**Appendix 2 (a)**

**SEVERE ALLERGIES: PROCEDURES AND INDIVIDUAL HEALTHCARE PLAN TEMPLATE**

**Schools MUST ensure that the following points are implemented:**

1. School Handbook informs parents of their responsibility to ensure that all relevant information pertaining to their child’s health needs, including any changes to their condition or medication, is provided to the school.
2. For pupils who have been diagnosed with an allergy by their GP but have not required to attend the allergy clinic at the Royal Hospital for Children and Young People or St John’s Hospital, the following is carried out:

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| (i) | Completion of ‘*Request for Use of Medication and/or Administration of Healthcare in School’* (see Appendix 4) |  |
| (ii) | Completion of an individualised:  *‘Symptom and Action Flowchart for Allergic Reaction NOT Including an adrenaline Pen’* (see below)***or***  *‘Symptom and Action Flowchart for Allergic Reaction Including an Adrenaline Pen’* (see below) |  |
| (iii) | A supply of the appropriate medication is given to the school by the parent in the original packaging/container in which it was purchased/dispensed including any patient information leaflet, and is clearly labelled with the pupil’s name in full and the dose to be given |  |

**Parent to confirm that** (*please tick*)**:**

|  |  |  |
| --- | --- | --- |
| (i) | At the end of the summer term (June), as long as the expiry date of any prescribed long-term emergency medication being held in school exceeds the following October holiday period, I accept the school will securely hold the medication during the summer break for use at the start of the new term; or |  |
| (ii) | At the end of the summer term (June), I will collect any prescribed long-term emergency medication from the school; or |  |
| (iii) | I accept that at the end of the summer term (June), school staff will dispose of any prescribed long-term emergency medication that remains in school without my previous notification. NB: Prescribed long-term emergency medication is considered to be treatments for Asthma, Diabetes, Epilepsy and Severe Allergies. |  |

1. For pupils who have been newly diagnosed with a severe allergy at the Royal Hospital for Children and Young People or St John’s Hospital allergy clinic:

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| --- | --- | --- |
| (i) | Parents provide a completed ‘*Individual Healthcare Plan: Severe Allergies’*  (see below) |  |
| (ii) | A supply of the appropriate medication is given to the school by the parent in the original packaging/container in which it was purchased/dispensed including any patient information leaflet, and is clearly labelled with the pupil’s name in full and the dose to be given |  |

**Parent to confirm that** (*please tick*):**:**

|  |  |  |
| --- | --- | --- |
| (i) | At the end of the summer term (June), as long as the expiry date of any prescribed long-term emergency medication being held in school exceeds the following October holiday period, I accept the school will securely hold the medication during the summer break for use at the start of the new term; or |  |
| (ii) | At the end of the summer term (June), I will collect any prescribed long-term emergency medication from the school; or |  |
| (iii) | I accept that at the end of the summer term (June), school staff will dispose of any prescribed long-term emergency medication that remains in school without my previous notification. NB: Prescribed long-term emergency medication is considered to be treatments for Asthma, Diabetes, Epilepsy and Severe Allergies. |  |

1. For pupils with allergies who also have an inhaler:

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| --- | --- | --- |
| (i) | Parents provide a completed ‘*Request Form for Use of Inhaler in School’*  (see Appendix 3) |  |
| (ii) | Parents complete a ‘*Symptom and Action Flowchart for Asthma Attack*’ (see Appendix 3) |  |
| (iii) | A supply of the appropriate medication is given to the school by the parent in the original packaging/container in which it was purchased/dispensed including any patient information leaflet, and is clearly labelled with the pupil’s name in full and the dose to be given |  |

**Parent to confirm that** (*please tick*)**:**

|  |  |  |
| --- | --- | --- |
| (i) | At the end of the summer term (June), as long as the expiry date of any prescribed personal inhalers being held in school exceeds the following October holiday period, I accept the school will securely hold the medication during the summer break for use at the start of the new term; or |  |
| (ii) | At the end of the summer term (June), I will collect any prescribed personal inhalers from the school; or |  |
| (iii) | I accept that at the end of the summer term (June), school staff will dispose of any prescribed personal inhalers that remain in school without my previous notification.  **NB**: Prescribed long-term emergency medication is considered to be treatments for Asthma, Diabetes, Epilepsy and Severe Allergies. |  |

1. Individual Healthcare Plans are reviewed at least annually and/or if there is a change of condition.

**N.B.** Care Inspectorate advice is that in Early Learning and Childcare settings it is good practice to review all agreed medical intervention at least every three months to check that the medication is still required, is in date and that the dose has not changed.

1. For pupils requiring medication in school a copy of the prescription or prescription re-order form detailing the medication and dosage must be attached to the IHP.
2. On completion of IHPs and following reviews, copies should be given to parents.
3. Medication is accessible, stored securely and as detailed below:  
     
   In **Early Learning & Childcare** settings:

2 adrenaline pens should be kept in the pupil’s classroom in a zipped ‘poly pocket’ with the personalised Symptom and Action Flowchart.

In **Primary Schools**:

1 adrenaline pen should be kept in the pupil’s classroom in a zipped ‘poly pocket’ with the personalised Symptom and Action Flowchart. Another adrenaline pen should be kept in a

zipped ‘poly pocket’ with the personalised Symptom and Action Flowchart, in a central, secure, easily accessible place.

In **Secondary Schools**:

The pupil should carry one adrenaline pen.

Another adrenaline pen should be kept in a zipped ‘poly pocket’ with the personalised Symptom and Action Flowchart, in a central, secure, easily accessible place.

In **Special Schools where registered nurses are not available** in school at all times:

2 adrenaline pens should be kept in the pupil’s classroom in a zipped ‘poly pocket’ with the personalised Symptom and Action Flowchart.

In **Special Schools where registered nurses are available** in school at all times:

1 adrenaline pen will be kept in the medical room under the management of the school nurse team and 1 will be kept in a zipped bag with the pupil at all times.

**Schools MUST ensure that consideration is also given to:**

* **Dietary Control**

If a pupil is affected by a medically diagnosed food allergy, the school should take all reasonable steps to ensure that the pupil does not eat any foods other than those approved by the parent.

**N.B.** Schools should not ban certain foods from being sent into school, e.g. it is not possible to make a school ‘nut-free’. A reasonable adjustment may be to discourage families from using particular foods where there are known allergies.

* **The School Curriculum**

Reasonable adjustments should be considered with regard to a pupil’s allergies and the classes/activities to be undertaken, e.g. food preparation or use of certain materials in science.

* **General School Arrangements**

The class register should be clearly marked to indicate pupils with allergies so that when a supply teacher takes a class she/he is aware of any pupils with allergies in that class.

Photographs of the child should also be made available to relevant staff, e.g. kitchen/dining hall staff, to ensure they are aware of which pupils have severe allergies.

Such arrangements require to be in line with Section 8.2: Confidentiality of the Procedures.

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| --- | --- | --- | --- |
| **Pupil’s name:** |  |  |  |
| **Date of birth:** |  |  |
| **CHI (if known):** |  |  |
| **Address:** |  |  |
| **School:** |  |  | Insert photograph of pupil |

|  |
| --- |
| This Individual Healthcare Plan should be completed by the pupil’s parent.   * If medication is required in school a copy of the prescription or the prescription re-order form detailing the medication and dosage must be attached to this plan.   Once completed, the parent is responsible for taking a copy of this Individual Healthcare Plan to all relevant hospital appointments for updating.  Please read the Privacy Notice available at:  <https://www.westlothian.gov.uk/media/45140/Privacy-Notice/pdf/ASN_Privacy_Notice_14092020_.pdf?m=637357012009700000> |

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| **Parent Contact 1** | | | | **Parent Contact 2** | | | |
| **Name:** |  | | | **Name:** |  | | |
| **Relationship to pupil:** | | |  | **Relationship to pupil:** | | |  |
| **Address:** | |  | | **Address:** | |  | |
| 🕾 **Home:** | |  | | 🕾 **Home:** | |  | |
| 🕾 **Work:** | |  | | 🕾 **Work:** | |  | |
| 🕾 **Mobile:** | |  | | 🕾 **Mobile:** | |  | |
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| **Hospital/Clinic Contact(s)** | | | | **General Practitioner(s)** | | | |
| **Name:** | |  | | **Name:** | |  | |
| **Job title:** | |  | | **Job title:** | |  | |
| **Address:** | |  | | **Address:** | |  | |
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**Details of Medical Condition**

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| **This pupil is allergic to:** |
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**Details of Symptoms:**

The pupil will present with some of the following symptoms:

* itching
* red blotchy rash
* tingling/burning sensation in mouth
* tingling/burning sensation in lips
* swelling of lips
* swelling of eyes
* swelling of face
* swelling round sting
* increased rate of breathing
* behaviour change, less responsive or confused
* collapse

**Details of Medication Required in School:**

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dose** | **Comment** |
| **Antihistamine:**   |  | | --- | |  |   (Insert name of medication) |  | As per action flowchart.  Repeat if vomited within 30 minutes. (Continue 4 hourly for 24 hours) |
| **Salbutamol Inhaler**  **(If asthmatic)** |  | As per action flowchart.  2-10 puffs via spacer, 2 puffs initially then 1 puff per minute. |
| **Adrenaline Pen**   |  | | --- | |  |   (Insert name of medication) |  | As per action flowchart.  Parent: please consult your GP when your child’s weight has reached 30kg as they will require the adult adrenaline pen. |

**Agreement to Individual Healthcare Plan**

**NHS Confirmation:**

**(If, on completion of risk assessment, Head Teacher determines that this is required):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of approving healthcare professional:** | | |  | | |
| **Job Title:** | |  | | | |
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| **Signature:** | | | | **Date:** |  |

(A letter detailing medication/care, dated and signed by the approving healthcare professional can be attached to this Individual Healthcare Plan and be accepted as the approving signature.)

**Parent:**

* I have read the [Privacy Notice](https://www.westlothian.gov.uk/media/45140/Privacy-Notice/pdf/ASN_Privacy_Notice_14092020_.pdf?m=637357012009700000).
* I request that the school contacts the healthcare professional(s) named on this form if required, and for those professionals to advise the school in any relevant matters in connection with my child’s healthcare as they relate to this form.
* I accept responsibility for keeping the school informed of anything that might be relevant in relation to the implementation of this care.
* I accept responsibility for ensuring that there are supplies of any relevant in-date medication, materials or equipment for my child’s needs in the original packaging/container in which it was purchased/dispensed including any patient information leaflet, clearly labelled with my child’s name in full and the dose to be given.
* At the end of the summer term (June), as long as the expiry date of any prescribed long-term emergency medication (including prescribed personal inhalers) being held in school exceeds the following October holiday period, I acknowledge there is the option for the school to securely hold the medication during the summer break for use at the start of the new term. I confirm that Sections 2, 3 and 4 of this form have been completed to highlight my intentions.
* I accept that at the end of the summer term (June), school staff will dispose of any prescribed long-term emergency medication (including prescribed personal inhalers) that remain in school without my previous notification.

## NB: Prescribed long-term emergency medication is considered to be treatments for Asthma, Diabetes, Epilepsy and Severe Allergies.

I wish my child to have the care/medication detailed in this plan and I accept that the emergency services will be summoned, where appropriate.

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| --- | --- | --- | --- | --- |
| **Name of parent:** | |  | | |
| **Signature:** |  | | **Date:** |  |

**Pupil – aged 12 years or over (if appropriate):**

* I agree to the requested healthcare arrangements detailed in this plan.
* I have read and understood the [Privacy Notice](https://www.westlothian.gov.uk/media/45140/Privacy-Notice/pdf/ASN_Privacy_Notice_14092020_.pdf?m=637357012009700000).

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

**The Head Teacher/designated person:**

* I agree to the procedures detailed in this plan being administered in school.
* The healthcare/medication will be administered by staff who have knowledge and understanding of the appropriate healthcare and interventions.
* In the event of an emergency, the emergency services will be summoned and the school will follow advice received from the health professionals.

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| **Name of Head Teacher/designated person:** | |  | | |
| **Job Title:** |  | | | |
| **Signature:** |  | | **Date:** |  |

**Staff administering the healthcare to the pupil:**

* I have read this pupil’s Individual Healthcare Plan.
* I have knowledge of and understand the healthcare and medication requirements detailed in this plan.
* I agree to administer the healthcare and medication to this pupil as detailed in this Plan.

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| **Staff Member** | **Job Title** | **Date** | **Signature** |
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| **Pupil’s name:** |  | **Date of birth:** |  | **School:** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Review agreement of parent and pupil aged 12 years or over (if appropriate)** | | | | | | **Review agreement of Head Teacher/school** | |
| * I can confirm that the existing Individual Healthcare Plan continues to reflect the current needs of my child/this pupil, and propose that a further review is undertaken in line with the next review date which I have detailed below\*. * I will inform the school if my child’s/this pupil’s needs change prior to the next review date, and will arrange with the school for a replacement Individual Healthcare Plan to be completed. * I request that the school contacts the named healthcare professional(s) and for those professionals to advise the school in any relevant matters in connection with this Individual Healthcare Plan. * I accept responsibility for keeping the school informed of anything that might be relevant in relation to the implementation of this care. * I accept responsibility for ensuring that there are supplies of any relevant in-date medication, materials or equipment for my child’s needs in the original packaging/container in which it was purchased/dispensed including any patient information leaflet, clearly labelled with my child’s name in full and the dose to be given. * At the end of the summer term (June), as long as the expiry date of any prescribed long-term emergency medication (including prescribed personal inhalers) being held in school exceeds the following October holiday period, I acknowledge there is the option for the school to securely hold the medication during the summer break for use at the start of the new term. I confirm that Sections 2, 3 and 4 of this form have been completed to highlight my intentions. * I accept that at the end of the summer term (June), school staff will dispose of any prescribed long-term emergency medication (including prescribed personal inhalers) that remain in school without my previous notification. * I wish my child/this pupil to have the care/medication detailed in this plan and I accept that the emergency services will be summoned, where appropriate. | | | | | | * I agree to the procedures detailed in this plan being administered in school. * The medication will be administered by staff who have the knowledge and understanding of the appropriate healthcare and interventions. * In the event of an emergency, the emergency services will be summoned and the school will follow advice received from the health professionals. | |
| **Date review undertaken** | **Method**  **(F) Face to Face**  **(P) Post**  **(T) Telephone** | **Name of parent reviewing (BLOCK LETTERS)** | **Parent’s signature**  **(if review conducted face to face or by post)** | **Pupil’s signature (if appropriate)** | **\*Next proposed review date** | **Name of staff member (BLOCK LETTERS)** | **Staff member’s signature** |
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**N.B. On completion of the above, copies should be given to parent.**

* Dial 999
* Follow instructions from ambulance control
* Stay with child
* If no improvement in breathing or alertness after 5 minutes, give second Adrenaline Pen
* Contact parents
* Give used Adrenaline Pen to ambulance staff

Lie pupil down and raise pupil’s feet.

**Administer Adrenaline Pen**

* Remove outer safety cap
* Grip Adrenaline Pen firmly around the middle with arrow (needle end) to floor
* Hold the needle end of the Adrenaline Pen 2 cm from the upper outer thigh
* Jab the Adrenaline Pen into the leg until you hear it click
* Hold the Adrenaline Pen firmly in place for 10 seconds
* Remove Adrenaline Pen from leg
* Send someone to collect the 2nd Adrenaline Pen held in school

**Severe Reaction**

* Swollen tongue
* Hoarse voice, difficulty swallowing
* Cough, difficulty breathing, noisy, laboured breathing
* Change in colour, pale, clammy
* Feeling faint
* Deteriorating consciousness
* Collapse

**Mild/Moderate Reaction**

* Swollen lips
* Flushed, itchy, blotchy skin
* Abdominal pain and nausea
* Swelling around eyes
* Fast breathing

Give Antihistamine Dose:

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(as stated on pharmacy label)

If asthmatic, give reliever via spacer (2 puffs).

Another 8 puffs, 1 puff per minute, can be given.

Contact parent to inform them that their child has had an allergic reaction.

Supervise closely.

If condition worsens to severe reaction:

If child vomits within 30 minutes of being given antihistamine give another full dose.

Regular dosing of Antihistamine as directed on pharmacy label for 24 hours.

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| **Symptom and Action Flowchart for Allergic Reaction (Anaphylaxis)** | | | |
| **Including an Adrenaline Pen** | | |  |
| Refer to Individual Healthcare Plan and medication container for dosages. | | | Insert photograph of pupil |
|  | | |
| **Pupil’s name:** |  |  |
| **Date of birth:** |  |  |
|  | |  |
| **Signature of parent:** | |  |
| **Date:** | |  |
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| **Symptom and Action Flowchart for Allergic Reaction (Anaphylaxis)** | | | | | |
| **NOT Including an Adrenaline Pen** | | | | |  |
| Refer to Individual Healthcare Plan and medication container for dosages. | | | | | Insert photograph of pupil |
|  | | | | |
| **Pupil’s name:** | | |  |  |
| **Date of birth:** | | |  |  |
|  | | | |  |
| **Signature of parent/carer:** | | | |  |
| **Date:** | | | |  |
| * Dial 999 * Follow instructions from ambulance control * Stay with child * Contact parents   **Severe Reaction**   * Swollen tongue * Hoarse voice, difficulty swallowing * Cough, difficulty breathing, noisy, laboured breathing * Change in colour, pale, clammy * Feeling faint * Deteriorating consciousness * Collapse   Lie pupil down and raise pupil’s feet.  **Mild/Moderate Reaction**   * Swollen lips * Flushed, itchy, blotchy skin * Abdominal pain and nausea * Swelling round eyes * Fast breathing   Give Antihistamine Dose:   |  | | --- | |  |   (as stated on pharmacy label)  If asthmatic, give reliever via spacer (2 puffs).  Another 8 puffs, 1 puff per minute, can be given if needed.  Contact parent to inform them that their child has had an allergic reaction.  If condition worsens to severe reaction:  Regular dosing of Antihistamine as directed on pharmacy label for 24 hours.  Supervise closely.  If child vomits within 30 minutes of being given Antihistamine give another full dose. |  |  | |  |