel different. It is important, too, to allay parents' fears by reassuring them that prompt and efficient action will be taken in accordance with medical advice and guidance.

Anaphylaxis is manageable. With sound precautionary measures and support from the staff, school/setting life may continue as normal for all concerned.

## **Procedures**

When a child/young person has been identified as being at risk of anaphylaxis, the school/setting need to take steps to ensure that prompt and efficient action will be taken in accordance with medical advice and guidance.

An emergency procedure and protocol should be developed and agreed by the parents, the school/setting and the child's doctor.

The protocol includes:

- emergency procedure
- medication, if agreed
- food management (if food allergy)
- staff training
- precautionary measures
- consent and agreement.

A protocol forms an agreement that the best possible support is in place for both the child/young person and staff. It may be necessary that children/young people in secondary schools wear a form of identification of their medical condition as teachers may not be familiar with the child/young person's medical needs, e.g. medi bracelet to alert staff.

An example of a protocol is available on Webshop. All staff should be informed of the protocol and advised of their responsibilities in case of a reaction.

*Once an agreement has been made to administer medication the school/setting will have a responsibility to do so if anaphylactic shock occurs*

## **Training**

All staff responsible for administering the medication named in the protocol must be trained. This can be organised by contacting the healthcare professional. The medication should be kept in school/setting and be easily accessible. It is recommended that several key members of staff are trained to administer the medication.

As in all cases of administering medication, a parental consent form should be completed and kept in school/setting. An example of a consent form is available on Webshop. A record of staff who have received training in the administration of this medicine must be kept. An example of this form is available on Webshop.

When an offsite activity or educational visit takes place, a member of staff trained in administering the medication should attend with the medication, e.g. class teacher/parent.