

Hasbury Church of England Primary School / NHS Partnership

The Health of our pupils is of paramount importance poor health can result in a barrier to learning and it is our aim to support Dudley NHS Primary Care in regularly monitoring the health and well-being of individuals.

Our partnership with the NHS enables us to provide facilities for a number of timed checks to be carried out. For your information these are listed below:

- **The Dudley South NHS Primary Care Trust monitors all school Health Advisors caseloads regularly and updated when necessary. This reflects in a good medical liaison between Primary School and Secondary Schools.**
- **It is important that all medical issues are transferred between schools.**
- **Hasbury Church of England Primary School Primary's School Health Adviser (SHA) is Mrs Alex Pejovic and she can be contacted at Halesowen Health Centre.**
- **The care scheme of work that the SHA offers is:-**

Prior to school entry

- **Attend new parents evening**

School entry (Foundation Stage at Hasbury Church of England Primary School Primary)

- **Liaison with class teacher/First Aid Coordinator**
- **Health questionnaire to all parents**
- **Measurement of height and weight**
- **Hearing Sweep test**
- **Children who are highlighted with a medical/developmental problem will be offered a selective school entry health assessment or referred to the appropriate agency.**

Throughout Primary School

- **Referrals from education staff. Reviews of height, weight and hearing will be offered.**
- **Regular 'drop in' sessions for children and parents.**

Year 6

- **Confidential health questionnaire to all parents on transfer to secondary school.**
- **Measurement of height/weight**

Hasbury Church of England Primary School Primary School has an excellent working relationship with our School Health Advisor.

We are working towards promoting good health and ensuring children with any problems are dealt with in a caring confidential manner.

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1 Asthma Policy

1.1 Introduction

“Asthma is a potentially life threatening condition which demands to be taken seriously. With a child admitted to hospital every 12 minutes because of asthma it is essential that schools – where children spend the majority of their time – are able to support children with asthma in their care.

Asthma has become one of the most important medical conditions in the western world.

Most classrooms will have an average of 4-5 children with asthma making it the most common long term medical condition in schools today”

“At school a child with asthma has the right to expect:

- **Immediate access to their inhaler**
- **Appropriate support to fully participate in PE and all activities**
- **Help in catching up with lessons after time off school**
- **An environment free of asthma triggers such as cigarette smoke”.**

(Taken from the National Asthma Campaign, 1999.)

1.2 Aims

Hasbury Church of England Primary School Primary School adopts this policy to ensure that pupils’ individual health needs are met in line with the LEA Inclusion Policy.

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

- **To recognise the needs of all the children with asthma**
- **To ensure that children with asthma participate fully in all aspects of school life**
- **To recognise that immediate access to the child’s inhaler is vital**
- **To maintain a high level of awareness throughout the school regarding all named pupils and their needs.**

1.3 Guidance

In order to achieve these aims, the following guidance should be carried out:-

- **All staff are given basic awareness training about asthma and the use of an inhaler. This training will be updated annually by the school nurse**
- **All staff have a clear understanding of the procedure to follow when a child has a asthma attack**

- **Inhalers for children are accessible at all times. Inhalers to be kept in their classrooms clearly labelled.**
- **Emergency inhalers are kept in the Office and renewed by the school nurse**
- **Inhalers are taken on all school trips and children noted in the Risk Assessment**
- **The school maintains a register of asthmatics with up to date medical details which is kept in the office.**
- **Parents will be reminded via the last summer and the first autumn newsletter to ensure inhalers are in date.**

1.4 Management of Asthma in School

- **Early administration of the correct reliever treatment, usually a blue inhaler, will cause the majority of attacks to be completely resolved.**
- **Parents/carers should supply a labelled inhaler and if needed a spacer device.**
- **Parents/carers should provide written details, on the Dudley Asthma Pupil Form, which are kept in the Office (Appendix D1), of the treatment needed in an attack. The child is then put onto the Asthma Register.**
- **Parents/carers should notify the school of any changes in the treatment, details are evaluated by the school nurse annually.**
- **All teachers must be aware of the children in their class with asthma and their treatment.**
- **Teachers should remind pupils whose asthma is triggered by exercise to take their inhaler before the lesson. Each child's inhaler must be labelled and kept at the site of the lesson.**
- **If a child needs to use their inhaler during the lesson they will be encouraged to do so. Staff must check if a spacer is required.**

1.5 In the event of an asthma attack

- **Ensure that 2 puffs of the blue inhaler are taken immediately. Whenever possible do not move the child, give the medication where ever the child is.**
- **If symptoms do not resolve continue 1 puff every minute for 5 mins.**
- **If symptoms persist with no change after 5 – 10 mins revert to Emergency situation.**
- **If the child's own inhaler is not accessible. The schools emergency device is to be used. Details of attack to be filled in on the form inside Asthma Register. Asthma Medication Issue form (Appendix D2) to be filled in and sent home to inform parents.**
- **Stay calm and reassure the child. Stay with the child until the attack is over.**
- **Encourage the child to breathe slowly and deeply.**
- **After the attack and as soon as they feel better, the child can return to normal school activities.**
- **The child's parents/carers must be informed of the attack.**
- **If a child has repeated attacks and NO personal inhaler is at school, the parents/carers should be contacted. If no communication the school nurse should then be informed.**

1.6 In a Emergency Situation

Call the ambulance if:-

- **The reliever has NO effect after 5-10 minutes**
- **The child is either distressed or unable to talk**
- **The child is getting exhausted**
- **You have any doubts at all about their condition**
- **Continue to give the inhaler 1 puff every minute until help arrives.**

1.7 Safety and Hygiene Issues

The drug in the blue inhalers which is used to relieve symptoms is very safe and cannot do any harm if given too much.

No harm will come to a non-asthmatic child that takes an inhaler.

Emergency spacer devices are for universal use and should be washed in warm soapy water, NOT RINSED, and allowed to dry in the air after each use to prevent cross infection.

The school nurse should be contacted for repeat prescriptions of the emergency inhaler when needed.

2 Anaphylactic Policy

2.1 Introduction

‘Anaphylaxis is an extreme allergic reaction requiring urgent medical treatment.

It is a harmful response by the body to a substance’.

Approximately 7% of the population are allergic to certain foods/ bites/ stings and various types of drugs. So it is therefore very likely that most teachers will come in contact with a child who suffers from an anaphylactic reaction.

If anaphylaxis is dealt with calmly and reassuringly, the child will benefit and other pupils will develop a healthy and accepting attitude towards the condition.

Hasbury Church of England Primary School Primary should ensure that all staff are trained and receive annual up dates by the school nurse to support the management of anaphylaxis in school.

2.2 Aims

- **To ensure that children who have an acute allergy to nuts, eggs, fish and bee/wasp stings have access to their medication.**
- **To provide regular information, training annually and up to date awareness of the identified children within the school.**
- **To provide a safe environment where in children are protected from curriculum activities which may aggravate their allergy- i.e. cookery**
- **To maintain a high level of awareness throughout the school regarding all named pupils and their needs.**

2.3 Key Stage 1

Parents will be seen by Alex Periodic (Dudley Schools Nurse) and an Anaphylaxis Management Plan filled in (Appendix H) – discussing child’s condition, signs and symptoms plus medical treatment.

A photograph will be attached and the forms kept in school office.

Parent/carers must ensure that two up to date Epipens are clearly labelled and given to the teacher.

It is the responsibility of the Senior Lunch Time Supervisor to collect the Epipens at the beginning of lunch and keep them with her in a green First Aid bum bag, returning them to the classes at the end of lunch time.

2.4 Key Stage 2

All children who have a severe allergy are given a green bum bag to carry their Epipens with them at all times. Parents/carers to fill in Request of Carry own medicine form (Appendix I) as child enters into Key Stage 2 which are kept in the blue anaphylactic folder in the office.

It is the parents/carers responsibility to ensure the Epipen is in date.

Parents will be reminded via the last summer and the first autumn newsletter to ensure that Epipens are updated.

Children suffering with anaphylaxis will be photographed annually in order to provide a visual detailed information board in the staffroom.

2.5 Emergency Procedure – in the event of an Anaphylactic Attack

A). It is important that immediately a child complains of any of the following severe symptoms the Epipen is given immediately –

- **Excessive swelling of lips/ mouth/ tongue**
- **Difficulty in breathing/ talking**
- **Drowsiness**
- **Wheezing**
- **The child may fall into unconsciousness (child to be put into the Recovery Position and if needed CPR performed.)**

The injection is given through the clothing, into the top of the thigh- to the count of 10, giving a measured dose of Adrenaline.

Only the Epipen prescribed for the named child should be administered, as the dose is preset to the child's body weight.

If no change in condition after 10 minutes the second Epipen must be given. All treatment relayed to Ambulance staff.

A child cannot be overdosed with Adrenaline, it is better to give the Epipen than not.

When an ambulance is called the Head/Deputy or the next senior member of staff in their absence must be informed immediately.

When a child is given their Epipen they must be transferred to hospital and a member of staff should go with them.

Parents/carers must be informed immediately.

Best practise states that after a child is given the Epipen an ‘Anaphylactic Reaction Chart’ must be filled in and sent with the child to hospital. Forms are kept in the blue anaphylactic folder in the Office. (Appendix J)

It is very important that the used Epipen is sent to the hospital with the child, so the staff can see treatment already had.

B). Some children have a milder form of the allergy and therefore need only a dose of Piriton at the onset of their symptoms. This should be kept in their classroom clearly labelled.

Mild symptoms may be:-

Facial rash

Tickly sensation in back of throat

Muscle ache

Mild swelling of lips/ mouth/ tongue

Headache

They will be able to talk/ breathe normally

Irritability

as prescribed

You must stay with the child for at least 30 minutes to ensure symptoms do not become worse. Ensure plenty of reassurance is given.

The child’s parents/carers should be informed to collect the child, as the child should not be left alone for up to 3 hours afterwards.

The parent/carers must be informed of all treatment given.

If a child is prescribed Piriton an ‘Administration of Medicine’ form must be filled in by a parent/carer. These are kept in the school office. (Appendix K)

3 Epilepsy Policy

3.1 Introduction

One person in every 130 has epilepsy and 75% of people with the condition will have their first seizure before the age of 20. It is therefore likely that most teachers will come in contact with a pupil with epilepsy at some time during their career.

If epilepsy is dealt with calmly and reassuringly, the child will benefit and other pupils will develop a healthy and accepting attitude towards the condition.

- **Epilepsy is a descriptive term and not a specific illness or disease.**
- **It is an altered chemical state of the brain leading to outbursts of extra electrical activity within it.**
- **People that suffer from epilepsy may have seizures or fits. There are many types of seizures, the most common being Absence (petitmal) and Tonic / clonic stage (grand mal).**

Pupils with epilepsy come under the definition of having a disability as described in the “Code of Practice” and are covered by the Special Education Needs and Disability Act (SENDA) and the Disability Discrimination Duties.

3.2 Guidance

In 2002 new duties came into place in the Disability Discrimination of Epilepsy – schools must not discriminate against disabled pupils in the provision of education and in respect of admission to schools and in Inclusion.

- **The school must not treat disabled pupils less favourably.**
- **The school must make reasonable adjustments. Schools should plan in advance to meet the needs of a disabled child.**
- **It is unlawful to exclude a disabled child from school for a reason relating to their disability.**
- **Epilepsy Management Plans and Alert Charts should be filled in with the parents, kept in the office and a copy sent to the class teacher. (Appendix E)**
- **A photograph of the child will be taken and put on the First Aid board in the staff room and updated annually.**
- **The school will keep a record following any seizure, forms kept in the blue Epilepsy folder in the office copy of form should be sent to parents. (Appendix F)**

3.3 Aims

Hasbury Church of England Primary School Primary School adopts this policy to ensure that pupil's individual health needs are met in line with the LEA Inclusion Policy.

- To recognise the needs of all children with Epilepsy.
- To ensure that children with Epilepsy participate fully in all aspects of school life.
- To recognise that immediate treatment is vital.
- To maintain a high level of awareness throughout the school regarding all named pupils and their needs.

3.4 Symptoms of Epilepsy

A) Major Seizures (Tonic / Clonic Stage)

A seizure of this kind is distressing to watch, we all want to help but there is little to be done.

Sometimes sufferers have a warning / aura eg. Certain smell, taste or sensation.

Tonic Stage:

- Sufferer falls unconscious
- Muscles go rigid
- They can go blue in the face
- They can bite their tongue

Clonic Stage:

- Muscles go into spasm
- They will have violent movements of the limbs
- They can froth at the mouth
- They can become incontinent

The duration of the seizure is hardly ever more than 2 minutes. In a severe case another fit could begin straight away, at this point 999 must be called.

After the clonic spasms have stopped the sufferer may go into a sleep, which they should be allowed to do.

B) Absence (Petit mal)

These are much briefer and can be numerous.

They have a loss of consciousness for only 1-2 seconds: they will feel 'dazed' afterwards.

3.5 First Aid Treatment of Epilepsy

Major Seizures

- Inform a trained First Aider if possible
- Never leave the child alone until fully recovered

- **Do not move the child unless they are in danger**
- **Move any objects on which they could hurt themselves**
- **Do not put anything in their mouth**
- **Do not restrict their movements**
- **Turn them into the recovery position once the seizure is over and cushion their head**
- **Provide reassurance / reorientation following the seizure**
- **Maintain their dignity / privacy at all times**
- **Seizure chart to be filled in after the event**
- **Normally there is no need to ring 999, ensure parents are contacted to collect the child if required.**

Minor Seizures

- **Be understanding**
- **Repeat what has happened / missed in the classroom**
- **Note that it has happened and how frequent**
- **Inform the parents**

Management of other children's needs

- **Stay calm**
- **Send for another adult**
- **Reassure the children and arrange for them to leave the room**
- **Consider a simple explanation of epilepsy for them**

3.6 Health and Safety Issues

A) Assessing the Risk

The vast majority of children in schools have good seizure control and will not experience a seizure whilst at school. However, some factors associated with the condition such as side effects of drug therapy may affect the pupil's awareness and their ability to react quickly.

When assessing a child for a task the following factors should be taken into account:

- **Make use of the child's individual care plan**
- **Seizure type**
- **Frequency of the seizures**
- **Pattern of the seizures**
- **Seizure triggers**
- **Environment (use of white boards etc.)**

B) Managing the Risk

Under DDA it is illegal to discriminate against a child as a result of their medical condition. This means that strategies need to be put into place to enable the child to access their full curriculum entitlement.

Strategies may include:

- **Supervision of certain tasks eg. Cooking, technology**
- **Use of peer support**
- **Consideration taken during PE**
- **1:1 supervision at high risk seizure times.**

4 First Aid Policy

4.1 Aims

To maintain an appropriate ratio of qualified staff, at all levels, who under go regular first aid training

To secure a sound provision of first aid trained staff for all school based activities both within and outside school

To ensure the Health and Safety of all pupils throughout the school

4.2 Role of the Staff

- **Teachers have a common law responsibility to look after the children in their care. Guidelines for staff are included in the Staff Handbook.**
- **Non- teaching staff, act under the direction of the Head teacher/ Deputy.**
- **General guidance for parents about school procedures is included in the school prospectus.**

4.3 First Aid Supplies

First aid boxes are maintained at various locations around the school clearly marked, and the medical room is accessible to all children when needed.

First Aid Boxes contain the following:-

- **Selection of plasters**
- **Disposable gloves**
- **Triangular Bandage**
- **Selection of dressings/ bandages**
- **Tape**
- **Medical wipes**

These items can be used by any person in the absence of a first aider, without aggravating the injury and until further help is summoned.

There are green first aid bags in every class room and medical cabinets situated in the both medical rooms and one outside the Staffroom.

4.4 The Administration of Medicines

There are strict procedures laid down by LA which the school must follow. Parents should contact the school office regarding the administration of any medicines to children. A form must be filled in by parents and signed by the Head teacher before the school will administer measured doses of medicines. All medicines are kept in the school office. Under no circumstances must children come with medicines to school to self-administer. These will be taken away from children and parents/carers will be contacted to come and remove unauthorised medicines from the school. The safety of our children is paramount and we will only accept medicines in school where the procedures above have been followed.

4.5 Procedure for Accidental Injury

If anyone should become ill or suffer injury as a result of an accident the following procedure should be followed:-

- **Immediate first aid must be given by the nearest member of staff AS far as knowledge permits, and a message sent to the nearest First Aider.**
- **The casualty must be given all possible reassurance and ONLY if absolutely necessary be moved. If at all possible the patient should not be left alone.**
- **A message must be sent to the Office so that the Head/Deputy are immediately informed.**
- **As soon as possible the parents/carers will be informed.**
- **Pupils must be sent to hospital immediately by ambulance in the following cases:**
 - **Any head injuries and wounds needing stitches**
 - **All suspected fractures**
 - **Any signs of unconsciousness, even for a few seconds**
 - **Anaphylactic shock**

N.B. Legally pupils must be sixteen to be given medical treatment without parental consent, however in ‘Life or Death’ situations treatment is given immediately.

- **Where parents request ambulance attendance other than for the conditions above, any costs will be met by the family.**
- **In cases where an Ambulance is not required the casualty may be transferred to Hospital by car- by the Head and Deputy Head or by a parent/ carer. (See Child Protection Policy)**
- **Following the accident the Accident Report book must be completed, and returned to the Deputy’s Office.**

4.6 Child Reporting Sickness

The school takes its responsibility for the Health, Safety and Welfare of all our children very seriously. It is vital to have consistent procedures for the handling of day to day illness.

- **When a child reports feeling unwell, it is up to the teacher to decide whether or not the child should be sent home. If the child is sent home then the school office will phone the parents informing them that their child is feeling unwell.**

- **In cases where the child has a bump to the head, a ‘bump head’ letter, must be sent home with the child explaining to the parent/carer what has happened and the accident book filled in. School office to phone parents to inform them of the bump, the parents can then decide whether or not they child should go home.**
- **Parents with a child suffering from a short term serious illness are encouraged to contact the School.**
- **We do not encourage children to miss lessons and do not allow unsupervised children to stay indoors during breaks, so before a child is sent back to school after an illness, parents should ensure that the child can cope with the whole school day.**

4.7 Exclusion Conditions

There are regulated exclusion periods for:

- **Fevers**
- **Infection**
- **Gastro illnesses**
- **Skin infections**
- **General infections**
- **Infestations**

Children should remain away for the regulated time stated on the following pages, to prevent epidemics occurring.

Disease	Usual Incubation Period	Period of communicability	Minimal period of exclusion from school	
			Cases– subject to clinical recovery	Contacts – family/close
Rubella (German measles)	2 – 3 weeks	7 days before to 4 days after onset of rash	Until recovered/4 days from onset rash	None
Measles	7 – 18 days	Just before start symptoms to 5 days after start of rash	Until recovered/5 days from onset of rash	None
Mumps	18 - 21 days	7 days before to 7 days after onset of swelling	7 days from onset of swelling	None
Chickenpox and Herpes zoster (Shingles)	14 – 21 days	1 – 2 days before to 5 days after onset of rash	Until rash dried – generally for 5 days from onset of rash (+see shingles)	None
Scarlet Fever (streptococcal)	1 - 3 days	Whilst organism in nose/throat – usually 48 hours from onset	Scarlet fever – 1 week onset Other – when treated	None
Whooping Cough	7 – 10 days	7 days after exposed to 21 days after onset paroxysmal cough	For 3 weeks after onset of cough and fully recovered.	None

Disease	Usual Incubation Period	Period of communicability	Minimal period of exclusion from school	
			Cases– subject to clinical recovery	Contacts – family/close
Gastroenteritis of unknown cause – include viral	Viral – may 12 – 48 hours	Whilst organism is present in stools	Until clinically well and no diarrhoea for 48 hours	Exclusion not routinely needed for contacts or family members
Dysentery (Shigella)	1 – 7 days	Most infectious when have diarrhoea Most infectious when have diarrhoea Less risk transmission when stools well formed	Depending on cause, children in nursery classes may be excluded longer In rare cases exclusion may be extended and stool specimens needed – will be a discretion of the CCDC	If symptoms develop, should also be excluded. Some cases may have stool tests if positive may advised by excluded. Extra precautions with food handlers – should have stool tests
Salmonella – food poisoning	12 – 72 hours			
Campylobacter – food poisoning	1 – 10 days (usual 2-5)			
Cryptosporidia infection	3 – 14 days			
Giardia infection	4 – 25 days			
E. Coli – verotoxin producing	1 – 14 days – usual 1 – 6 days	Whilst organism in stools	Until normal stools for 48 hours and may need stool specimens – discretion CCDC	Younger family contact may need to be excluded until case well – at discretion of the CCDC

Other Gastrointestinal Illness and Infective Jaundice

Hepatitis A	15 – 50 days – usual one month	1 -2 Weeks before onset to 1 week after onset jaundice	Until one week after onset of jaundice	None
Hepatitis B	48 – 180 days – usually 60 – 90 days	Whilst organism in body fluids. Can carry without symptoms.	Until clinically recovered	Not required – CCDC will advise
Typhoid Fever	7 – 21 days	Whilst organism in stools or urine	At discretion of the CCDC	At discretion of the CCDC
Paratyphoid Fever	1 – 10 days			
Skin and Other Specific Site Infections				
Impetigo	4 – 10 days	Whilst purulent lesions. Antibiotics rapidly effective. Some carry organism	Once treatment started for 48 hours	None
Hand, foot and mouth disease – coxsackie virus	3 – 5 days	Whilst acute illness. May persist in stools for months.	Until clinically well	None
Firth disease (Slapped cheeks syndrome)	3 – 5 days before appearance of rash	Reduced once rash appears	None	None
Disease	Usual Incubation Period	Period of communicability	Minimal period of exclusion from school	
Herpes simplex (cold sores)	2 – 11 days	Until lesion is dry/not secreting	May not practical – until dried	Children with eczema best avoid contact
Conjunctivitis	Vary – 24 – 72 hours	During active infection	Once inflammation improving and discharge stopped – start treatment	None
Respiratory infections, Bronchitis, parainfluenza	1 – 10 days	Duration of active illness	Until recovered	None
Serious General Infections				
Meningococcal infection – Meningitis	2 – 7 days	Whilst organism in nose and throat	Until full clinical recovery CCDC will advise	No exclusion – may receive antibiotics
Meningitis – viral	Variable	Variable	Until recovery only	None
Diphtheria	2 – 5 days	Whilst organism is throat or nose	At discretion of the CCDC	At discretion of the CCDC
Poliomyelitis	3 – 21 days	Whilst virus in stools	At discretion of the CCDC	At discretion of the CCDC
Tuberculosis	25 – 90 days	Whilst organism is sputum. Non-infectious 2 weeks after start treatment	CCDC and TB Nurses will advise	Contacts of cases of pulmonary TB will be screened. CCDC will advise re school contacts
Infestations and Skin Infections				
Lice of head or body –pediculosis	Eggs hatch in 7 days, mature in 8	Whilst lice or nits alive on person or clothes	Until treated effectively	Family need to be examined and may be treated

	days			
Scabies	2 – 6 weeks; if re exposure may be only 1 – 4 days	Until eggs and mites destroyed by treatment	For 24 hours after treatment	Family need treating also
Ringworm scalp – tinea	10 – 14 days	Whilst active lesions present can very infectious	Until started effective treatment – ideally for 2 week after start treatment	None – unless signs infection
Ringworm of the body	4 – 10 days	Whilst lesions present	Until started treatment	None – unless signs infection
Ringworm of feet – Athletes foot	Uncertain	Whilst lesions present	No exclusions – can do barefoot activities – treatment is advised	None
Verrucae plantaris – plantar warts	2 – 4 months – ranges 1 – 20 months	Uncertain – whilst lesions visible	No exclusion from school/activities. May cover with plaster – benefit uncertain	None
Worms – include threadworms	Variable	Until worms treated	Until treated	Family may need treating eg. threadworms

4.8 Head Lice

If any child is found to have head lice they must be sent home immediately to be treated and then may return after treatment.

Head lice information letters should then be sent out to the appropriate year group. These letters are kept in the Office. (Appendix C)

4.9 Reporting Accidents

Employees

- A) All accidents to employees/ non-employees or pupils must be recorded in the Accident Books which are kept in either the Rainbow Room (Early Years' Building) or Reprographic Room (Upper Years' Building) Entries should be made as soon as possible after the injury, by the member of staff who has treated the pupil.

If any pupil sustains a severe injury following an accident Risk Assessment form should be completed and sent to Risk Management within 5 days.