

Whitecote Primary School



Medical Conditions Policy (with reference to Supporting Pupils with Medical Conditions Guidance)

Agreed: April 2025

Review: April 2027

Health and Safety Handbook for Schools

SUPPORTING CHILDREN / YOUNG PERSONS WITH MEDICAL CONDITIONS POLICY V1.0 2022 –

**TO BE USED IN CONJUNCTION WITH
PG505 - Supporting pupils with Medical Conditions
in School / DfE document “Supporting pupils at
school with medical conditions”**

Section 5: General School Safety

WHITECOTE PRIMARY SCHOOL

SUPPORTING CHILDREN / YOUNG PERSONS WITH MEDICAL CONDITIONS POLICY

1. Introduction

This policy is written to support those children and young people with individual medical conditions and outlines how their conditions will be met at Whitecote Primary School.

This policy and the supporting guidance [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document "Supporting children / young persons at school with medical conditions"](#) should be read together and aim to ensure that:

1. Children / young people, staff and parents / carers understand how our school will support children / young people with medical conditions.
2. The whole school environment is inclusive and favourable to children and young people with medical conditions. This includes the physical environment, as well as social, sporting, and educational activities.
3. Our staff are trained in the impact medical conditions can have on children and young people in order to be safe, welcoming, and supportive of children and young people with medical conditions.
4. Our school understands that children and young people with the same medical condition will not necessarily have the same needs.
5. Our staff understand their duty of care to children and young people with medical conditions and know what to do in the event of an emergency.

2. Policy Statement

We are an inclusive community that welcomes and supports children and young people with medical conditions. We provide all children and young people with equal opportunities in our school.

This policy and supporting guidance [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document "Supporting children / young persons at school with medical conditions"](#) / meets the requirements under [Section 100 of the Children and Families Act 2014](#), which places a duty on governing boards to make arrangements for supporting children and young peoples at their school with medical conditions. It is also based on the Department for Education's statutory guidance on [supporting children / young persons with medical conditions at school](#).

This policy and supporting guidance [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document "Supporting children / young persons at school with medical conditions"](#) describe the essential criteria for how we will meet the needs of children and young people with short, long-term and / or complex medical conditions, including diabetes and asthma. No child or young person will be denied admission or prevented from taking up a place in this school because arrangements for their medical condition have not been made. However, in line with our safeguarding duties, we must ensure that children / young person's health is not put at unnecessary risk from, for example, infectious diseases. There may be times we cannot accept a child / young person in school where it would be seriously detrimental to the health of that child / young person or others to do so.

All relevant staff understand the medical conditions that affect children and young people at our school. We also make sure all our staff understand their duty of care to children and young people in the event of them requiring medical intervention. We accept responsibility for members of staff who give or supervise children and young people with the taking of medication / medical procedures during the school day.

The named member of our staff responsible for this medical conditions policy and its implementation is the Head Teacher.

3. Roles and responsibilities.

3.1 Our governing body.

Our governing body has ultimate responsibility to make arrangements to support children and young people with medical conditions. Our governing body will also ensure that sufficient staff have received suitable training and are competent before they are responsible for supporting children with medical conditions.

They will do this by:

- Reporting by the school to Teaching, Learning and Pupil Support Governing body meetings,

3.2 Our Headteacher

Our headteacher will:

- make sure all staff are aware of this policy and supporting guidance in [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document "Supporting children / young persons at school with medical conditions"](#) and understand their role in its implementation,
- ensure that there is a sufficient number of trained staff available to implement this policy and deliver against all Educational Health Care Plans (EHCPs), including in contingency and emergency situations,
- ensure that all staff who need to know are aware of a child's condition,
- take overall responsibility for the development and monitoring of EHCPs,
- contact the school nursing service in the case of any children and young people who have a medical condition that may require support at school, but who has not yet been brought to the attention of the school nursing service,
- ensure that systems are in place for obtaining information about a child's medical conditions and that this information is kept up to date,
- ensure that supply and peripatetic staff are made aware of relevant information to support children with medical conditions.

3.3 Our Staff.

Supporting children and young people with medical conditions during school hours is not the sole responsibility of one person. Any member of staff may be asked to provide support to children and young people with medical conditions, although they will not be required to do so unless this is specifically part of their role in school. This includes the administration of medicines.

Our staff will take into account the conditions of children and young people with medical conditions that they teach. All staff will know what to do and how to respond accordingly when they become aware that a child or young person with a medical need requires help.

Our school staff are responsible for:

- following the procedures outlined in this policy and supporting guidance document [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document “Supporting children / young persons at school with medical conditions”](#),
- retaining confidentiality within policy guidelines,
- contacting parents / carers and/or emergency services when necessary and without delay,
- if they have children or young persons with medical conditions in their class or group; understanding the nature of the conditions in order to adequately support them. This information will be provided to them.

The Headteacher has overall responsibility for the development of EHCPs for children / young persons with medical conditions. Health Professionals will write the EHCP and the day-to-day management, production and oversight of EHCPs has been delegated to Jemma Lockwood, SENCO and Karen Johnstone Assistant SENCO.

3.4 Our Parents / Carers.

We expect that our parents / carers:

- will provide the school with sufficient and up-to-date information about their child / young persons medical conditions,
- will be involved in the development and review of their child / young person’s EHCP and may be involved in its drafting,
- will carry out any action they have agreed to as part of the implementation of the EHCP, e.g. provide medicines and equipment, provide up to date asthma plans and any other health plans.
- are responsible for making sure their child / young person is well enough to attend school. Parents / carers should keep children / young people at home when they are acutely unwell.
- will provide medicines and equipment in line with this policy and supporting guidance in [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document “Supporting children / young persons at school with medical conditions”](#) e.g. in original labelled containers, in date and sufficient for the child / young person’s conditions,
- will provide up to date contact information and ensure that they or another responsible adult are contactable at all times for if their child / young person becomes unwell at school,
- will only request medicine or medical procedures to be administered at school when it would be detrimental to their child / young person’s health or school attendance not to do so,
- will provide written agreement before any medicines can be administered to their child / young person,

If an EHCP is required for their child / young person, it is expected that our parents / carers will work with our school and healthcare professionals to develop and agree it.

3.5 Our children and young people.

Children and young people with medical conditions will often be best placed to provide information about how their condition affects them. Our children and young people will be involved as far as possible in discussions about their medical support needs and contribute as much as possible to the development of their EHCPs. They are also expected to comply with their EHCPs.

3.6 School nurses and other healthcare professionals.

We will work with our Local Health Authority School Health Service and Nursing Team to support the medical needs of children and young persons in our school. This may include assistance with supporting medical conditions, assistance with EHCPs, and assistance with supplementing information provided by the child’s or young person’s parents / carers or GP. We will also seek their

advice for where specialist local health teams can be contacted for particular conditions e.g. asthma, diabetes, epilepsy etc.

The School Health Service and Nursing Team are also the main contacts for advice on training for staff to administer medication or take responsibility for other aspects of support.

The School Health Service and Nursing Team will notify our school when a child or young person has been identified as having a medical condition that will require support in school. This will be before the child or young person starts our school, wherever possible. They may also support staff to implement a child's EHCP.

Healthcare professionals, such as GPs and paediatricians, will liaise with the School Health Service and Nursing Team and notify them of any children and young people identified as having a medical condition. They may also provide us advice on developing EHCPs.

4. Storage, administration and management of medications.

4.1 Provision of medication.

We will allow medications to be brought to school when it is essential e.g. where it would be detrimental to a child or young person's health if the medicine was not administered during the 'school day'.

Wherever possible, parents / carers are advised to request that any prescription is such that the child / young person does not need to take any medication whilst at school e.g. a dose-frequency of 3 times per day rather than 4 times per day dose.

We will only accept medication in its original container and with the prescriber's instructions for administration if the medication is prescribed.

We will allow non prescription medication to be provided if it is essential (as above) and needs to be taken during the school day. We will follow the same procedures for all medication.

4.2 Administration of medication.

We will administer medication / medical procedures or supervise the self-administration of medication / medical procedures only where there is specific prior written permission from the parents / carers. Such written consent will need to state the medicine and the dose to be taken / or the details of the medical procedure.

We will follow the detailed guidance in [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document "Supporting children / young persons at school with medical conditions"](#) regarding administration of medication / medical procedures including disposal of out-of-date medication, record keeping and training for staff.

No child or young person under the age of 16 will be given aspirin or medicines containing ibuprofen unless prescribed by a doctor.

4.3 Self-Management.

We will allow and encourage children and young people who are competent to do so, to manage their own medication. This will be based on discussions with the child / young person and their parents / carers. Specific written consent from parents / carers will still be required. Where necessary we will supervise the child or young person whilst they are taking it.

Our school allows the following medication / medical equipment to be carried by our children and young people where it is deemed they are competent, and it is safe to do so:

- Asthma inhalers,
- Auto Injection devices,
- Diabetes devices / insulin
- Other medication may be requested and will be considered on a case-by-case basis.

4.4 Refusal to take medicine.

We will not force a child or young person to take medication / undergo a medical procedure should they refuse.

If information provided by the parent / carer and/or GP suggests that the child or young person is at great risk due to refusal we will contact parents / carers immediately and may also seek medical advice and/or emergency services support.

Where the information provided indicates that they will not be at great risk, but parents / carers have informed us that the medication / medical procedure is required we will contact the parent / carer as soon as possible.

4.5 Storage of medication / medical devices.

We will store, manage, and dispose of out-of-date medication and medical devices in line with the detailed guidance in [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document "Supporting children / young persons at school with medical conditions"](#).

We will ensure that any medication required critically in the case of an emergency e.g. asthma inhalers, Adrenaline Auto Injectors (AAI), insulin, is always readily available wherever the child or young person is on our school premises or off site on school visits / activities.

4.6 Emergency Situations.

Our staff will follow our school's normal emergency procedures (for example, calling 999). All children / young person's EHCPs will clearly set out what constitutes an emergency and will explain what to do.

If a child or young person needs to be taken to hospital, our staff will stay with them until the parent / carer (or designated adult) arrives or accompany a child / young person taken to hospital by ambulance and stay with them until the parent / carer (or designated adult) arrives.

5. EHCPs and Individual Children and young people Risk Assessments (IPRAs).

We will follow the detailed guidance in [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document "Supporting children / young persons at school with medical conditions"](#) regarding both the development and monitoring of EHCPs and when an IPRA may be required.

We will review EHCPs at least annually, or earlier if evidence is presented that the child / young person's needs have changed.

5.1 Being notified that a child has a medical condition.

When our school is notified that a child / young person has a medical condition, the process outlined below will be followed to decide whether the child / young person requires an EHCP.

Our school will make every effort to ensure that arrangements are put into place within 2 weeks, or by the beginning of the relevant term for children / young persons who are new to our school.

When notification of a child with a medical condition is received, our school will:

- Gather all the required information by providing parents / carers with the appropriate form and having follow-up conversations where necessary.
- Where possible, make appropriate arrangements for staff to administer any medication or medical procedures and to receive whatever training is necessary.
- Where required, instigate an EHCP.

6. School trips, off site activities and sporting activities.

We will follow the detailed guidance in [PG505 - Supporting Children / young persons with Medical Conditions in School / DfE document "Supporting children / young persons at school with medical conditions"](#) regarding school trips, off site activities and sporting activities and ensure that any medical conditions are included in the specific risk assessments for those activities.

7. Unacceptable practice

Our school staff will use their discretion and judge each case individually with reference to the child / young person's EHCP, but it is generally not acceptable to:

- Prevent children / young persons from easily accessing their inhalers, medication or administering their medication when and where necessary.
- Assume that every child / young person with the same condition requires the same treatment.
- Ignore the views of the child / young person or their parents / carers.
- Ignore medical evidence or opinion (although this may be challenged).
- Send children / young persons with medical conditions home frequently for reasons associated with their medical condition or prevent them from staying for normal school activities, including lunch, unless this is specified in their EHCPs.
- If the child / young person becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable.
- Penalise children / young persons for their attendance record if their absences are related to their medical condition, e.g. hospital appointments.
- Prevent children / young persons from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively.
- Require parents / carers, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their child / young person, including with toileting issues. No parent / carer should have to give up working because the school is failing to support their child / young person's medical needs.
- Prevent children / young persons from participating or create unnecessary barriers to children / young person's participating, in any aspect of school life, including school trips.
- Administer, or ask children / young persons to administer, medicine in school toilets.

8. Complaints.

If our parents / carers or children / young people have any issues with the support provided they should initially contact Helen Burling, Deputy Head Teacher, to discuss their concerns. If, for whatever reason, this does not resolve the issue, they may make a formal complaint via the school's complaints procedure which is published on our schools' website.

9. Review.

This policy will be reviewed and approved by our governing body at least annually.

Template A: individual healthcare plan

Name of school/setting

Child's name

Group/class/form

Date of birth

Child's address

Medical diagnosis or condition

Date

Review date

Family Contact Information

Name

Phone no. (work)

(home)

(mobile)

Name

Relationship to child

Phone no. (work)

(home)

(mobile)

Clinic/Hospital Contact

Name

Phone no.

G.P.

Name

Phone no.

Who is responsible for providing support in school

--

Describe medical needs and give details of child's symptoms, triggers, signs, treatments, facilities, equipment or devices, environmental issues etc

Name of medication, dose, method of administration, when to be taken, side effects, contra-indications, administered by/self-administered with/without supervision

Daily care requirements

Specific support for the pupil's educational, social and emotional needs

Arrangements for school visits/trips etc

Other information

Describe what constitutes an emergency, and the action to take if this occurs

Who is responsible in an emergency (*state if different for off-site activities*)

Plan developed with

Staff training needed/undertaken – who, what, when

Form copied to

Template B: parental agreement for setting to administer medicine

The school/setting will not give your child medicine unless you complete and sign this form, and the school or setting has a policy that the staff can administer medicine.

Date for review to be initiated by	
Name of school/setting	
Name of child	
Date of birth	
Group/class/form	
Medical condition or illness	

Medicine

Name/type of medicine <i>(as described on the container)</i>	
Expiry date	
Dosage and method	
Timing	
Special precautions/other instructions	
Are there any side effects that the school/setting needs to know about?	
Self-administration – y/n	
Procedures to take in an emergency	

NB: Medicines must be in the original container as dispensed by the pharmacy

Contact Details

Name	
Daytime telephone no.	
Relationship to child	
Address	
I understand that I must deliver the medicine personally to	[agreed member of staff]

The above information is, to the best of my knowledge, accurate at the time of writing and I give consent to school/setting staff administering medicine in accordance with the school/setting policy. I will inform the school/setting immediately, in writing, if there is any change in dosage or frequency of the medication or if the medicine is stopped.

Signature(s) _____

Date _____

Template C: record of medicine administered to an individual child

Name of school/setting	
Name of child	
Date medicine provided by parent	/ /
Group/class/form	
Quantity received	
Name and strength of medicine	
Expiry date	/ /
Quantity returned	
Dose and frequency of medicine	

Staff signature _____

Signature of parent _____

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date	/ /	/ /	/ /
Time given			
Dose given			
Name of member of staff			
Staff initials			

C: Record of medicine administered to an individual child (Continued)

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Date			
Time given			
Dose given			
Name of member of staff			
Staff initials			

Template E: staff training record – administration of medicines

Name of school/setting

Name

Type of training received

Date of training completed

Training provided by

Profession and title

I confirm that [name of member of staff] has received the training detailed above and is competent to carry out any necessary treatment. I recommend that the training is updated [name of member of staff].

Trainer's signature _____

Date _____

I confirm that I have received the training detailed above.

Staff signature _____

Date _____

Suggested review date _____

Template F: contacting emergency services

Request an ambulance - dial 999, ask for an ambulance and be ready with the information below.

Speak clearly and slowly and be ready to repeat information if asked.

1. your telephone number
2. your name
3. your location as follows [insert school/setting address]
4. state what the postcode is – please note that postcodes for satellite navigation systems may differ from the postal code
5. provide the exact location of the patient within the school setting
6. provide the name of the child and a brief description of their symptoms
7. inform Ambulance Control of the best entrance to use and state that the crew will be met and taken to the patient
8. put a completed copy of this form by the phone

Template G: model letter inviting parents to contribute to individual healthcare plan development

Dear Parent,

DEVELOPING AN INDIVIDUAL HEALTHCARE PLAN FOR YOUR CHILD

Thank you for informing us of your child's medical condition. I enclose a copy of the school's policy for supporting pupils at school with medical conditions for your information.

A central requirement of the policy is for an individual healthcare plan to be prepared, setting out what support each pupil needs and how this will be provided. Individual healthcare plans are developed in partnership between the school, parents, pupils, and the relevant healthcare professional who can advise on your child's case. The aim is to ensure that we know how to support your child effectively and to provide clarity about what needs to be done, when and by whom. Although individual healthcare plans are likely to be helpful in the majority of cases, it is possible that not all children will require one. We will need to make judgements about how your child's medical condition impacts on their ability to participate fully in school life, and the level of detail within plans will depend on the complexity of their condition and the degree of support needed.

A meeting to start the process of developing your child's individual health care plan has been scheduled for xx/xx/xx. I hope that this is convenient for you and would be grateful if you could confirm whether you are able to attend. The meeting will involve [the following people]. Please let us know if you would like us to invite another medical practitioner, healthcare professional or specialist and provide any other evidence you would like us to consider at the meeting as soon as possible.

If you are unable to attend, it would be helpful if you could complete the attached individual healthcare plan template and return it, together with any relevant evidence, for consideration at the meeting. I [or another member of staff involved in plan development or pupil support] would be happy for you contact me [them] by email or to speak by phone if this would be helpful.

Yours sincerely

Guidance on the use of emergency salbutamol inhalers in schools

Prepared by the Disabled and Ill Child Services Team, Department of Health

HOW TO RECOGNISE AN ASTHMA ATTACK

The signs of an asthma attack are

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

CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD

- Appears exhausted
- Has a blue/white tinge around lips
- Is going blue
- Has collapsed

WHAT TO DO IN THE EVENT OF AN ASTHMA ATTACK

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

Executive summary

From 1st October 2014 the Human Medicines (Amendment) (No. 2) Regulations 2014 will allow schools to buy salbutamol inhalers, without a prescription, for use in emergencies.

The emergency salbutamol inhaler should only be used by children, for whom written parental consent for use of the emergency inhaler has been given, who have either been

diagnosed with asthma and prescribed an inhaler, or who have been prescribed an inhaler as reliever medication.

The inhaler can be used if the pupil's prescribed inhaler is not available (for example, because it is broken, or empty).

This change applies to all primary and secondary schools in the UK. Schools are not required to hold an inhaler – this is a discretionary power enabling schools to do this if they wish. Schools which choose to keep an emergency inhaler should establish a policy or protocol for the use of the emergency inhaler based on this guidance.

Keeping an inhaler for emergency use will have many benefits. It could prevent an unnecessary and traumatic trip to hospital for a child and potentially save their life. Parents are likely to have greater peace of mind about sending their child to school. Having a protocol that sets out how and when the inhaler should be used will also protect staff by ensuring they know what to do in the event of a child having an asthma attack.

The protocol could be incorporated into a wider medical conditions policy which will be required by *Supporting Pupils* from 1st September 2014. The protocol should include the following – on which this guidance provides advice:

- arrangements for the supply, storage, care, and disposal of the inhaler and spacers in line with the school's policy on supporting pupils with medical conditions
- having a register of children in the school that have been diagnosed with asthma or prescribed a reliever inhaler, a copy of which should be kept with the emergency inhaler
- having written parental consent for use of the emergency inhaler included as part of a child's individual healthcare plan
- ensuring that the emergency inhaler is only used by children with asthma with written parental consent for its use
- appropriate support and training for staff in the use of the emergency inhaler in line with the school's wider policy on supporting pupils with medical conditions
- keeping a record of use of the emergency inhaler as required by *Supporting pupils* and informing parents or carers that their child has used the emergency inhaler
- having at least two volunteers responsible for ensuring the protocol is followed

1. About this guidance

From 1st October 2014 the Human Medicines (Amendment) (No. 2) Regulations 2014 will allow schools to obtain, without a prescription, salbutamol inhalers, if they wish, for use in emergencies.¹ This will be 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).

This change applies to all primary and secondary schools in the UK.² Schools are not required to hold an inhaler – this is a discretionary power enabling schools to do this if they wish. Please note that only those institutions described in regulation 22 of the Human Medicines (Amendment) (No. 2) Regulations 2014, which amends regulation 213 of the Human Medicines Regulations 2012 may legally hold emergency asthma inhalers containing salbutamol.

Regulation 27 of the Human Medicines (Amendment) (No. 2) Regulations 2014 amends Schedule 17 of the Human Medicines Regulations 2012, and sets out the principles of supply to schools.

This guidance is non-statutory, and has been developed by the Department of Health with key stakeholders, to capture the good practice which schools in England should observe in using emergency inhalers and which should form the basis of any school protocol or policy. The guidance has been updated to take account of issues raised during the public consultation, and the Department is grateful to all who submitted comments and suggestions, which we have endeavoured to incorporate.

This guidance does not apply to schools in Wales, Northern Ireland and Scotland, which as devolved administrations have responsibility for issuing their own guidance for schools which wish to make use of this power (and have their own distinct policies on how staff may support children's health needs in the school setting). The principles of safe usage of inhalers in this guidance however are universal and based on recognised good practice.

The Children and Families Act 2014 requires governing bodies of English schools to make arrangements for supporting pupils at school with medical conditions. This duty came into force on 1st September 2014 and will be supported by the statutory guidance *Supporting pupils at school with medical conditions. Statutory guidance for governing bodies of maintained schools and proprietors of academies in England*,³ referred to hereafter as *Supporting pupils*. This guidance is therefore designed to be read in conjunction with *Supporting pupils*, and every school's protocol or policy on use of the inhaler should have regard to it.

Supporting Pupils expects schools to:

- develop policies for supporting pupils with medical conditions and review them regularly;
- develop individual healthcare plans for pupils with medical conditions that identify the child's

medical condition, triggers, symptoms, medication needs and the level of support needed in an emergency.

¹ <http://www.legislation.gov.uk/uksi/2014/1878/contents/made>

² Including maintained schools, independent schools, independent educational institutions, pupil referral units and alternative provision academies. Maintained nursery schools are also eligible to hold an emergency salbutamol inhaler.

³ <https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions>

have procedures in place on managing medicines on school premises;

- ensure staff are appropriately supported and trained.

2. Introduction

Asthma is the most common chronic condition, affecting one in eleven children. On average, there are two children with asthma in every classroom in the UK.⁴ There₅ are over 25,000 emergency hospital admissions for asthma amongst children a year in the UK.

Children should have their own reliever inhaler at school to treat symptoms and for use in the event of an asthma attack. If they are able to manage their asthma themselves they should keep their inhaler on them, and if not, it should be easily accessible to them.

However, an Asthma UK survey found that 86% of children with asthma have at some time been without an inhaler at school having forgotten, lost or broken it, or the inhaler having run out. However, before 1 October 2014, it was illegal for schools to hold emergency salbutamol inhalers for the use of pupils whose own inhaler was not available.

In 2013 in response to this, and following advice from the Commission of Human Medicines 2013 the Medicines and Healthcare Products Regulatory Agency (MHRA) recommended changes to legislation to enable schools to purchase and hold emergency salbutamol inhalers, without a prescription. A public consultation was held (the results can be found at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/341902/Department_of_Health_response_to_asthma_consultation.pdf). There was overwhelming support for changing the regulations to allow schools to hold an emergency inhaler.

The regulations which enable this come into force on 1st October 2014. The MHRA also recommended that the use of emergency inhalers be supported by appropriate protocols and this guidance provides advice on what such a protocol should contain.

Any school which chooses to hold an emergency inhaler may wish to consider including a cross-reference to the asthma policy in the school's policy for supporting pupils with medical conditions. The use of an emergency asthma inhaler should also be specified in a pupils individual healthcare plan where appropriate.

There are a number of resources which provide information on asthma, and how it can be treated listed in section 7 together with contact details for support organisations. This guidance is not intended to be a detailed guide to the diagnosis or treatment of asthma in general. If any member of staff has reason to suspect a child has asthma or a respiratory condition, they should notify the parents, so they can take the child to a doctor. Section 5 gives advice on what to do in an emergency.

A school's medical conditions policy or asthma policy may already cover elements of the emergency inhaler protocol, for example ensuring appropriate support and training for teachers. Policies will likely already cover elements such as arrangements for storage, care and disposal of medication, ensuring written consent for administration or supervision of administration of medication, keeping a record of administration of medication, and informing parents in relation to children's own inhalers, and could simply be expanded to cover the emergency inhaler.

⁴ Asthma UK, 'Asthma Facts and FAQs', <http://www.asthma.org.uk/asthma-facts-and-statistics>

⁵ The NHS Atlas of Variation in Healthcare for Children and Young People gives the numbers of emergency admissions of children and young people for asthma in each former PCT / local authority area <http://www.sepho.org.uk/extras/maps/NHSAAtlasChildHealth/atlas.html>

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

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.*

Fig. 1 – a child being helped to use an inhaler with spacer.

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);



- - 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 and returned 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>

⁶ This advice is in line with the British Thoracic Society's *The use of placebo inhaler devices, peak flow meters and inspiratory flow meters in clinical practice. Practical Recommendations* (2005)
<http://www.brit-thoracic.org.uk/Portals/0/Clinical%20Information/Asthma/Other%20useful%20links/placeboinhalersfinal.pdf>

4. Children who can use an inhaler

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 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.

There should already be procedures in place to ensure that schools are notified of children that have additional health needs and this information, will enable them to compile an asthma register. Some schools will already have such a register as part of an asthma policy or medical conditions policy.

The asthma register is crucial as in larger schools and secondary schools in particular, there may be many children with asthma, and it will not be feasible for individual members of staff to be aware of which children these are (in primary settings, where a teacher has responsibility for a single class each

year this is more reasonable). Consequently, schools should ensure that the asthma register is easy to access and is designed to allow a quick check of whether or not a child is recorded as having asthma, and consent for an emergency inhaler to be administered. A school may wish to include – with parental consent - a photograph of each child, to allow a visual check to be made.

As part of the school's asthma policy, when the emergency inhaler is to be used, a check should be made that parental consent has been given for its use, in the register. Schools should have in their asthma policy a proportionate and flexible approach to checking the register.

The school should seek written consent from parents of children on the register for them to use the salbutamol inhaler in an emergency. A draft consent form is at Annex B. Schools will want to consider when consent for use of the inhaler is best obtained. Options include:

- obtaining consent at the same time as for administering or supervising administration of a child's own inhaler under an asthma policy or medical conditions policy, or as part of development of an individual healthcare plan
- obtaining consent at the same time as seeking consent for the flu vaccination or other vaccinations

Keeping a record of parental consent on the asthma register will also enable staff to quickly check whether a child is able to use the inhaler in an emergency. Consent should be updated regularly – ideally annually - to take account of changes to a child's condition.

5. Responding to asthma symptoms and an asthma attack

Salbutamol inhalers are intended for use where a child has asthma. The symptoms of other serious conditions/illnesses, including allergic reaction, hyperventilation and choking from an inhaled foreign body can be mistaken for those of asthma, and the use of the emergency inhaler in such cases could lead to a delay in the child getting the treatment they need.

For this reason, the emergency inhaler should only be used by children who have been diagnosed with asthma, and prescribed a reliever inhaler, or who have been prescribed an reliever inhaler AND whose parents have given consent for an emergency inhaler to be used.

It is recommended that each school's asthma policy includes general information on how to recognise and respond to an asthma attack, and what to do in emergency situations. Staff should be aware in particular of the difficulties very young children may have in explaining how they feel. Often guidance provided to schools by local authorities will provide this information. Some schools will already have this information in an asthma policy or medical conditions policy.

Asthma UK has produced demonstration films on using a metered-dose inhaler and spacers suitable for staff and children. <http://www.asthma.org.uk/knowledge-bank-treatment-and-medicines-using-your-inhalers>

Education for Health is a charity providing asthma training with the most up to date guidelines and best practice
<http://www.educationforhealth.org>

Common 'day to day' symptoms of asthma are:

- Cough and wheeze (a 'whistle' heard on breathing out) when exercising
- Shortness of breath when exercising

- Intermittent cough

These symptoms are usually responsive to use of their own inhaler and rest (e.g. stopping exercise). They would not usually require the child to be sent home from school or to need urgent medical attention.

Signs of an asthma attack include:

- Persistent cough (when at rest)
- A wheezing sound coming from the chest (when at rest)
- Being unusually quiet
- The child complains of shortness of breath at rest, feeling tight in the chest

(younger children may express this feeling as a tummy ache)

- Difficulty in breathing (fast and deep respiration)
- Nasal flaring
- Being unable to complete sentences
- Appearing exhausted
- A blue / white tinge around the lips
- Going blue

If a child is displaying the above signs of an asthma attack, the guidance below on responding to an asthma attack should be followed.

CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD

- Appears exhausted
- Has a blue/white tinge around lips
- Is going blue
- Has collapsed

Responding to signs of an asthma attack

- Keep calm and reassure the child
- Encourage the child to sit up and slightly forward.
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with child while inhaler and spacer are brought to them
- Immediately help the child to take two separate puffs of the salbutamol via the spacer immediately
- If there is no immediate improvement, continue to give two puffs every two minutes up to a maximum of 10 puffs, or until their symptoms improve. The inhaler should be shaken between puffs.
- Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better
- If the child does not feel better or you are worried at ANYTIME before you have reached 10 puffs, CALL 999 FOR AN AMBULANCE
- If an ambulance does not arrive in 10 minutes give another 10 puffs in the same way
- The child's parents or carers should be contacted after the ambulance has been

called.

- A member of staff should always accompany a child taken to hospital by ambulance and stay with them until a parent or carer arrives.

Recording use of the inhaler and informing parents/carers

Use of the emergency inhaler should be recorded. This should include where and when the attack took place (e.g. PE lesson, playground, classroom), how much medication was given, and by whom. *Supporting pupils* requires written records to be kept of medicines administered to children.

The child's parents must be informed in writing so that this information can also be passed onto the child's GP. The draft letter at Annex B may be used to notify parents.

6. Staff

Any member of staff may volunteer to take on these responsibilities, but they cannot be required to do so. These staff may already have wider responsibilities for administering medication and/or supporting pupils with medical conditions.

In the following advice, the term 'designated member of staff' refers to any member of staff who has responsibility for helping to administer an emergency inhaler, e.g. they have volunteered to help a child use the emergency inhaler, and been trained to do this, and are identified in the school's asthma policy as someone to whom all members of staff may have recourse in an emergency.

Schools will want to ensure there are a reasonable number of designated members of staff to provide sufficient coverage. In small schools, it may be that all members of staff are designated members of staff.

Schools should ensure staff have appropriate training and support, relevant to their level of responsibility. *Supporting Pupils* requires governing bodies to ensure that staff supporting children with a medical condition should have appropriate knowledge, and where necessary, support.

It would be reasonable for **ALL** staff to be:

- trained to recognise the symptoms of an asthma attack, and ideally, how to distinguish them from other conditions with similar symptoms;
- aware of the asthma policy;
- aware of how to check if a child is on the register;
- aware of how to access the inhaler;
- aware of who the designated members of staff are, and the policy on how to access their help.

As part of the asthma policy, the school should have agreed arrangements in place for all members of staff to summon the assistance of a designated member of staff, to help administer an emergency inhaler, as well as for collecting the emergency inhaler and spacer. These should be proportionate, and flexible – and can include phone calls being made or responsible secondary school-aged children asking for the assistance of another member of staff and/or collecting the inhaler (but not checking the register), and procedures for supporting a designated member's class while they are helping to administer an inhaler.

The school's policy should include a procedure for allowing a quick check of the register as part of initiating the emergency response. This does not necessarily need to be undertaken by a designated

member of staff, but there may be value in a copy of the register being held by at least each designated member. If the register is relatively succinct, it could be held in every classroom.

Designated members of staff should be trained in:

- recognising asthma attacks (and distinguishing them from other conditions with similar symptoms)
- responding appropriately to a request for help from another member of staff; 18
- recognising when emergency action is necessary;
- administering salbutamol inhalers through a spacer;
- making appropriate records of asthma attacks.
-

The Asthma UK films on using metered-dose inhalers and spacers are particularly valuable as training materials. <http://www.asthma.org.uk/knowledge-bank-treatment-and-medicines-using-your-inhalers>

Children with inhalers will also be able to demonstrate to their teacher how they use it; the school nurse may also be able to advise on appropriate use.

In a number of areas, local asthma teams have provided training for school staff in supporting children with asthma, including use of the inhaler, and schools could contact their local NHS Hospital Trust for information on how children with asthma are supported, and improving links between the NHS and the school.

It is recommended that schools should also ensure that:

- a named individual is responsible for overseeing the protocol for use of the emergency inhaler, and monitoring its implementation and for maintaining the asthma register;
- at least two individuals are responsible for the supply, storage care and disposal of the inhaler and spacer.

Liability and indemnity

Supporting pupils requires that governing bodies ensure that when schools are supporting pupils with medical conditions, they have appropriate levels of insurance in place to cover staff, including liability cover relating to the administration of medication.

Local Authorities may provide schools which are administering inhalers with appropriate indemnity cover; however schools will need to agree any such indemnity cover directly with the relevant authority or department.

7. Useful links

For convenience both hot links and full URLs are given below.

Supporting pupils at school with medical conditions. Statutory guidance for governing bodies of maintained schools and proprietors of academies in England (Department for Education, 2014).

<https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions>

Access to Education and Support for Children and Young People with Medical Needs (Welsh Assembly Government Circular No: 003/2010, May 2010)

<http://wales.gov.uk/topics/educationandskills/publications/guidance/medicalneeds/?lang=en>

The Administration of Medicines in Schools (Scottish Executive, 2001),

<http://www.scotland.gov.uk/Publications/2001/09/10006/File-1>

Supporting Pupils with Medication Needs, (Department of Education, Department of Health, Social Services and Public Safety, 2008)

http://www.deni.gov.uk/index/support-and-development-2/special_educational_needs_pg/special_educational_needs-supporting_pupils_with_medication_needs-2.htm

Asthma UK Website

<http://www.asthma.org.uk/>

Education for Health

<http://www.educationforhealth.org>

School Asthma Cards

<http://www.asthma.org.uk/Shop/school-asthma-card-pack-of-20-healthcare-professionals>

NHS Choices, Asthma in Children

<http://www.nhs.uk/conditions/asthma-in-children/pages/introduction.aspx>

NICE Quality Standard

<http://publications.nice.org.uk/quality-standard-for-asthma-qs25>

Children and Maternal Health Intelligence Network

<http://www.chimat.org.uk/>

Getting it right for children, young people and families. Maximising the contribution of the school nursing team: Vision and Call to Action (March 2012).

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216464/dh_133352.pdf

Annex A

Child showing symptoms of asthma / having asthma attack

1. I can confirm that my child has been diagnosed with asthma / has been prescribed an inhaler [delete as appropriate].
2. My child has a working, in-date inhaler, clearly labelled with their name, which they will bring with them to school every day.
3. In the event of my child displaying symptoms of asthma, and if their inhaler is not available or is unusable, I consent for my child to receive salbutamol from an emergency inhaler held by the school for such emergencies.

Signed: Date:

Name (print).....

Child's name:

Class:
.....

Parent's address and contact details:
.....
..
.....
..
.....

.. Telephone:
.....

E-mail:
.....

Annex B

CONSENT FORM:
USE OF EMERGENCY SALBUTAMOL INHALER [Insert school name]

Child's name: Class:
.....
Date:

Dear....., [*Delete as appropriate*]

This letter is to formally notify you that.....has had problems with his / her breathing today. This happened when.....

A member of staff helped them to use their asthma inhaler.

They did not have their own asthma inhaler with them, so a member of staff helped them to use the emergency asthma inhaler containing salbutamol. They were given puffs.

Their own asthma inhaler was not working, so a member of staff helped them to use the emergency asthma inhaler containing salbutamol. They were given puffs. .

[*Delete as appropriate*]

Although they soon felt better, we would strongly advise that you have your seen by your own doctor as soon as possible. Yours sincerely,

SPECIMEN LETTER TO INFORM PARENTS OF EMERGENCY SALBUTAMOL INHALER USE



My Asthma Plan

1 My usual asthma medicines

- My preventer inhaler is called _____
_____ and its colour is _____
- I take _____ puff/s of my preventer inhaler in the morning and _____ puff/s at night. I do this every day even if I feel well.
- Other asthma medicines I take every day:

- My reliever inhaler is called _____
_____ and its colour is _____
I take _____ puff/s of my reliever inhaler when I wheeze or cough, my chest hurts or it's hard to breathe.
- My best peak flow is _____

If I need my blue inhaler to do any sport or activity, I need to see my doctor or asthma nurse.



2 My asthma is getting worse if...

- I wheeze or cough, my chest hurts or it's hard to breathe, **or**
- I need my reliever inhaler (usually blue) three or more times a week, **or**
- My peak flow is less than _____, **or**
- I'm waking up at night because of my asthma (this is an important sign and I will book a next day appointment)

If my asthma gets worse, I will:

- Take my preventer medicines as normal
- And also take _____ puff/s of my blue reliever inhaler every four hours
- See my doctor or nurse within 24 hours if I don't feel better



URGENT! "If your blue reliever inhaler isn't lasting for four hours you are having an asthma attack and you need to take emergency action now (see section 3)"



Remember to use my spacer with my inhaler if I have one.

(If I don't have one, I'll check with my doctor or nurse if it would help me)

Other things to do if my asthma is getting worse

3 I'm having an asthma attack if...

- My reliever inhaler isn't helping or I need it more than every four hours, **or**
- I can't talk, walk or eat easily, **or**
- I'm finding it hard to breathe, **or**
- I'm coughing or wheezing a lot or my chest is tight/hurts, **or**
- My peak flow is less than _____

If I have an asthma attack, I will:



Call for help



Sit up — don't lie down. Try to be calm.



Take one puff of my reliever inhaler (with my spacer if I have it) **every 30 to 60 seconds** up to a total of 10 puffs.



If I don't have my blue inhaler, or it's not helping, I need to call **999** straightaway.



While I wait for an ambulance I can use my blue reliever again, every 30 to 60 seconds (up to 10 puffs) if I need to.

Even if I start to feel better, I don't want this to happen again, so I need to see my doctor or asthma nurse **today**.



My Asthma Plan

My asthma triggers:

List the things that make your asthma worse and what you can do to help

I will see my doctor or asthma nurse at least once a year (but more if I need to)

Date I got my asthma plan:

Date of my next asthma review:

Doctor/asthma nurse contact details:

Your asthma plan tells you what medicines to take to stay well

And what to do when your asthma gets worse

Parents – get the most from your child’s action plan

- **Take a photo** and keep it on your mobile (and your child’s mobile if they have one)
- **Stick a copy** on your fridge door
- **Share** your child’s action plan with school

Learn more about what to do during an asthma attack www.asthma.org.uk/advice/asthma-attacks

Always keep your reliever inhaler (usually blue) and your spacer with you.



You might need them if your asthma gets worse.



Questions? Ask Asthma UK’s nurses:

Call on **0300 222 5800** (9am-5pm; Mon-Fri)

Or message on **WhatsApp** **07378 606 728** (9am-5pm; Mon-Fri)



Name: _____



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! My asthma triggers

Taking my asthma medicine each day will help reduce my reaction to these triggers. Avoiding them where possible will also help.

i People with allergies need to be extra careful as attacks can be more severe.

! My asthma review

I should have at least one routine asthma review every year. **I will bring:**

- My action plan to see if it needs updating.
- Any inhalers and spacers I have, to check I'm using them correctly and in the best way.
- Any questions about my asthma and how to cope with it.

Next asthma review date: _____

GP/asthma nurse contact

Name:

Phone number:

Out-of-hours contact number

(ask your GP surgery who to call when they are closed)

Name:

Phone number:



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How to use it

Your written asthma action plan can help you stay on top of your asthma.

To get the most from it, you could...

- 1 Put it somewhere easy for you and your family to find** – like your fridge door, noticeboard, or bedside table.
- 2 Keep a photo of it on your mobile phone or tablet** – so you can check it wherever you are. You can also send it to a family member or friend, so they know what to do if your asthma symptoms get worse.
- 3 Check in with it regularly** – put a note on your calendar, or a monthly reminder on your phone to read it through. Are you remembering to use your day-to-day asthma medicines? Do you know what to do if your symptoms get worse?
- 4 Take it to every healthcare appointment about your asthma** – including A&E/consultant. Ask your GP or asthma nurse to update it if their advice for you changes.

Get more advice & support from Asthma UK:

- Speak to a specialist asthma nurse about managing your asthma on: **0300 222 5800**
- Message our expert asthma nurses on Whatsapp on: **07378 606728**
- Get news, advice and download information packs at: **www.asthma.org.uk**
- Follow us on Facebook for news and tips about your asthma: **www.facebook.com/asthmauk**

The step-by-step guide that helps you stay on top of your asthma

Your asthma action plan

Fill this in with your GP or nurse



Name and date:



Any asthma questions?
Call our friendly helpline nurses
0300 222 5800
Monday-Friday, 9am-5pm
www.asthma.org.uk



Every day asthma care:

My asthma is being managed well:

- With this daily routine I should expect/aim to have no symptoms.
- If I've not had any symptoms or needed my reliever inhaler for at least 12 weeks, I can ask my GP or asthma nurse to review my medicines in case they can reduce the dose.
- My personal best peak flow is:

My daily asthma routine:

My **preventer** inhaler (insert name/colour):

I need to take my **preventer** inhaler every day even when I feel well

I take puff(s) in the morning and puff(s) at night.

My **reliever** inhaler (insert name/colour):

I take my **reliever** inhaler only if I need to I take puff(s) of my reliever inhaler if any of these things happen:

- ★ I'm wheezing
- ★ My chest feels tight
- ★ I'm finding it hard to breathe
- ★ I'm coughing

Other medicines and devices (eg spacers) I use for my asthma every day:



When I feel worse:

My asthma is getting worse if I'm experiencing any of these:

- My symptoms are coming back (wheeze, tightness in my chest, feeling breathless, cough).
- I am waking up at night.
- My symptoms are interfering with my usual day-to-day activities (eg at work, exercising).
- I am using my reliever inhaler three times a week or more.
- My peak flow drops to below:

URGENT! If you need your reliever inhaler more than every four hours, you're having an asthma attack and you need to take emergency action now.

What I can do to get on top of my asthma now:

If I haven't been using my preventer inhaler, I'll start using it regularly again or if I have been using it...

Increase my preventer inhaler dose to puffs times a day until my symptoms have gone and my peak flow is back to my personal best.

Take my reliever inhaler as needed (up to puffs every four hours).

I carry my reliever inhaler with me when I'm out.

URGENT! See a doctor or nurse within 24 hours if you get worse at any time or you haven't improved after seven days.

Other advice from my GP about what to do if my asthma is worse (eg SMART/MART or rescue steroid tablets):



In an asthma attack:

I'm having an asthma attack if I'm experiencing any of these:

- My reliever inhaler is not helping or I need it more than every four hours.
- I find it difficult to walk or talk.
- I find it difficult to breathe.
- I'm wheezing a lot or I have a very tight chest or I'm coughing a lot.
- My peak flow is below:

What to do in an asthma attack



1 Sit up straight – try to keep calm.



2 Take one puff of your reliever inhaler (usually blue) every 30 - 60 seconds, up to a maximum of 10 puffs.



3 If you feel worse at any point OR you don't feel better after 10 puffs call 999 for an ambulance.



4 Repeat step 2 after 15 minutes while you're waiting for an ambulance.

After an asthma attack:

See your GP within 48 hours to make sure you're not at risk of another attack. If you get worse see them urgently. Finish any medicines they prescribe you, even if you start to feel better. If you don't improve after treatment, see your GP urgently.

What to do in an asthma attack if I'm on SMART/MART:

Recognition and management of an allergic reaction/anaphylaxis

Signs and symptoms include:

Mild-moderate allergic reaction:

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

ACTION:




- Stay with the child, call for help if necessary
- Locate adrenaline autoinjector(s)
- Give antihistamine according to the child's allergy treatment plan
- Phone parent/emergency contact



**Watch for signs of ANAPHYLAXIS
(life-threatening allergic reaction):**

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

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

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

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

After giving Adrenaline:

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

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

Schools may administer their “spare” adrenaline auto-injector (AAI), obtained, without prescription, for use in emergencies, if available, but only to a pupil at risk of anaphylaxis, where both medical authorisation and written parental consent for use of the spare AAI has been provided.

The school’s spare AAI can be administered to a pupil whose own prescribed AAI cannot be administered correctly without delay.

AAIs can be used through clothes and should be injected into the upper outer thigh in line with the instructions provided by the manufacturer.

If someone appears to be having a severe allergic reaction (anaphylaxis), you **MUST** call 999 without delay, even if they have already used their own AAI device, or a spare AAI.

In the event of a possible severe allergic reaction in a pupil who does not meet these criteria, emergency services (999) should be contacted and advice sought from them as to whether administration of the spare emergency AAI is appropriate.

Practical points:

1. When dialling 999, give clear and precise directions to the emergency operator, including the postcode of your location.
2. If the pupil’s condition deteriorates and a second dose adrenaline is administered after making the initial 999 call, make a second call to the emergency services to confirm that an ambulance has been dispatched.
3. Send someone outside to direct the ambulance paramedics when they arrive.
4. Tell the paramedics:
 - if the child is known to have an allergy;
 - what might have caused this reaction e.g. recent food; — the time the AAI was given.

The guidance in this document has been developed in conjunction with representatives of the following organisations:

3. British Society for Allergy & Clinical Immunology (Paediatric Allergy Group)
4. British Paediatric Allergy, Immunity and Infection Group
5. Royal College of Paediatrics and Child Health
6. Allergy UK
7. Anaphylaxis Campaign.

The Department of Health would like to thank Dr. Paul J. Turner for his work on this guidance.

Executive summary

From 1 October 2017 the Human Medicines (Amendment) Regulations 2017 will allow all schools to buy adrenaline auto-injector (AAI) devices without a prescription, for emergency use in children who are at risk of anaphylaxis but their own device is not available or not working (e.g. because it is broken, or out-of-date).

The school's spare AAI should only be used on pupils known to be at risk of anaphylaxis, for whom both medical authorisation and written parental consent for use of the spare AAI has been provided.

The school's spare AAI can be administered to a pupil whose own prescribed AAI cannot be administered correctly without delay.

An anaphylactic reaction always requires an emergency response

Any AAI(s) held by a school should be considered a spare / back-up device and not a replacement for a pupil's own AAI(s). Current guidance from the Medicines and Healthcare Products Regulatory Agency (MHRA) is that anyone prescribed an AAI should carry two of the devices at all times. This guidance does not supersede this advice from the MHRA,¹ and any spare AAI(s) held by a school should be in addition to those already prescribed to a pupil.

This change applies to all primary and secondary schools (including independent schools) in the UK. Schools are not required to hold AAI(s) – this is a discretionary change enabling schools to do this if they wish. Those facilities choosing to hold a spare AAI(s) should establish a policy or protocol for their use in line with “Supporting pupils at school with medical conditions: Statutory guidance for governing bodies of maintained schools and proprietors of academies in England”² (*Supporting Pupils*), and with reference to the guidance in this document.

The protocol could be incorporated into the wider medical conditions policy required by *Supporting Pupils*. An effective protocol should include the following – on which this guidance provides advice:

- arrangements for the supply, storage, care, and disposal of spare AAI(s) in line with *Supporting Pupils*.

¹ <https://www.gov.uk/drug-safety-update/adrenaline-auto-injector-advice-for-patients>

² <https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3>

- a register of pupils who have been prescribed an AAI(s) (or where a doctor has provided a written plan recommending AAI(s) to be used in the event of anaphylaxis).
- written consent from the pupil's parent/legal guardian for use of the spare AAI(s), as part of a pupil's individual healthcare plan.
- ensuring that any spare AAI is used only in pupils where both medical authorisation and written parental consent have been provided.
- appropriate support and training for staff in the use of the AAI in line with the schools wider policy on supporting pupils with medical conditions.
- keeping a record of use of any AAI(s), as required by *Supporting Pupils* and informing parents or carers that their pupil has been administered an AAI and whether this was the school's spare AAI or the pupil's own device.

1. About this guidance

From 1 October 2017 the Human Medicines (Amendment) Regulations 2017 will allow schools to obtain, without a prescription, adrenaline auto-injector (AAI) devices, if they wish, for use in emergencies. This will be for any pupil who holds both medical authorisation and parental consent for an AAI to be administered. The AAI(s) can be used if the pupil's own prescribed AAI(s) are not immediately available (for example, because they are broken, out-of-date, have misfired or been wrongly administered).

This change applies to all primary and secondary schools (including independent schools) in the UK. Schools are not required to hold spare AAI(s) – this is a discretionary change enabling schools to do this if they wish. Only those institutions described in regulation 22 of the Human Medicines (No.2) Regulations 2014, which amends regulation 213 of the Human Medicines Regulations 2012 may legally hold spare AAIs.

Regulation 8 of the Human Medicines (Amendment) Regulations 2017 amends schedule 17 of the Human Medicines Regulations 2012, and sets out the principles of supply to schools.

Guidance on the use of AAIs in schools

This guidance is non-statutory, and has been developed by the Department of Health with key stakeholders, to capture the good practice which schools in England should observe in using spare AAIs. Schools may wish to use this as the basis of any protocol or policy. This guidance does not apply to schools and childcare facilities in Wales, Northern Ireland and Scotland, which as devolved administrations have responsibility for issuing their own guidance for those facilities which wish to make use of this power (and have their own distinct policies on how staff may support children's health needs in the school setting). The principles of safe usage of AAI(s) in this guidance however are universal and based on recognised good practice.

The Children and Families Act 2014 requires governing bodies of English schools to make arrangements for supporting pupils with medical conditions. This duty came into force on 1st September 2014 and is supported by the statutory guidance *Supporting Pupils*.³ This guidance is therefore designed to be read in conjunction with *Supporting Pupils*, and every school's protocol or policy on use of the AAI should have regard to it.

3 <https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3>

Supporting Pupils expects schools to:

- develop policies for supporting pupils with medical conditions and review them regularly.
- develop individual healthcare plans for pupils with medical conditions that identify the pupil's medical condition, triggers, symptoms, medication needs and the level of support needed in an emergency.
- have procedures in place on managing medicines on the premises.
- ensure staff are appropriately supported and trained.

2. Introduction

Anaphylaxis is a severe and often sudden allergic reaction. It can occur when a susceptible person is exposed to an allergen (such as food or an insect sting). Reactions usually begin within minutes of exposure and progress rapidly, but can occur up to 2-3 hours later. It is potentially life threatening and always requires an immediate emergency response.

What can cause anaphylaxis?

Common allergens that can trigger anaphylaxis are:

- foods (e.g. peanuts, tree nuts, milk/dairy foods, egg, wheat, fish/seafood, sesame and soya)
- insect stings (e.g. bee, wasp)
- medications (e.g. antibiotics, pain relief such as ibuprofen)
- latex (e.g. rubber gloves, balloons, swimming caps).

The severity of an allergic reaction can be influenced by a number of factors including minor illness (like a cold), asthma, and, in the case of food, the amount eaten. It is very unusual for someone with food allergies to experience anaphylaxis without actually eating the food: contact skin reactions to an allergen are very unlikely to trigger anaphylaxis.

The time from allergen exposure to severe life-threatening anaphylaxis and cardio-respiratory arrest varies, depending on the allergen:

- Food: While symptoms can begin immediately, severe symptoms often take 30+ minutes to occur. However, some severe reactions can occur within minutes, while others can occur over 1-2 hours after eating.⁴ Severe reactions to dairy foods are often delayed, and may mimic a severe asthma attack without any other symptoms (e.g. skin rash) being present.
- Severe reactions to insect stings are often faster, occurring within 10-15 minutes.⁴

⁴ Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers. Resuscitation Council (UK). Available at: <https://www.resus.org.uk/anaphylaxis/emergency-treatment-of-anaphylactic-reactions/>

Why does anaphylaxis occur?

An allergic reaction occurs because the body's immune system reacts inappropriately to a substance that it wrongly perceives as a threat. The reaction is due to an interaction between the substance ("allergen") and an antibody called Immunoglobulin E (IgE). This results in the release of chemicals such as histamine which cause the allergic reaction. In the skin, this causes an itchy rash, swelling and flushing. Many children (not just those with asthma) can develop breathing problems, similar to an asthma attack. The throat can tighten, causing swallowing difficulties and a high pitched sound (stridor) when breathing in.

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

How common is anaphylaxis in schools?

Up to 8% of children in the UK have a food allergy.⁵ However, the majority of allergic reactions to food are not anaphylaxis, even in children with previous anaphylaxis. Most reactions present with mild-moderate symptoms, and do not progress to anaphylaxis. Fatal allergic reactions are rare, but they are also very unpredictable. In the UK, 17% of fatal allergic reactions in school-aged children happen while at school.⁶ Schools therefore need to consider how to reduce the risk of an allergic reaction, in line with *Supporting Pupils*. Box 1 provides a list of actions that schools and parents can take to reduce the risk of exposure to allergens.

⁵ UK Food Standards Agency. <https://www.food.gov.uk/science/allergy-intolerance>

⁶ Turner PJ, Gowland MH, Sharma V et al. Increase in hospital admissions due to anaphylaxis but no increase in fatalities: an analysis of UK national anaphylaxis data, 1992–2012. *J Allergy Clin Immunol* 2015;135:956-63. Available at: [http://www.jacionline.org/article/S0091-6749\(14\)01516-4/fulltext](http://www.jacionline.org/article/S0091-6749(14)01516-4/fulltext)

Box 1: Reducing the risk of allergen exposure in children with food allergy⁷

- Bottles, other drinks and lunch boxes provided by parents for children with food allergies should be clearly labelled with the name of the child for whom they are intended.
- If food is purchased from the school canteen, parents should check the appropriateness of foods by speaking directly to the catering manager. The child should be taught to also check with catering staff, before purchasing.
- Where food is provided by the school, staff should be educated about how to read labels for food allergens and instructed about measures to prevent cross-contamination during the handling, preparation and serving of food. Examples include: preparing food for children with food allergies first; careful cleaning (using warm soapy water) of food preparation areas and utensils.
- Food should not be given to food-allergic children in primary schools without parental engagement and permission (e.g. birthday parties, food treats).
- Implement policies to avoid trading and sharing of food, food utensils or food containers.
- Unlabelled food poses a potentially greater risk of allergen exposure than packaged food with precautionary allergen labelling suggesting a risk of contamination with allergen.
- Use of food in crafts, cooking classes, science experiments and special events (e.g. fetes, assemblies, cultural events) needs to be considered and may need to be restricted depending on the allergies of particular children and their age.
- In arts/craft, an appropriate alternative ingredient can be substituted (e.g. wheat-free flour for play dough or cooking). Consider substituting non-food containers for egg cartons.
- When planning out-of-school activities such as sporting events, excursions (e.g. restaurants and food processing plants), school outings or camps, think early about the catering requirements of the food-allergic child and emergency planning (including access to emergency medication and medical care).

Treatment

While “allergy” medicines such as antihistamines can be used for mild allergic reactions, they are ineffective in severe reactions – only adrenaline is recommended for severe reactions (anaphylaxis). The adrenaline treats both the symptoms of the reaction, and also stops the reaction and the further release of chemicals causing anaphylaxis. However, severe reactions may require more than one dose of adrenaline, and children can initially improve but then deteriorate later. It is therefore essential to always call for an ambulance to provide further medical attention, whenever anaphylaxis occurs. The use of adrenaline as an injection into the muscle is safe and can be life-saving.

⁷ Vale S, Smith J, Said M, Mullins RJ, Loh R. ASCIA guidelines for prevention of anaphylaxis in schools, pre-schools and childcare: 2015 update. *J Paediatr Child Health*. 2015 Oct;51(10):949-54.

Children and young people diagnosed with allergy to foods or insect stings are frequently prescribed AAI devices, to use in case of anaphylaxis. AAI (current brands available in the UK are EpiPen®, Emerade®, Jext®) contain a single fixed dose of adrenaline, which can be administered by non-healthcare professionals such as family members, teachers and first-aid responders.

Children at risk of anaphylaxis should have their prescribed AAI(s) at school for use in an emergency. The MHRA recommends that those prescribed AAIs should carry TWO devices at all times, as some people can require more than one dose of adrenaline and the AAI device can be used wrongly or occasionally misfire.

Depending on their level of understanding and competence, children and particularly teenagers should carry their AAI(s) on their person at all times or they should be quickly and easily accessible at all times. If the AAI(s) are not carried by the pupil, then they should be kept in a central place in a box marked clearly with the pupil's name but NOT locked in a cupboard or an office where access is restricted.

It is not uncommon for schools (often primary schools) to request a pupil's AAI(s) are left in school to avoid the situation where a pupil or their family forgets to bring the AAI(s) to school each day. Where this occurs, the pupil must still have access to an AAI when travelling to and from school.

Further Information

There are a number of resources which provide information on allergies and anaphylaxis, and how they can be treated listed in section 7 together with contact details for support organisations. This guidance is not intended to be a detailed guide to the diagnosis or treatment of anaphylaxis in general. If any member of staff has reason to suspect a pupil has an allergy, they should notify the parents, so they can take their child to a doctor. Section 5 gives advice on what to do in the event of an allergic reaction.

Incorporating into existing School Policy

A school's medical conditions policy or allergy policy may already cover elements of the AAI protocol, for example ensuring appropriate support and training for teachers. Policies will likely already cover elements such as arrangements for storage, care and disposal of medication, ensuring written consent for administration or supervision of administration of medication, keeping a record of administration of medication, and informing parents in relation to children's own inhalers, and could simply be expanded to cover the emergency AAI.

3. Arrangements for the supply, storage, care and disposal of AAI's

Supply

Schools can purchase AAI's from a pharmaceutical supplier, such as a local pharmacy, without a prescription, provided the general advice relating to these transactions are observed: i.e. small quantities on an occasional basis and the school does not intend to profit from it. A supplier will need a request signed by the principal or head teacher (ideally on appropriate 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.

A template letter which can be used for this purpose is provided in Appendix 1, and can also be downloaded at: www.sparepensinschools.uk. Please note that pharmacies are not required to provide AAI's free of charge to schools: the school must pay for them as a retail item.

A number of different brands of AAI are available in different doses depending on the manufacturer. It is up to the school to decide which brand(s) to purchase. Schools are advised to hold an appropriate quantity of a single brand of AAI device to avoid confusion in administration and training. Where all pupils are prescribed the same device, the school should obtain the same brand for the spare AAI. If two or more brands are currently held by the school, the school may wish to purchase the brand most commonly prescribed to its pupils. However, the decision as to how many devices and brands to purchase will depend on local circumstances and is left to the discretion of the school.

AAI's are available in different doses, depending on the manufacturer. The Resuscitation Council (UK) recommends that healthcare professionals treat anaphylaxis using the age-based criteria,⁸ as follows:

- For children age under 6 years: a dose of 150 microgram (0.15 milligram) of adrenaline is used (e.g. using an Epipen Junior (0.15mg), Emerade 150 or Jext 150 microgram device).
- For children age 6-12 years: a dose of 300 microgram (0.3 milligram) of adrenaline is used (e.g. using an Epipen (0.3mg), Emerade 300 or Jext 300 microgram device).

⁸ Emergency treatment of anaphylactic reactions: Guidelines for healthcare providers. Resuscitation Council (UK). Available at: <https://www.resus.org.uk/anaphylaxis/emergency-treatment-of-anaphylactic-reactions/>

- For teenagers age 12+ years: a dose of 300 or 500 microgram (Emerade 500) can be used.

In the context of supplying schools rather than individual pupils with AAI for use in an emergency setting, using these same age-based criteria avoids the need for multiple devices/ doses, thus reducing the potential for confusion in an emergency. Schools should consider the ages of their pupils at risk of anaphylaxis, when deciding which doses to obtain as the spare AAI. Schools may wish to seek appropriate medical advice when deciding which AAI device(s) are most appropriate.

The emergency anaphylaxis kit

It is good practice for schools holding spare AAIs to store these as part of an emergency anaphylaxis kit which should include:

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

Schools might like to keep the emergency kit together with an "emergency asthma inhaler kit" (containing a salbutamol inhaler device and spacer).⁹ Many food-allergic children also have asthma, and asthma is a common symptom during food-induced anaphylaxis.

Severe anaphylaxis is an extremely time-critical situation: delays in administering adrenaline have been associated with fatal outcomes. Schools should ensure that all AAI devices – including those belonging to a younger child, and any spare AAI in the Emergency kit – are kept in a safe and suitably central location: for example, the school office or staffroom to which all staff have access at all times, but in which the AAI is out of the reach and sight of children. They must not be locked away in a cupboard or an office where access is restricted. Schools should ensure that AAIs are accessible and available for use at all times, and not located more than 5 minutes away from where they may be needed. In larger schools, it may be prudent to locate a kit near the central dining area and another near the playground; more than one kit may be needed.

Any spare AAI devices held in the Emergency Kit should be kept separate from any pupil's own prescribed AAI which might be stored nearby; the spare AAI should be clearly labelled to avoid confusion with that prescribed to a named pupil.

9 <https://www.gov.uk/government/publications/emergency-asthma-inhalers-for-use-in-schools>

Storage and care of the AAI

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

- on a monthly basis the AAIs are present and in date.
- that replacement AAIs are obtained when expiry dates approach (this can be facilitated by signing up to the AAI expiry alerts through the relevant AAI manufacturer).

The AAI devices should be stored at room temperature (in line with manufacturer's guidelines), protected from direct sunlight and extremes of temperature.

Schools may wish to require parents to take their pupil's own prescribed AAIs home before school holidays (including half-term breaks) to ensure that their own AAIs remain in date and have not expired.

Disposal

Once an AAI has been used it cannot be reused and must be disposed of according to manufacturer's guidelines. Used AAIs can be given to the ambulance paramedics on arrival or can be disposed of in a pre-ordered sharps bin for collection by the local council.

School trips including sporting activities

Schools should conduct a risk-assessment for any pupil at risk of anaphylaxis taking part in a school trip off school premises, in much the same way as they already do so with regards to safe-guarding etc. Pupils at risk of anaphylaxis should have their AAI with them, and there should be staff trained to administer AAI in an emergency. Schools may wish to consider whether it may be appropriate, under some circumstances, to take spare AAI(s) obtained for emergency use on some trips.

4. Children to whom a spare AAI can be administered

The spare AAI in the Emergency Kit should only be used in a pupil where both medical authorisation and written parental consent have been provided for the spare AAI to be used on them. This includes children at risk of anaphylaxis who have been provided with a medical plan confirming this, but who have not been prescribed AAI. In such cases, specific consent for use of the spare AAI from both a healthcare professional and parent/guardian must be obtained. Such a plan is available from the British Society for Allergy and Clinical Immunology (BSACI).¹⁰

The school's spare AAI can be used instead of a pupil's own prescribed AAI(s), if these cannot be administered correctly, without delay

This information should be recorded in a pupil's individual healthcare plan. Where a pupil has no other healthcare needs other than a risk of anaphylaxis, schools may wish to consider using the BSACI Allergy Action Plan¹⁰. All children with a diagnosis of an allergy and at risk of anaphylaxis should have a written Allergy Management Plan.

Procedures should already be in place to ensure that schools are notified of pupils that have additional health needs, and this information will enable them to compile an allergy register. Some schools will already have such a register as part of their medical conditions policy.

The register could include:

- Known allergens and risk factors for anaphylaxis.
- Whether a pupil has been prescribed AAI(s) (and if so what type and dose).
- Where a pupil has been prescribed an AAI whether parental consent has been given for use of the spare AAI which may be different to the personal AAI prescribed for the pupil.
- A photograph of each pupil to allow a visual check to be made (this will require parental consent).

The register is crucial as in larger schools (and secondary schools in particular), it may not be feasible for individual members of staff to be aware of which pupils have been prescribed AAIs. Consequently, schools should ensure that the register is easy to access and easy to read. Schools will also need to ensure they have a proportionate and flexible approach to checking the register. DELAYS IN ADMINISTERING ADRENALINE HAVE BEEN

¹⁰ <http://www.sparepensinschools.uk/plans> or <http://www.bsaci.org/about/pag-allergy-action-plans-for-children>

ASSOCIATED WITH FATAL OUTCOMES. Allowing pupils to keep their AAIs with them will reduce delays, and allows for confirmation of consent without the need to check the register. Schools will want to consider when consent for use of the AAI is best obtained but the most appropriate time would be as part of the introduction or development of the individual care plan. Consent should be updated regularly – ideally annually – to take account of changes to a pupil’s condition.

5. Responding to the symptoms of an allergic reaction

AAIs are intended for use in emergency situations when an allergic individual is having a reaction consistent with anaphylaxis, as a measure that is taken until an ambulance arrives. Therefore, unless directed otherwise by a healthcare professional, the spare AAI should only be used on pupils known to be at risk of anaphylaxis, where both medical authorisation and written parental consent for use of the spare AAI has been provided.

This information should be recorded in a pupil's individual healthcare plan which should be signed by a healthcare professional and kept in the schools allergy register.

In the event of a possible severe allergic reaction in a pupil who does not meet these criteria, emergency services (999) should be contacted and advice sought from them as to whether administration of the spare emergency AAI is appropriate.

It is recommended the school allergy policy includes general information on how to recognise and respond to an allergic reaction, and what to do in emergency situations. Some schools will already have this information in an allergy policy or medical conditions policy. Staff should be aware of the difficulties younger children may have in explaining how they feel.

Further information and film clips showing adrenaline being administered can be found at: <http://www.sparepensinschools.uk>

The signs of an allergic reaction are:

Mild-moderate allergic reaction:

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

ACTION:




- Stay with the child, call for help if necessary
- Locate adrenaline autoinjector(s)
- Give antihistamine according to the child's allergy treatment plan
- Phone parent/emergency contact



Watch for signs of ANAPHYLAXIS (life-threatening allergic reaction):

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

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

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

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

After giving Adrenaline:

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

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

Mild-moderate symptoms are usually responsive to an antihistamine. The pupil does not normally need to be sent home from school, or require urgent medical attention. However, mild reactions can develop into anaphylaxis: children having a mild-moderate (non-anaphylactic) reaction should therefore be monitored for any progression in symptoms.

What to do if any symptoms of anaphylaxis are present

Anaphylaxis commonly occurs together with mild symptoms or signs of allergy, such as an itchy mouth or skin rash. Anaphylaxis can also occur on its own without any mild-moderate signs. In the presence of any of the severe symptoms listed in the red box on page 1, it is vital that an adrenaline auto-injector is administered without delay, regardless of what other symptoms or signs may be present.

Always give an adrenaline auto-injector if there are ANY signs of anaphylaxis present.

You should administer the pupil's own AAI if available, if not use the spare AAI. The AAI can be administered through clothes and should be injected into the upper outer thigh in line with the instructions issued for each brand of injector.

IF IN DOUBT, GIVE ADRENALINE

After giving adrenaline do NOT move the pupil. Standing someone up with anaphylaxis can trigger cardiac arrest. Provide reassurance. The pupil should lie down with their legs raised.¹¹ If breathing is difficult, allow the pupil to sit.

If someone appears to be having a severe allergic reaction, it is vital to call the emergency services without delay – even if they have already self-administered their own adrenaline injection and this has made them better. A person receiving an adrenaline injection should always be taken to hospital for monitoring afterwards.

ALWAYS DIAL 999 AND REQUEST AN AMBULANCE IF AN AAI IS USED.

Practical points:

- Try to ensure that a person suffering an allergic reaction remains as still as possible, and does not get up or rush around. Bring the AAI to the pupil, not the other way round.
- When dialling 999, say that the person is suffering from anaphylaxis (“ANA-FIL-AX-IS”).
- Give clear and precise directions to the emergency operator, including the postcode of your location.
- If the pupil's condition does not improve 5 to 10 minutes after the initial injection you should administer a second dose. If this is done, make a second call to the emergency services to confirm that an ambulance has been dispatched.
- Send someone outside to direct the ambulance paramedics when they arrive.
- Arrange to phone parents/carers.

¹¹ In a young pregnant person, the advice is to lie the person on their left side.

- Tell the paramedics:
 - if the child is known to have an allergy;
 - what might have caused this reaction e.g. recent food; — the time the AAI was given.

Recording use of the AAI and informing parents/carers

In line with *Supporting Pupils*, use of any AAI device should be recorded. This should include:

- Where and when the REACTION took place (e.g. PE lesson, playground, classroom).
- How much medication was given, and by whom.
- Any person who has been given an AAI must be transferred to hospital for further monitoring. The pupil's parents should be contacted at the earliest opportunity. The hospital discharge documentation will be sent to the pupil's GP informing them of the reaction.

6. Staff

Any member of staff may volunteer to take on the responsibilities set out in this guidance, but they cannot be *required* to do so. These staff may already have wider responsibilities for administering medication and/or supporting pupils with medical conditions.

SEVERE ANAPHYLAXIS IS AN EXTREMELY TIME-CRITICAL SITUATION: DELAYS IN ADMINISTERING ADRENALINE HAVE BEEN ASSOCIATED WITH FATAL OUTCOMES. It is therefore appropriate for as many staff as possible to be trained in how to administer AAI.

In the following advice, the term 'designated members of staff' refers to any member of staff who has responsibility for helping to administer a spare AAI (e.g. they have volunteered to help a pupil use the emergency AAI, and been trained to do this, and are identified in the school's medical conditions or allergy policy as someone to whom all members of staff may have recourse in an emergency.)

Schools will want to ensure there are a reasonable number of designated members of staff to provide sufficient coverage, including when staff are on leave. In many schools, it would be appropriate for there to be multiple designated members of staff who can administer an AAI to avoid any delay in treatment.

Schools should ensure staff have appropriate training and support, relevant to their level of responsibility. *Supporting Pupils* requires governing bodies to ensure that staff supporting children with a medical condition should have appropriate knowledge, and where necessary, support.

It would be reasonable for ALL staff to:

- be trained to recognise the range of signs and symptoms of an allergic reaction;
- understand the rapidity with which anaphylaxis can progress to a life-threatening reaction, and that anaphylaxis may occur with prior mild (e.g. skin) symptoms;
- appreciate the need to administer adrenaline without delay as soon as anaphylaxis occurs, before the patient might reach a state of collapse (after which it may be too late for the adrenaline to be effective);
- be aware of the anaphylaxis policy;
- be aware of how to check if a pupil is on the register;
- be aware of how to access the AAI;

- be aware of who the designated members of staff are, and the policy on how to access their help.

Schools must arrange specialist anaphylaxis training for staff where a pupil in the school has been diagnosed as being at risk of anaphylaxis. The specialist training should include practical instruction in how to use the different AAI devices available. Online resources and introductory e-learning modules can be found at <http://www.sparepensinschools.uk>, although this is NOT a substitute for face-to-face training.

As part of the medical conditions policy, the school should have agreed arrangements in place for all members of staff to summon the assistance of a designated member of staff, to help administer an AAI, as well as for collecting the spare AAI in the emergency kit. These should be proportionate, and flexible – and can include phone calls being made to another member of staff or responsible secondary school-aged children asking for the assistance of another member of staff and/or collecting the AAI (but not checking the register), and procedures for supporting a designated staff member's class while they are helping to administer an AAI.

DELAYS IN ADMINISTERING ADRENALINE HAVE BEEN ASSOCIATED WITH FATAL OUTCOMES. Thought should be given to where delays could occur (for example, a phone call is made to summon help but there is no answer).

The school's policy should include a procedure for allowing a quick check of the register as part of initiating the emergency response. This does not necessarily need to be undertaken by a designated member of staff, but there may be value in a copy of the register being held by at least each designated member. If the register is relatively succinct, it could be held in every classroom. Alternatively, allowing pupils to keep their AAI(s) with them will reduce delays, and allows for confirmation of consent without the need to check the register.

Designated members of staff should be trained in:

- recognising the range of signs and symptoms of severe allergic reactions;
- responding appropriately to a request for help from another member of staff;
- recognising when emergency action is necessary;
- administering AAI's according to the manufacturer's instructions;
- making appropriate records of allergic reactions.

Training material

It is recommended that schools should also ensure that:

- a named individual is responsible for overseeing the protocol for use of the spare AAI, and monitoring its implementation and for maintaining the allergy register;
- at least two individuals are responsible for the supply, storage care and disposal of the AAI.

Liability and indemnity

Supporting pupils requires that governing bodies ensure that when schools are supporting pupils with medical conditions, they have appropriate levels of insurance in place to cover staff, including liability cover relating to the administration of medication. The only exception will be where the actions of the employee amount to serious and wilful misconduct. Carelessness, inadvertence or a simple mistake do not amount to serious and wilful misconduct.

Local Authorities may provide schools which are administering AAls with appropriate indemnity cover; however schools will need to agree any such indemnity cover directly with the relevant authority. Proprietors of academies should ensure that either the appropriate level of insurance is in place or that the academy is a member of the Department for Education's Risk Protection Arrangement (RPA).

7. Useful Links

- Spare Pens in Schools <http://www.sparepensinschools.uk>
- Official guidance relating to supporting pupils with medical needs in schools:
 - Supporting pupils at school with medical conditions. Statutory guidance for governing bodies of maintained schools and proprietors of academies in England (Department for Education, 2014).
<https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3>
 - Supporting Learners with Healthcare Needs. (Welsh Government, 2017).
<http://learning.gov.wales/resources/browse-all/supporting-learners-with-healthcare-needs/?lang=en>
 - The Administration of Medicines in Schools (Scottish Executive, 2001).
<http://www.scotland.gov.uk/Publications/2001/09/10006/File-1>
 - Supporting Pupils with Medication Needs, (Department of Education, Department of Health, Social Services and Public Safety Northern Ireland, 2008)
<https://www.education-ni.gov.uk/articles/support-pupils-medication-needs>
- Allergy UK <https://www.allergyuk.org/>
 - Whole school allergy and awareness management (Allergy UK)
<https://www.allergyuk.org/schools/whole-school-allergy-awareness-and-management>
- Anaphylaxis Campaign
<https://www.anaphylaxis.org.uk>
 - AllergyWise training for schools
<https://www.anaphylaxis.org.uk/information-training/allergywise-training/for-schools/>
 - AllergyWise training for school nurses (Anaphylaxis Campaign)
<http://www.anaphylaxis.org.uk/information-resources/allergywise-training/for-healthcare-professionals/>
- Education for Health
<http://www.educationforhealth.org>

- Food allergy quality standards (The National Institute for Health and Care Excellence, March 2016)
<https://www.nice.org.uk/guidance/qs118>
- Anaphylaxis: assessment and referral after emergency treatment (The National Institute for Health and Care Excellence, 2011)
<https://www.nice.org.uk/guidance/cg134?unlid=22904150420167115834>

ANNEX: Letter template to Pharmacy to obtain an AAI

Schools must provide a written letter when ordering “spare” back-up adrenaline auto-injector devices.

A sample letter is provided below, which can be printed on the school’s headed paper and signed by the principal or head teacher at the school. Ideally appropriate headed paper should be used, although this is not a legislative requirement.

In line with legislation, the order must state:

- the name of the school for which the adrenaline auto-injector devices are required;
- the purpose for which that devices are required; and
- the total quantity required for each device.

[To be completed on headed school paper]

[Date]

We wish to purchase emergency Adrenaline Auto-injector devices for use in our school/ college.

The adrenaline auto-injectors will be used in line with the manufacturer’s instructions, for the emergency treatment of anaphylaxis in accordance with the Human Medicines (Amendment) Regulations 2017. This allows schools to purchase “spare” back-up adrenaline auto-injectors for the emergency treatment of anaphylaxis. (Further information can be found at <https://www.gov.uk/government/consultations/allowing-schools-to-hold-spare-adrenaline-auto-injectors>).

Please supply the following devices:

Brand name*		Dose* (state milligrams or micrograms)	Quantity required
	Adrenaline auto-injector device		
	Adrenaline auto-injector device		

Signed: _____ Date: _____

Print name:
Head Teacher/Principal

*AAls are available in different doses and devices. Schools may wish to purchase the brand most commonly prescribed to its pupils (to reduce confusion and assist with training). Guidance from the Department of Health to schools recommends:

For children age under 6 years:	For children age 6-12 years:	For teenagers age 12+ years:
Epipen Junior (0.15mg) or Emerade 150 microgram or Jext 150 microgram	Epipen (0.3 milligrams) or Emerade 300 microgram or Jext 300 microgram	Epipen (0.3 milligrams) or Emerade 300 microgram or Emerade 500 microgram or Jext 300 microgram

Further information can be found at <http://www.sparepensinschools>.

This child has the following allergies:

Name: _____

DOB: _____

Photo

Mild/moderate reaction:

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

Action to take:




- Stay with the child, call for help if necessary
- Locate adrenaline autoinjector(s)
- **Give antihistamine:**
.....
(If vomited, can repeat dose)
- Phone parent/emergency contact

● Watch for signs of ANAPHYLAXIS (life-threatening allergic reaction)

Anaphylaxis may occur without skin symptoms: ALWAYS consider anaphylaxis in someone with known food allergy who has **SUDDEN BREATHING DIFFICULTY**

- | | | |
|---|--|---|
| A AIRWAY | B BREATHING | C CONSCIOUSNESS |
| <ul style="list-style-type: none"> • Persistent cough • Hoarse voice • Difficulty swallowing • Swollen tongue | <ul style="list-style-type: none"> • Difficult or noisy breathing • Wheeze or persistent cough | <ul style="list-style-type: none"> • Persistent dizziness • Pale or floppy • Suddenly sleepy • Collapse/unconscious |

IF ANY ONE (OR MORE) OF THESE SIGNS ABOVE ARE PRESENT:

- 1 Lie child flat with legs raised** (if breathing is difficult, allow child to sit)
  
- 2 Immediately dial 999** for ambulance and say ANAPHYLAXIS ("ANA-FIL-AX-IS")
- 3** In a school with "spare" back-up adrenaline autoinjectors, **ADMINISTER the SPARE AUTOINJECTOR** if available
- 4** Commence CPR if there are no signs of life
- 5 Stay with child** until ambulance arrives, **do NOT stand child up**
- 6** Phone parent/emergency contact

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

You can dial 999 from any phone, even if there is no credit left on a mobile. Medical observation in hospital is recommended after anaphylaxis. For more information about managing anaphylaxis in schools and "spare" back-up adrenaline autoinjectors, visit: sparepensinschools.uk

Emergency contact details:

1) Name: _____



2) Name: _____



Parental consent: I hereby authorise school staff to administer the medicines listed on this plan, including a 'spare' back-up adrenaline autoinjector (AAI) if available, in accordance with Department of Health Guidance on the use of AAIs in schools.

Signed:

Print name:

Date:

For more information about managing anaphylaxis in schools and "spare" back-up adrenaline autoinjectors, visit: sparepensinschools.uk

Additional instructions:

If wheezy: DIAL 999 and GIVE ADRENALINE using a "back-up" adrenaline autoinjector if available, then use asthma reliever (blue puffer) via spacer

This BSACI Action Plan for Allergic Reactions is for children and young people with mild food allergies, who need to avoid certain allergens. For children at risk of anaphylaxis and who have been prescribed an adrenaline autoinjector device, there are BSACI Action Plans which include instructions for adrenaline autoinjectors. These can be downloaded at bsaci.org

For further information, consult NICE Clinical Guidance CG116 Food allergy in children and young people at guidance.nice.org.uk/CG116

This is a medical document that can only be completed by the child's healthcare professional. It must not be altered without their permission. This document provides medical authorisation for schools to administer a 'spare' adrenaline autoinjector in the event of the above-named child having anaphylaxis (as permitted by the Human Medicines (Amendment) Regulations 2017). The healthcare professional named below confirms that there are no medical contra-indications to the above-named child being administered an adrenaline autoinjector by school staff in an emergency. **This plan has been prepared by:**

Sign & print name:

Hospital/Clinic:



Date:

This child has the following allergies:

Name: _____

DOB: _____

Photo

Mild/moderate reaction:

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

Action to take:

- Stay with the child, call for help if necessary
- Locate adrenaline autoinjector(s)
- **Give antihistamine:**

(If vomited,
can repeat dose)




- Phone parent/emergency contact

● Watch for signs of ANAPHYLAXIS (life-threatening allergic reaction)

Anaphylaxis may occur without skin symptoms: ALWAYS consider anaphylaxis in someone with known food allergy who has **SUDDEN BREATHING DIFFICULTY**

- | | | |
|--|--|---|
| <p>A AIRWAY</p> <ul style="list-style-type: none"> • Persistent cough • Hoarse voice • Difficulty swallowing • Swollen tongue | <p>B BREATHING</p> <ul style="list-style-type: none"> • Difficult or noisy breathing • Wheeze or persistent cough | <p>C CONSCIOUSNESS</p> <ul style="list-style-type: none"> • Persistent dizziness • Pale or floppy • Suddenly sleepy • Collapse/unconscious |
|--|--|---|

IF ANY ONE (OR MORE) OF THESE SIGNS ABOVE ARE PRESENT:

- 1 Lie child flat with legs raised** (if breathing is difficult, allow child to sit)



- 2 Use Adrenaline autoinjector without delay** (eg. EpiPen®) (Dose: . . . mg)
- 3 Dial 999** for ambulance and say ANAPHYLAXIS ("ANA-FIL-AX-IS")
***** IF IN DOUBT, GIVE ADRENALINE *****


AFTER GIVING ADRENALINE:

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

You can dial 999 from any phone, even if there is no credit left on a mobile. Medical observation in hospital is recommended after anaphylaxis.

Emergency contact details:

1) Name: _____
 _____

2) Name: _____
 _____

Parental consent: I hereby authorise school staff to administer the medicines listed on this plan, including a 'spare' back-up adrenaline autoinjector (AAI) if available, in accordance with Department of Health Guidance on the use of AAIs in schools.

Signed: _____

Print name: _____

Date: _____

For more information about managing anaphylaxis in schools and "spare" back-up adrenaline autoinjectors, visit: sparepensinschools.uk

How to give EpiPen®

-  PULL OFF BLUE SAFETY CAP and grasp EpiPen. Remember: "blue to sky, orange to the thigh"
-  Hold leg still and PLACE ORANGE END against mid-outer thigh "with or without clothing"
-  PUSH DOWN HARD until a click is heard or felt and hold in place for **3 seconds**. Remove EpiPen.

Additional instructions:

If wheezy, GIVE ADRENALINE FIRST, then asthma reliever (blue puffer) via spacer

This is a medical document that can only be completed by the child's healthcare professional. It must not be altered without their permission. This document provides medical authorisation for schools to administer a 'spare' back-up adrenaline autoinjector if needed, as permitted by the Human Medicines (Amendment) Regulations 2017. During travel, adrenaline auto-injector devices must be carried in hand-luggage or on the person, and **NOT** in the luggage hold. **This action plan and authorisation to travel with emergency medications has been prepared by:**

Sign & print name: _____

Hospital/Clinic: _____

 _____ Date: _____

This child has the following allergies:

Name:

DOB:

Photo

Mild/moderate reaction:

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

Action to take:

- Stay with the child, call for help if necessary
- Locate adrenaline autoinjector(s)
- Give antihistamine:

(If vomited, can repeat dose)

- Phone parent/emergency contact

Watch for signs of ANAPHYLAXIS (life-threatening allergic reaction)

Anaphylaxis may occur without skin symptoms: ALWAYS consider anaphylaxis in someone with known food allergy who has **SUDDEN BREATHING DIFFICULTY**

- | | | |
|---|--|---|
| A AIRWAY | B BREATHING | C CONSCIOUSNESS |
| <ul style="list-style-type: none"> • Persistent cough • Hoarse voice • Difficulty swallowing • Swollen tongue | <ul style="list-style-type: none"> • Difficult or noisy breathing • Wheeze or persistent cough | <ul style="list-style-type: none"> • Persistent dizziness • Pale or floppy • Suddenly sleepy • Collapse/unconscious |

IF ANY ONE (OR MORE) OF THESE SIGNS ABOVE ARE PRESENT:

- 1 Lie child flat with legs raised** (if breathing is difficult, allow child to sit)



- 2 Use Adrenaline autoinjector without delay** (eg. Jext®) (Dose: . . . mg)

- 3 Dial 999** for ambulance and say ANAPHYLAXIS ("ANA-FIL-AX-IS")

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

AFTER GIVING ADRENALINE:

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

You can dial 999 from any phone, even if there is no credit left on a mobile. Medical observation in hospital is recommended after anaphylaxis.

Emergency contact details:

1) Name:



2) Name:



Parental consent: I hereby authorise school staff to administer the medicines listed on this plan, including a 'spare' back-up adrenaline autoinjector (AAI) if available, in accordance with Department of Health Guidance on the use of AAI in schools.

Signed:

Print name:

Date:

For more information about managing anaphylaxis in schools and "spare" back-up adrenaline autoinjectors, visit: sparepensinschools.uk

How to give Jext®



1
Form fist around Jext® and PULL OFF YELLOW SAFETY CAP



2
PLACE BLACK END against outer thigh (with or without clothing)



3
PUSH DOWN HARD until a click is heard or felt and hold in place for 10 seconds



4
REMOVE Jext®. Massage injection site for 10 seconds

Additional instructions:

If wheezy, GIVE ADRENALINE FIRST, then asthma reliever (blue puffer) via spacer

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Sign & print name:

Hospital/Clinic:



Date:

This child has the following allergies:

Name: _____

DOB: _____

Photo

Mild/moderate reaction:

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

Action to take:

- Stay with the child, call for help if necessary
- Locate adrenaline autoinjector(s)
- Give antihistamine:

(If vomited, can repeat dose)

- Phone parent/emergency contact

Watch for signs of ANAPHYLAXIS (life-threatening allergic reaction)

Anaphylaxis may occur without skin symptoms: ALWAYS consider anaphylaxis in someone with known food allergy who has **SUDDEN BREATHING DIFFICULTY**

- | | | |
|---|--|---|
| A AIRWAY | B BREATHING | C CONSCIOUSNESS |
| <ul style="list-style-type: none"> • Persistent cough • Hoarse voice • Difficulty swallowing • Swollen tongue | <ul style="list-style-type: none"> • Difficult or noisy breathing • Wheeze or persistent cough | <ul style="list-style-type: none"> • Persistent dizziness • Pale or floppy • Suddenly sleepy • Collapse/unconscious |

IF ANY ONE (OR MORE) OF THESE SIGNS ABOVE ARE PRESENT:

- 1 Lie child flat with legs raised** (if breathing is difficult, allow child to sit)



- 2 Use Adrenaline autoinjector without delay** (eg. Emerade®) (Dose: . . . mg)

- 3 Dial 999** for ambulance and say ANAPHYLAXIS ("ANA-FIL-AX-IS")

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

AFTER GIVING ADRENALINE:

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

You can dial 999 from any phone, even if there is no credit left on a mobile. Medical observation in hospital is recommended after anaphylaxis.

Emergency contact details:

1) Name: _____



2) Name: _____



Parental consent: I hereby authorise school staff to administer the medicines listed on this plan, including a 'spare' back-up adrenaline autoinjector (AAI) if available, in accordance with Department of Health Guidance on the use of AAI in schools.

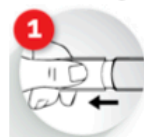
Signed: _____

Print name: _____

Date: _____

For more information about managing anaphylaxis in schools and "spare" back-up adrenaline autoinjectors, visit: sparepensinschools.uk

How to give Emerade®



REMOVE NEEDLE SHIELD



PRESS AGAINST THE OUTER THIGH



HOLD FOR 5 SECONDS
Massage the injection site gently, then call 999, ask for an ambulance stating "Anaphylaxis"

Additional instructions:

If wheezy, GIVE ADRENALINE FIRST, then asthma reliever (blue puffer) via spacer

This is a medical document that can only be completed by the child's healthcare professional. It must not be altered without their permission. This document provides medical authorisation for schools to administer a 'spare' back-up adrenaline autoinjector if needed, as permitted by the Human Medicines (Amendment) Regulations 2017. During travel, adrenaline auto-injector devices must be carried in hand-luggage or on the person, and **NOT** in the luggage hold. **This action plan and authorisation to travel with emergency medications has been prepared by:**

Sign & print name: _____

Hospital/Clinic: _____



Date: _____