FIRST AID AND SICK CHILD POLICY
Available on The Gower School (TGS) website and upon request from the school office of all sites

Legal Status:

- Complies with Part 3, Paragraph 14 of the Education (Independent School Standards) (England) (Amended) Regulations 2015.
- Complies with Reporting of Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)
- Complies with the Guidance First aid in schools, early years and further education updated 14 February 2022
- Complies with the Health and Safety (First Aid) Regulations 1981, version L74 (Third edition, published 2013 – reissued with minor amendments in 2018)
- The Gower School is mindful of its duty to report to the Health and Safety Executive (HSE) any instances that fall within the Reporting Injuries, Diseases or Dangerous Occurrences Regulations 2013 (RIDDOR 0345 300 9923)
- See EYFS Statutory Framwork re the requirement for paediatric first aid training. For the EYFS and Ofsted requirements, at least one person who has a current paediatric first aid (PFA) certificate must be on the premises and available at all times when children are present, and must accompany children on outings. The full PFA course will last for a minimum of 12 hours.

TGS has an appointed person for the health and safety of the school's employees and anyone else on the premises. This includes all teaching and non-teaching staff, volunteers, children and visitors (including contractors). They must ensure that a risk assessment of the school is undertaken and that the appointments, training and resources for first aid arrangements are appropriate and in place.

Applies to:

- The whole school including the Early Years Foundation Stage (EYFS), out of school care, the breakfast club, the afterschool clubs, the holiday club and all other activities provided by the school, inclusive of those outside of the normal school hours;
- All staff (teaching and support staff), students on placement, the proprietor and volunteers working in the school.

Related documents:

- Administration of Medication Policy
- Special Medical Needs Policy

Monitoring and Review:

- This policy will be subject to continuous monitoring, refinement and audit by the Principal.
- The Principal will undertake a formal annual review of this policy for the purpose of monitoring and of the efficiency with which the related duties have been discharged, by no later than May 2027, or earlier if significant changes to the systems and arrangements take place, or if legislation, regulatory requirements or best practice guidelines so require.

Signed:

Emma Gowers

Miss Emma Gowers
Principal and Proprietor

Date reviewed: May 2026
Date of next review: May 2027

Introduction
This policy is designed to ensure that all children can attend school and/or nursery regularly and participate in activities.

This policy outlines our statutory responsibility to provide adequate and appropriate first aid to children, staff, parents and visitors and the procedures in place to meet that responsibility. The HSE recommend that there will be at least one person available at all times (per 50 employees) who has completed first aid at work (FAW) or emergency first aid at work (EFAW) training. The majority of TGS staff have completed this training. However, staff must NEVER perform any First Aid Procedures that they have not been adequately trained to do. Unless first-aid cover is part of a staff member's contractual duties, first-aiders are selected on a voluntary basis, except where there is a requirement for both employees and volunteers to have completed paediatric first aid training. First-aiders must complete a training course approved by the HSE. TGS will ensure that there are an appropriate number of first aiders on site at all times when children are present.

All companies are required by The Health and Safety (First Aid) Regulations 1981 version L74 (Third edition, published 2013 – reissued with minor amendments in 2018) to provide trained first aid, resources and treatment for staff in the event of injury or ill health at work. Although the regulations only require the employer to provide cover for staff, it is the school's policy to extend this cover to children and visitors. First-aiders' main duties are to give immediate help to casualties with common injuries and those arising from specific hazards at school, and, when necessary, to ensure that an ambulance or other professional medical help is called.

TGS will provide:
- Practical arrangements at the point of need;
- the names of those qualified in first aid and the requirement for updated training every three years;
- at least one qualified person on each school site when children are present. TGS have more that the recommended number of Paediatric First Aid trained staff and named first aiders in the building during nursery and school hours;
- information on how accidents are to be recorded and parents informed;
- access to first aid kits;
- support children with particular medical conditions (for example asthma, epilepsy, diabetes);
- suitable hygiene procedures for dealing with the spillage of body fluids;
- guidance on when to call an ambulance;
- information to RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995), under which schools are required to report to the Health and Safety Executive (telephone 0345 300 9923).

Methodology
This First Aid Needs Assessment will consider the following topics:
- The nature of the work, the hazards and the risks
- The new classification of first aiders
- The nature of the workforce
- School's history of accidents and illness
- Excursions/Sports Fixtures/Lone Workers
- The distribution of the workforce
- The remoteness of the site from emergency medical services
- The assessment of the number of first aiders required

Aims
- To ensure that first aid provision is available at all times while people are on school and/or nursery premises, and also off the premises whilst on visits.
- To provide first aid treatment where appropriate for all users of the school and/or nursery (with particular reference to children and staff)
- To provide or seek secondary first aid where necessary and appropriate.
- To treat a casualty, relatives and others involved with care, compassion and courtesy.

Objectives
- To appoint the appropriate number of suitably trained people as Appointed Persons and First Aiders to meet the needs of the school and/or nursery
- To provide relevant training and ensure monitoring of training needs
- To provide sufficient and appropriate resources and facilities
- To inform staff and parents of TGS first aid arrangements

First-aid arrangements
The employer (the Proprietor who is also the Principal) or delegated manager must inform all staff of the first-aid arrangements, the location of equipment, facilities and first-aid personnel, and the procedures for monitoring and reviewing the school's first-aid needs. A simple method of keeping staff and children informed is by displaying first-aid notices in staff and common areas. The information will be clear and easily understood. Notices must be displayed in a prominent place, preferably one in each building if the school is on several sites. First-aid information in induction programmes will ensure that new staff and children are told about the first-aid arrangements. It is also good practice to include such information in a staff handbook.
Source: G*uidance on First Aid for Schools: A Good Practice Guide.*

Classification for first aiders.
There are now three levels of workplace first aider:

- Emergency First Aider at Work (EFAW) – 1 day course
- Paediatric First Aider – minimum of 12 hours
- First Aider at Work (FAW) –18-hour course.
  (Details of the type of training needed for EFAW and FAW are attached at Annex A)

The Nature of the Workforce
We have considered the needs and health of all employees, children, and visitors/contractors. There will be one or more First Aider at Work (FAW) on duty. Before a child is accepted for a placement in the school with specific health problems/disability, such as heart conditions, asthma, diabetes etc. a separate risk assessment will be completed if required by the Premises Manager or a delegated manager who must consider the training needs for the First Aiders within the school.

The Premises Manager is responsible for ensuring that there is adequate first aid cover available at all times, including when a first aider is on annual leave, a training course, a lunch break or other foreseeable absences.

It is not acceptable to provide an 'Emergency First Aider at Work' (six-hour course) to cover foreseeable absences of a First Aider at Work' (18-hour course). The evidence of the level of injury in our school is relatively low and generally confined to child injuries, most of which are results from slips/trips and falls or occasioned on the sports grounds, in the school hall or in the parks. Again, most of the injuries are minor and require minimal first aid attention.

When considering first-aiders, we will consider an individual's:

- reliability and communication skills
- aptitude and ability to absorb new knowledge and learn new skills
- ability to cope with stressful and physically demanding emergency procedures
- normal duties: a first aider must be able to leave their usual post and go immediately to an emergency.

<u>Definitions</u>
First Aid
The arrangements in place are to initially manage any injury or illness suffered at work. It does not matter if the injury or illness was caused by the work being carried out. It does not include giving of any tablets or medicine to treat illness.

Full First Aider
A person who has completed a course of first aid training with a training establishment approved by the Health and Safety Executive and holds a current certificate.

Full Paediatric First Aider
A person who has completed a full (2-day) course of first aid training with a training establishment approved by the Health and Safety Executive and holds a current certificate.

Appointed Person
A person who has completed a 1-day course of emergency first aid from a competent trainer and holds a current certificate and who:

- takes charge when someone is injured or becomes ill
- looks after the first-aid equipment
- ensures that an ambulance or other professional medical help is summoned when appropriate.

The minimum requirement is that an appointed person must take charge of the first-aid arrangements. An appointed person is not a first aider and will not give first-aid treatment for which they have not been trained. Any member of staff may volunteer for duties as an appointed person. There are no rules on the exact number of first-aid personnel. This will be a judgement based upon local circumstances and a suitable and sufficient risk assessment.
See *Guidance on First Aid for Schools: A Good Practice Guide* (sections 43 to 46) for guidance on numbers. From the HSE perspective, there will be at least one person available at all times (per 50 employees) who is trained with an HSE qualification.

Policy Statement
The Gower School will undertake to ensure compliance with all the relevant legislation with regard to the provision of first aid for children, staff, parents and visitors. We will ensure that procedures are in place to meet that responsibility. This policy will be read in conjunction with TGS Health and Safety policy and policy on Safeguarding children on school visits. It will be reviewed annually.

First Aid Facilities
The Principal appoints a competent person to ensure that the appropriate number of first-aid containers are available according to the risk assessment of the site and activity.

- All first-aid containers must be marked with a white cross on a green background;
- First aid containers will always be taken when the children take part in any specialist facilities and during any offsite activities/educational visits. First aid containers must be taken when teachers take children off-site for Physical Education (PE);
- Spare stock will be kept in school;
- Responsibility for checking and restocking the first-aid containers is that of the all staff and is overseen by the Premises Manager. The First Aiders must notify the relevant offices any necessity of restocking of the first aid boxes.

Training
First Aiders are trained and have had specific instruction regarding some other health conditions. The list of staff with current first aid training is available at the nursery site, 28 North Road, N7 9GG. All first aid qualifications are updated every three years in accordance with regulations.

We aim to ensure that all our staff – teaching and support staff – are trained as paediatric first aiders.

Both a *full first aider* and at least one *paediatric first aid certificate (PFA)* will always be on the premises and a *paediatric first aider* will always accompany the EYFS children when using any specialist facilities and during any offsite activity/education visit. First aid kits are available on the premises, and for educational visits and offsite activities. A full or emergency PFA certificate is now a requirement for level 2/3 EYFS workers who qualified on or after 30th June 2016 in order to be included in the ratios. The PFA course undertaken, which must be renewed every three years, must meet the standards set out in Annex A of the EYFS Framework – i.e. a full or emergency PFA course delivered by a competent provider of regulated qualifications such as St John Ambulance, the British Red Cross and Safe and Sound.

First Aiders' responsibilities

- To give first response treatment
- To summon an ambulance through the school and/or nursery office, when necessary.
- To inform the school and/or nursery office when children are too unwell to stay at school and/or nursery. The office will contact parents to collect their child and, when required, inform them of the accident and the hospital to which their child is being taken.
- To keep a legible written record of attendances, with dates, times and treatment given.

Policy on First Aid in School and/or Nursery
All staff, both teaching and non-teaching are responsible for dealing with minor incidents requiring first aid. During lesson time, first aid is administered by the qualified class teacher, assistant, or nursery practitioner or one of the first aiders. If an accident occurs off site, then first aiders will deal with any accidents. The first aiders are authorised to apply dressings and compresses and take reasonable steps to facilitate symptom relief. Fully stocked first aid kits are available in all areas of the nursery and school. Any action taken will be recorded. Accidents must be recorded using Medical Tracker, and if serious, parents will be informed by telephone. All parents will be informed if their child has a head injury via phone. If an injury or illness involves spillage of body fluids gloves will be worn. If there are any concern about the first aid which should be administered, then the qualified first aiders must be consulted.

The arrangements for first-aid provision will be adequate to cope with all foreseeable incidents. The number of designated first-aiders will not, at any time, be less than the number required by law. This is determined by risk assessment (Local Authority guidance). Designated staff will be given such training in first-aid techniques as is required to give them an appropriate level of competence. The Principal is responsible for ensuring that a sufficient back-up stock is held on site. Notices will be displayed in prominent locations throughout the establishment identifying how to summon first aid in an emergency, who the first aiders are and their contact and location details. All first aid-signs and containers must be identified by a white cross on a green background. A written record will be kept of all

first-aid administered either on the school premises or as a part of a school related activity. Any member of TGS community who perceives that he or she is dealing with an emergency requiring the immediate calling of an ambulance, for example, the onset of a heart attack or stroke, will phone for an ambulance immediately rather than wait until a first aider or an appropriate deputy appears.

Arrangements for dealing with an injured or sick child:
In the case of an injury, the first aider will:

1. Ascertain by inspection and discussion with child or staff member the nature of the child's injury or illness.
2. Comfort or advise as necessary. This may be sufficient and the child can return to class or break. Inform staff members of the nature of any concerns if appropriate.
3. Treat injury or illness if required. Clean wound with non-alcohol wipe or running water and cover with a plaster if still bleeding and no allergy exists.
4. Record any action taken on Medical Tracker
5. If a child is then well enough he/she will return to class.
6. If problems persist or there are doubts as to the seriousness of any injury, then parents will be telephoned and asked what they would like to do. If he/she wishes to collect their child appropriate arrangements are made. SLT and Principal to be informed.
7. If a severe illness or injury is suspected, parents will be asked on the phone call to take their child to hospital. If the parent is unable to get to school immediately, an appropriate member of staff will take the child to hospital in a taxi.
8. If any issue arises during treatment or discussion with the child that the first aider feels should be taken further, she/he will telephone or speak to the parents and/or the Designated Safeguarding Lead or most appropriate member of staff.

N.B. The First Aiders will have up to date Emergency First Aid training and some will have a full and current First Aid at Work Certificate. At least one staff working specifically in the EYFS department has Paediatric First Aid Training Certificates. They are not, however, medically qualified and hence cannot give medical advice.

Sick children:
We understand that working parents need to be able to go to work, however if a child is unwell, then they will be better cared for in their own home with a parent and/or carer. Additionally, the prompt exclusion of children and staff who are unwell with an infectious disease is essential to preventing the spread of infection in education and childhood settings. If a parent or carer insists on a child with symptoms attending school and/or nursery, where the child has a confirmed or suspected case of an infectious illness, TGS can make the decision to refuse the child. This is necessary to protect other children and staff from possible infection.

Please see Annex: Exclusion periods for infectious illnesses.

Hygiene/Infection control
Staff will take precautions to avoid infection and must follow basic hygiene procedures. Staff will have access to single-use disposable gloves and hand-washing facilities, which must be used when dealing with any blood or other bodily fluids. Staff will take care when dealing with such fluids, and when disposing of dressings or equipment. Make sure any waste (wipes, pads, paper towels etc.) are placed in a disposable bag and fastened securely. Any children's clothes will be placed in a plastic bag and fastened securely ready to take home.

Radiation and risk management
If a child has had a medical procedure, which results in the child passing small amounts of radioactive isotopes from their urine (wee) and/or faeces (poo) then we will implement the following procedures:

- Give the child plenty to drink. This will help the isotope pass out of their body as quickly as possible.
- If the child is toilet-trained, they should go to the toilet as often as possible. When they have used the toilet, it should be flushed twice and the child must wash their hands thoroughly with soap and water.
- If the child is potty training, flush the toilet twice after emptying the potty. Wash the potty and your hands thoroughly in warm soapy water.
- If the child is in nappies, you should change them frequently and dispose of the dirty nappy in an outside bin. Wash your hands thoroughly after nappy changing.
- If you are pregnant or think you could be pregnant, you should avoid contact with the child's bodily fluids, such as urine, faeces and vomit.

Supporting sick or injured child
With reference to sick children and medicine we:

- Make every effort to keep abreast of new information relating to infectious, notifiable and communicable diseases and local health issues.
- Isolate a child if we feel that other children or staff are at risk.
- Contact parents to take children home if they are feeling unwell/being sick/have diarrhoea/have had an accident/may have an infectious disease.

- Ring emergency contact numbers if the parent or carer cannot be reached.
- Make every effort to care for the child in a sympathetic, caring and sensitive manner.
- Respect the parents' right to confidentiality
- Keep other parents informed about any infectious diseases that occur.
- Expect parents to inform the office if their child is suffering from any illness or disease that may put others at risk.
- We will ensure that we implement our policy on administration of medicines.

Confidentiality
Information given by parents regarding their child's health will be treated in confidence and only shared with other staff when necessary or appropriate.

Monitoring
Accident reports can be used to help the Premises Manager to identify trends and areas for improvement. They also could help to identify training or other needs and may be useful for insurance or investigative purposes. The Premises Manager tracks the accident records. This policy will be reviewed annually.

Record keeping
Statutory accident records: The Principal must ensure that readily accessible accident records, written or electronic, are kept for a minimum of seven years. The Principal must ensure that a record is kept of any first aid treatment given by first aiders or appointed persons. This should include:

- the date, time and place of incident
- the name (and class) of the injured or ill person
- details of their injury/illness and what first aid was given
- what happened to the person immediately afterwards
- name of the first aider or person dealing with the incident.
- Evidence to acknowledge parents have been informed of an accident
- head injury: the parent will be called and a record maintained to confirm contact has been made
- RIDDOR to be completed where applicable

Reporting
All accidents and injuries will be reported using Medical Tracker. Email notifications are sent to parents advising them of an accident. A full and detailed account needs to be recorded on Medical Tracker including any treatment given. The accidents are tracked by the Premises Manager to ensure that accidents are not occurring in the same area. If so, this will be addressed with the Principal and Head of Nursery.

Reporting to Parents: In the event of accident or injury, parents must be informed on the same day. The member of staff in charge at the time will decide how and when this information will be communicated, in consultation with the Principal/Head of Nursery if necessary. Parents are always called if there is a head injury, no matter how apparently minor. If a parent/carer goes home without being informed of the accident, it is the responsibility of the member of staff in charge, to call the parent or inform the office, so that they can do so.

Accidents involving staff: Work related accidents resulting in death or major injury (including as a result of physical violence) must be reported immediately (major injury examples: dislocation of hip, knee or shoulder; amputation; loss of sight; fracture other than to fingers, toes or thumbs) to RIDDOR. Work-related accidents must be reported where they result in an employee being away from work, or unable to do their normal work duties, for more than 7 consecutive days as the result of their injury. This 7-day period does not include the day of the accident but does include weekends and rest days. The report must be made within 15 days of the accident.

Accidents involving children or visitors: Accidents where the person is killed or is taken from the site of the accident to hospital and where the accident arises out of or in connection with:

- any school activity (on or off the premises)
- the way a School activity has been organised or managed (e.g. the supervision of a field trip)
- equipment, machinery or substances
- the design or condition of the premises. Need to be reported without delay to HSE, followed by Form F2508 and to Ofsted and local child protection agencies in the event of a serious accident, illness or injury to, or death of, any child while in their care

For more information on how and what to report to the HSE, please see:
http://www.hse.gov.uk/riddor/index.htm. It is also possible to report online via this link.

Basic First Aid

If someone is injured, the following steps will keep them as safe as possible until professional help arrives:

- Keep calm.
- If people are seriously injured call 999; contact the First Aider.
- Make sure you and the injured person are not in danger.
- Assess the injured person carefully and act on your findings using the basic first aid steps below.
- Keep an eye on the injured person's condition until the emergency services arrive.

Bleeding:

If someone is bleeding heavily, the main aim is to prevent further blood loss and minimise the effects of shock.

First, dial 999 and ask for an ambulance as soon as possible.

If you have disposable gloves, use them to reduce the risk of any infection being passed on.

Check that there's nothing embedded in the wound. If there is, take care not to press down on the object. Instead, press firmly on either side of the object and build up padding around it before bandaging to avoid putting pressure on the object itself.

Do not try to remove it because it may be helping to slow down the bleeding.

If nothing is embedded:

- Apply and maintain pressure to the wound with your gloved hand, using a clean pad or dressing if possible. Continue to apply pressure until the bleeding stops.
- Use a clean dressing or any clean, soft material to bandage the wound firmly.
- If bleeding continues through the pad, apply pressure to the wound until the bleeding stops, and then apply another pad over the top and bandage it in place. Do not remove the original pad or dressing, but continue to check that the bleeding has stopped.

If a body part, such as a finger, has been severed, place it in a plastic bag or wrap it in cling film. Do not wash the severed limb. Wrap the package in soft fabric and place in a container of crushed ice. Do not let the limb touch the ice. Make sure the severed limb goes with the patient to hospital.

Always seek medical help for bleeding, unless it's minor.

Burns and scalds:

- For all burns and scalds, cool the burn as quickly as possible with cool running water for at least 20 minutes, or until the pain is relieved.
- Call 999 or seek medical help, if needed.
- While cooling the burn, and before the area begins to swell, carefully remove any clothing or jewellery, unless it's attached to the skin.
- If you're cooling a large burnt area, particularly in babies, children and elderly people, be aware that it may cause hypothermia (it may be necessary to stop cooling the burn to avoid hypothermia).
- If the burn has cooled, cover it loosely with cling film. If cling film isn't available, use a clean, dry dressing or non-fluffy material. Do not wrap the burn tightly as swelling may lead to further injury.
- Do not apply creams, lotions or sprays to the burn.

Chemical burns

For chemical burns, wear protective gloves, remove any affected clothing, and rinse the burn with cool running water for at least 20 minutes to remove the chemical.

- If possible, determine the cause of the injury.
- In certain situations where a chemical is regularly handled, a specific chemical antidote may be available to use.
- Be careful not to contaminate and injure yourself with the chemical and wear protective clothing if necessary.
- **Call 999 for immediate medical help.**

Broken bones:
It can be difficult to tell if a person has a broken bone or a joint, as opposed to a simple muscular injury. If you're in any doubt, treat the injury as a broken bone. Call 999 if:

- They're in a lot of pain and in need of strong painkilling medication – call an ambulance and do not move them
- It's obvious they have a broken leg – do not move them, but keep them in the position you found them in and call an ambulance
- You suspect they have injured or broken their back – call an ambulance and do not move them.
- Do not give the person who is injured anything to eat or drink, as they may need an anaesthetic (numbing medication) when they reach hospital.

Embedded Objects and Splinters:
An object embedded in a wound (other than a small splinter) will not be removed as it may be removed as it may be stemming bleeding, or further damage may result.
In principle leave splinter in place, carefully clean the area with warm soapy water; use sterile dressing to cover it, report to parents, if the child is particularly uncomfortable contact parents.

Treatment Guidance
Bleed: Stop bleeding by applying pressure and elevating the limb/area losing blood (i.e. hold up leg/arm or for head injury sit the patient up).
Shock: Keep the child warm and quiet to minimise the shock. If the child feels faint and the injury is not to the upper torso, lay the child down and elevate their feet.

Find out all you can about what happened and whether the child is in pain. Always be encouraging never discuss the extent of the injury.

One person must take charge who will:
- Send for the first aider.
- Arrange for the Principal to be notified.
- Make arrangements for the care of the child's property.
- Arrange for the child's parent/s to be contacted and check that this has been done.

If the child is taken to hospital, an adult who must be prepared to remain there with the child, must accompany him or her.

If a child is ill or injured on an offsite activity
Remember that when a child is ill or injured this changes the day's arrangements. Always ensure there is enough supervision for the other children on the trip, so that the sick or injured member of the group can be properly looked after. A first aider with a first aid kit must be on all off-site activities. For further advice, please contact a first aider.

Head Injuries
If a child sustains a head injury the parent will be informed. If there is cause for concern (i.e. the child feels dizzy/sick or has disturbed vision), it will be reported to the Principal or Head of Nursery and the parents will be informed. The accident will be logged using Medical Tracker and will be updated if the child's injury requires further medical attention. A child will need to attend A&E if:

- they have been knocked out but have now woken up
- vomited (been sick) since the injury
- a headache that does not go away with painkillers
- a change in behaviour, like being more irritable or losing interest in things around you (especially in children under 5)
- been crying more than usual (especially in babies and young children)
- problems with memory
- a blood clotting disorder (like haemophilia) or you take medicine to thin your blood
- had brain surgery in the past

Symptoms usually start within 24 hours but sometimes may not appear for up to 3 weeks.

If a child is ill and needs to go home

The office will telephone home and ask a parent or responsible adult to collect the child. If children are not well enough to join in all school and/or nursery activities, they should not be in school or nursery. Parents should know that it is important that the school and/or nursery knows if any children are off with diarrhoea and vomiting and the recommendation is that children see their General Practitioner during the period of absence. It is important that they do not return to school and/or nursery until free of symptoms for 48 hours.

Specific Conditions - Asthma

First Aiders are aware of how to treat known conditions of children at The Gower School, for instance, asthma. Due to the number of children that suffer from this condition within TGS, a brief outline of the condition and treatment has been included in this policy. It is thought that the majority of these deaths are preventable. Due to this fact, it is essential that staff understand the causes that lead to an attack and how to deal with an attack when it happens.

All asthma sufferers have a care plan, and instances of medication administered are recorded on Medical Tracker, and in the classrooms.

Anaphylaxis

What is anaphylaxis?

Anaphylaxis is an acute allergic reaction requiring urgent medical attention. It can be triggered by a variety of allergies, the most common of which are contained in food (e.g. dairy products, nuts, peanuts, shellfish), certain drugs and the venom of stinging insects (e.g. bees, wasps, hornets). In its most severe form, the condition can be life-threatening.

Symptoms of anaphylaxis usually occur after exposure to the causative agent and may include itching, swelling of the throat and tongue, difficulty in swallowing, rashes appearing anywhere on the body, abdominal cramps and nausea, increased heart rate, difficulty in breathing, collapse and unconsciousness. No child would necessarily experience all of these symptoms at the same time.

Medication and control

Medication to treat anaphylactic reactions includes antihistamines, an adrenaline inhaler, or an adrenaline injection. The adrenaline injections most commonly prescribed are administered by an auto-injector, a device which is pre-loaded with the correct dose of adrenaline. The injections are easy to administer, usually into the fleshy part of the thigh either directly or through light clothing.

Medication for an individual child must be kept in a cabinet, which is readily accessible, in accordance with the School's health and safety policy. If a child has an auto-injector it is particularly important that this is easily accessible throughout the day. Medication must be clearly marked with the child's name and will be updated on a regular basis. It is the parents' responsibility to ensure that any medication retained at TGS is within its expiry date.

It is important that key staff in the school and/or nursery are aware of the child's condition and of where the child's medication is kept, as it is likely to be needed urgently.

It is not possible to overdose using an auto-injector as it only contains a single dose. In cases of doubt, it is better to give a child experiencing an allergic reaction an injection rather than hold back.

All children who have anaphylaxis will require a Care Plan, which parents or guardians will complete prior to starting at TGS. The Care Plan will give basic details and indicate whether in some circumstances the child will be allowed to carry medication on his/her person around the School. This will be kept with the child's file.

The child will require two auto-injectors on the premises.

Following discussion with the child and his/her parents, individual decisions will be made as to whether to provide basic information on the child's condition to his/her peer group so that they are aware of their classmate's needs and of the requirement for urgent action should an allergic reaction occur. Fellow children should also be advised not to share food or drink with a child who is likely to experience an anaphylactic reaction.

Managing children with anaphylaxis

- Staff will be aware of those children under their supervision who have a severe allergy resulting in anaphylaxis.
- Staff will ensure that all children who have an auto-injector prescribed to them, have their medication accompanying them at all times; this is carried by a member of staff who remains in close vicinity of the child.
- Staff will ensure that they have some knowledge of what to do if a child has an anaphylactic reaction. (Staff to be given training. If a child feels unwell, the First Aider will be contacted for advice.
- A child will always be accompanied to the hospital.

Away trips:

- A member of staff trained in the administration of medication will accompany children on offsite trips, taking responsibility for the safe storage of the child's medication, if the child cannot carry it themselves
- Staff supervising the trip must be aware of the child's condition and of any relevant emergency procedures.

Issues which may affect learning

Children with anaphylaxis will be encouraged to participate as fully as possible in all aspects of school and/or nursery life. It is not possible to ensure that a child will not come into contact with an allergen during the day but schools must bear in mind the potential risk to such children in the following circumstances and seek to minimise risk whenever possible.

What are the main symptoms?

- Itching or presence of a rash, swelling of the throat, difficulty in swallowing, difficulty in breathing, increased heart rate and unconsciousness.

What to do if a child has an anaphylactic reaction:

- Use an adrenaline auto-injector (such as an EpiPen)– instructions are included on the side of the injector.
- Call 999 for an ambulance and say that you think the child is having an anaphylactic reaction.
- Lie the child down – raise their legs, and if they are struggling to breathe, raise their shoulders or sit them up slowly
- If the child has been stung by an insect, try to remove the sting if it's still in the skin.
- If the symptoms have not improved after 5 minutes, use a 2nd adrenaline auto-injector.

Specific Conditions - Epilepsy

If a child joins TGS with this condition, as with other specific conditions, specific instructions on immediate treatment or action will be gained from the parent(s) so that these can be followed in the event of an attack. We have experienced children with Childhood Absence Epilepsy and the teachers and other staff have been made aware of the small periods of time the child(s) will be unable to respond to what is going on around them. Staff will always send for a Paediatric First Aider if in doubt about a child showing unusual signs. However, the following points outline how to recognise and act on a seizure:

<u>Tonic-Clonic seizures (previously called grand mal)</u>

The person goes stiff, loses consciousness and then falls to the ground. This is followed by jerking movements. A blue tinge around the mouth is likely. This is due to irregular breathing. Loss of bladder and/or bowel control may happen. After a minute or two the jerking movements should stop and consciousness may slowly return.

Do...

- Protect the person from injury - (remove harmful objects from nearby)
- Cushion their head
- Look for an epilepsy identity card or identity jewellery
- Aid breathing by gently placing them in the recovery position once the seizure has finished
- Stay with the person until recovery is complete
- Be calmly reassuring

Don't...

- Restrain the person's movements
- Put anything in the person's mouth
- Try to move them unless they are in danger
- Give them anything to eat or drink until they are fully recovered
- Attempt to bring them round

Call for an ambulance if...

- You know it is the person's first seizure
- The seizure continues for more than five minutes
- One tonic-clonic seizure follows another without the person regaining consciousness between seizures
- The person is injured during the seizure
- You believe the person needs urgent medical attention

Complex partial (focal) seizures
Sometimes the person is not aware of their surroundings or what they are doing. They may pluck at their clothes, smack their lips, swallow repeatedly, and wander around.

Do...
- Guide the person from danger
- Stay with the person until recovery is complete
- Be calmly reassuring
- Explain anything that they may have missed

Don't...
- Restrain the person
- Act in a way that could frighten them, such as making abrupt movements or shouting at them
- Assume the person is aware of what is happening, or what has happened
- Give the person anything to eat or drink until they are fully recovered
- Attempt to bring them round

Call for an ambulance if...
- You know it is the person's first seizure
- The seizure continues for more than five minutes
- The person is injured during the seizure
- You believe the person needs urgent medical attention

Asthma

What is Asthma?
Children with asthma have airways, which narrow as a reaction to various triggers. The triggers vary between individuals, but common ones include viral infections, cold air, grass pollen, animal fur, house dust mites and passive smoking. Exercise and stress can also precipitate asthma attacks in susceptible cases. The narrowing or obstruction of the airways causes difficulty in breathing and can be alleviated with treatment.

Asthma attacks are characterised by coughing, wheeziness, an inability to speak properly, and difficulty in breathing, especially breathing out. The child may become distressed and anxious and in very severe attacks the child's skin and lips may turn blue.

Medication and control
Medication to treat the symptoms of asthma usually comes in the form of inhalers that in most cases are colour coded. Instructions will be given on the medication as to which colour coding is relevant to inhaler use in different circumstances. Most children with asthma will take charge of and use their inhaler from an early age and it is good practice to allow children to carry their inhalers with them at all times, particularly during PE lessons. If a child is too young or immature to take responsibility for the inhaler, staff should ensure that the inhaler is kept in a safe but readily accessible place and is clearly marked with the child's name.

Children with asthma must have immediate access to their inhalers when they need them.

It would be helpful for parents to provide the School with a spare inhaler for use in case the original inhaler is left at home or runs out. Spare inhalers must be clearly labelled with the child's name and stored in a locked cabinet in accordance with the School's health and safety policy. It is the parents' responsibility to ensure that any medication retained at the school is within its expiry date. All asthmatic children will require a care plan, which parents or guardians will complete prior to starting at TGS. The care plan will give the basic details and indicate whether in some circumstances the child will be allowed to carry medication on his/her person around the School. This will be kept with the child's file. Note that it is difficult to "overdose" on the use of an inhaler. Following discussion with the child and his/her parents' individual decisions should be made as to whether to provide basic information on the child's condition to his/her peer group so that they are made aware of their classmate's needs.

Managing children with asthma
- Staff will be aware of those children under their supervision who have asthma.
- During games, staff will ensure that all children with asthma have their inhaler prior to commencement of a session.
- Staff will ensure that they have some knowledge of what to do if a child has an asthma attack. (Staff to seek advice from First Aider)
- If a child feels unwell, the First Aider will be contacted for advice.

- A child will always be accompanied to the hospital if necessary with a member of staff.

Trips away from school and/or nursery:

- A member of staff trained in first aid and the administration of medication must accompany the children on trips, taking responsibility for the safe storage of children medication, if the children cannot carry it themselves. Staff supervising the trip must be aware of the child's condition and of any relevant emergency procedures.

When an Asthmatic child joins the class or room

- Ask parents about child's asthma and current treatment
- The child's inhaler will be stored in their class's first aid bag and in a locked cupboard in the child's room in the nursery.
- If they require access to their medication to have with them during sport or off-site activities, this can be arranged through the office or the room leader.

Sport and an asthmatic child

Exercise is a common trigger for an asthma attack, but this should not be the reason for children not to participate in PE or Games. As far as possible, children should be encouraged to participate fully in all sporting events. Swimming is to be encouraged.

Asthmatic children are commonly allergic to grass pollen so this should be considered, especially during the summer months. Teachers will be aware of competitive situations when children with asthma may over exert themselves. Exercise triggered asthma will be helped if the teacher ensures that the child uses his/her inhaler before exercise begins and keeps it with them during the lesson. No child will be forced to continue games if they say they are too wheezy to continue.

How you can help during an attack

The following guidelines may be helpful:

1. Ensure that the reliever medicine is taken promptly and properly. A reliever inhaler should quickly open up narrowed air passages: try to make sure it is inhaled correctly. It should be administered via a Spacer (breather unit with rubber section to go over nose & mouth). Due to the high-speed release of an inhaler, it is difficult for even an adult patient to inhale at the right time to benefit from the medication, so it is recommended it is given in this way for maximum impact.

2. *Stay calm and reassure the child.*
   Attacks can be frightening, so stay calm and do things quietly and efficiently. Listen carefully to what the child is saying and what he or she wants. Try tactfully to take the child's mind off the attack. It is very comforting to have a hand to hold but don't put your arm around the child's shoulder as this is very restrictive.

3. *Help the child to breathe.*
   In an attack people tend to take quick and shallow breaths, so encourage the child to breathe slowly and deeply. Most people with asthma find it easier to sit fairly upright or leaning forwards slightly.
   They may want to rest their hands on their knees to support the chest. Leaning forwards on a cushion can be restful, but make sure that the child's stomach is not squashed up into the chest. Lying flat on the back is not recommended.

In addition to these three steps, loosen tight clothing around the neck and offer the child a drink of warm water because the mouth becomes very dry with rapid breathing.

How teachers and practitioners can help

- Ensure all asthmatic children take any necessary treatment before sport or activities.
- Ensure relievers are readily available for use by asthmatic children when required.
- Check with child and parent that correct treatments and instructions are supplied for outings.
- Be aware that materials brought into the classroom may trigger a child's asthma, and additional treatment may be necessary.
- Make a point of speaking to parents of children needing to use their inhaler for relief more often than usual.
- Act as an educator to children with asthma and their peers.
- Know what to do in an emergency.

Do's and Don'ts in Acute Asthma

- Don't panic.
- Do be aware of procedure to follow if the child does not improve after medication.
- Don't lie the child down - keep them upright.
- Don't open a window - cold air might make the condition worse.
- Don't crowd the child - give space - not cuddles.
- Do give reliever medication - bronchodilators.
- Do reassure the child.
- Do reassure the other children and move them away.

What are the main symptoms?

- Coughing, wheezing, inability to speak properly and difficulty in breathing out.

What to do if a child has an asthmatic attack

- Stay calm and reassure the child. Speak calmly and listen to what the child is saying.
- Summon assistance from the First Aider. Do not to leave the child alone.
- Make sure that any medicines and /or inhalers are use promptly and help the child to breathe by encouraging the child to breathe slowly and deeply and relax.
- Help the child to sit fairly upright or to lean forward slightly rather than lying flat on his/her back.
- If the child does not respond to medication or his/her condition deteriorates call an ambulance on 999
- Liaise with the First Aider about contacting the child's parents/guardians.

Diabetes

Diabetes is a condition in which the amount of glucose (sugar) in the blood is too high due to the body being unable to use it properly. This is because of a faulty glucose transport mechanism due to lack of insulin. Normally, the amount of glucose in the bloodstream is carefully controlled by a hormone called insulin. Insulin plays a vital role in regulating the level of blood glucose and, in particular, in stopping the blood glucose level from rising too high. Children with diabetes have lost the ability to produce insulin and therefore their systems are unable to control their blood glucose levels. If the blood glucose level is too high, a child may show symptoms of thirst, frequent trips to the toilet, weight loss and tiredness. Conversely, if the blood glucose level is too low a child may display symptoms which include hunger, drowsiness, glazed eyes, shaking, disorientation and lack of concentration.

Diabetes is serious and will receive the proper treatment once diagnosed medically. People with diabetes will have access to good, regular healthcare and may also need to take diabetes medication or insulin, or a combination of the two. All diabetic adults and children are registered on the 'at risk' list and the teacher made aware of their condition. The school and/or nursery office must be kept up to date with details of where parents can be contacted in an emergency, also telephone numbers of the child's doctor, hospital etc.

The child will always carry glucose or sugar in their pocket and may need to eat in class or before PE and games lessons. It is very important that diabetics eat meals at regular times and are allowed to eat small snacks at other times when they need extra food. The only major problem the diabetic child is likely to have in school will be an INSULIN REACTION (Hypoglycaemia). Some of the first signs may consist of confusion, poor work, poor handwriting. If any of these are noticed – sugar in any form is the correct treatment (sugar, sweets, sugary drinks). If reaction has not developed too far the child will return to normal but SHOULD NEVER BE SENT OUT OF THE ROOM WITHOUT SUPERVISION.

Insulin reactions do not occur very frequently. They are usually brought on by more exercise than usual, delay in getting meals or inadequate meals or excessive Insulin dosage. If a reaction occurs at school, parents will be advised by telephone and in writing. If the child has developed an Insulin reaction or is unwilling to swallow sugar, this will be considered an EMERGENCY - AND THE CHILD TAKEN TO HOSPITAL. Every effort will be made to contact the parents as soon as possible.

Medication and control

Diabetes cannot be cured but it can be treated effectively by injections of insulin and by following an appropriate diet. The aim of the treatment is to keep the blood glucose level close to the normal range so that it is neither too high (hyperglycaemia) nor too low (hypoglycaemia). All children with diabetes will require an Individual Health Care Plan. In most cases children will have their insulin injections before and after school but some children may require an injection at lunchtime, this will be discussed with the parent. If an older child needs to inject whilst at school, he/she will know how to undertake the procedure. However, the child may require privacy in which to administer the injection. Some children may also need to monitor their blood glucose levels on a regular basis and again privacy may be required for this procedure. Some children may have continuous insulin administration via a pump. Training will be given to staff if this is the case.

An essential part of the treatment of diabetes is an appropriate diet whereby regular meals and good food choices help to keep the blood glucose level near normal. A child with diabetes will have been given guidance on food choices that should be reduced in sugar and fat but high in starch. Most children with diabetes will also need to eat snacks between meals and occasionally during class time. These snacks usually consist of cereal bars, fruit, or biscuits. It is important to allow a child with diabetes to eat snacks without hindrance or fuss and to ensure that the lunchtime meal is taken at a regular time. It is also important that the School should establish with the child and his/her parents where supplies of fast acting sugar can be kept in case of a hypoglycaemic episode. The issue of close communication between parents and the School is fundamental to the care of children with diabetes, as many aspects of growth and development will have an impact on their diabetes control. It is the parents' responsibility to ensure that any medication retained at the School is within its expiry date. All diabetic children will require a care plan, which parents or guardians will complete prior to starting at Gower School. The care plan will give the basic details and indicate whether in some circumstances the child should be allowed to carry medication on his/her person around the School. This will be kept with the child's file. Following discussion with the child and his/her parents' individual decisions should be made as to whether to provide basic information on a child's condition to his/her peer group so that they are aware of their classmate's needs.

Managing children with diabetes

- Staff will be aware of those children under their supervision who have diabetes. The child may be wearing a Medic-Alert or Necklet which would identify the condition.
- Games staff will ensure that all children with diabetes have a snack with them (and their emergency medication and blood glucose monitoring kit) prior to commencement of a session.
- Staff will ensure that they have some knowledge of what to do if a child has a hypoglycaemic episode or a hyperglycaemic episode.
- If a child feels unwell, the First Aider will be contacted for advice.

Issues which may affect learning

Children with diabetes should have no difficulties in accessing all areas of the curriculum including sporting activities which are energetic. However, as all forms of strenuous activity use up glucose there are some simple precautions to follow in order to assist a child with diabetes in maintaining an adequate blood glucose level: Encourage the child to eat or drink some extra sugary food before the activity, have glucose tablets or a sugary drink readily available in case the child displays symptoms of hypoglycaemia, after the activity is concluded, encourage the child to eat some more food and take extra fluid - these additional snacks will not affect normal dietary intake.

What do in an emergency if a child has a hypoglycaemic (low blood sugar) episode?

Common causes:

A missed or delayed meal or snack, extra exercise, too much insulin during unstable periods, the child is unwell or the child has experienced an episode of vomiting.

Common symptoms are:

- Hunger, drowsiness, glazed eyes, shaking, disorientation, lack of concentration

i. Get someone to stay with the child - call for the First Aider/ambulance (if they are hypo, do not send them out of class on their own, their blood sugar may drop further and they may collapse.
ii. Give fast acting sugar immediately (the child should have this), e.g. Cola or lemonade, small carton of fruit juice or glucose tablets
iii. Recovery usually takes ten to fifteen minutes.
iv. Upon recovery give the child some carbohydrates, e.g. couple of biscuits, a sandwich or a banana.
v. Inform the First Aider and parents of the hypoglycaemic episode.
vi. In some instance it may be appropriate for the child to be taken home from school

NB. In the unlikely event of a child losing consciousness, call an ambulance (999) and the First Aider.

A hyperglycaemic episode (high blood sugar)

Hyperglycaemic episodes occur when the blood glucose level is too high. Children may display the following symptoms:

- Excessive thirst, passing urine frequently, vomiting, abdominal pain
- A change of behaviour

Care of children in a hyperglycaemic episode

- Do not restrict fluid intake or access to the toilet
- Contact the parents if concerned.

In both episodes, liaise with the First Aider about contacting the children's parents/carers

Cleaning up body fluids from floor surfaces

All appropriate precautions will be taken by the support staff when cleaning up after an incident involving blood, vomit, etc.
Avoid direct contact with body fluids, as they all have the potential to spread germs. Germs in vomit and faeces may become airborne, so it is very important to clean up body fluids quickly.

- Put on gloves and a disposable apron. Disposable latex or vinyl gloves are the best choice.
- Remove all visible material from the most soiled areas, using paper towels.
- Put all used paper towel and cloths into a sealed bag for the bin.
- Non- carpeted areas: Sanitize the area with antibacterial solution, leaving on the affected area for a minimum of 10 minutes.
- Carpeted areas: The area should be cleaned with antibacterial solution. The area should then be shampooed or steam cleaned within 24 hours.
- Wash the non-disposable cleaning equipment (mops, buckets) thoroughly with a Milton solution.
- Discard gloves, disposable apron. Finally wash your hands thoroughly using anti-bacterial soap and water.

Annexe:

Exclusion periods of infectious illnesses

Illness and spread	Symptoms	Exclusion
Chickenpox (varicella) and shingles Chickenpox is highly infectious and spreads by respiratory secretions or by direct contact with fluid from blisters. Direct contact with fluid from the blisters of a person that has shingles can cause chickenpox in someone who has never had it before.	Chickenpox has a sudden onset with fever, runny nose, cough and a generalised rash. The spotty rash starts with fluid filled blisters, which then scab over and eventually drop off. Some children have only a few spots, but other children can have spots that cover their entire body. In most children, the blisters crust up and fall off naturally within one to 2 weeks.	Children with chickenpox are generally infectious from 2 days before the rash appears and until all blisters have crusted over (usually 5 to 6 days after the start of the rash). Children with chickenpox should avoid contact with others for at least 5 days from the onset of the rash and until all blisters have crusted over. An individual with shingles is infectious to those who have not had chickenpox and should be excluded from education/childcare setting if they have a weeping rash that cannot be covered or until the blisters are dry and crusted over. Pregnant women should consult with their GP or midwife.
Conjunctivitis Conjunctivitis is an inflammation of the outer lining of the eye and eyelid causing a sore or itchy red eye(s) with a sticky or watery discharge. It can be caused by bacteria or viruses or allergies. Infective conjunctivitis is contagious, which means that it can be passed on by the individual touching or rubbing their eyes with their hands, or a towel then handles another person's face or towel.	The eye(s) becomes reddened and swollen and there may be a sticky or watery discharge. Eyes usually feel sore or itchy and 'gritty'. Topical ointment or eye drops can be obtained from a pharmacy to treat the infection.	If it is a bacterial infection, antibiotics may be prescribed and your child should be off for 24hrs. Topical ointment or eye drops can be obtained from a pharmacy/medical professional to treat the infection. Children can return after 24 hours once the eye(s) is clear of gunk.
Diarrhoea and vomiting Diarrhoea and/or vomiting may be due to a variety of causes including germs, toxins or non-infectious diseases. However, as a general principle, all cases of gastroenteritis should be regarded as potentially infectious unless	People affected by infectious gastrointestinal diseases may have diarrhoea and/or vomiting. Diarrhoea is defined as 3 or more liquid or semi-liquid stools within a 24-hour period.	Individuals can return 48 hours after diarrhoea and vomiting have stopped. If a particular cause of the diarrhoea and vomiting is identified, there may be additional exclusion advice, for example E. coli STEC and hep A.

there is good evidence to suggest otherwise. These infections are spread when the germs enter the gut by the mouth or when contaminated hands or objects are put in the mouth or after eating or drinking contaminated food or drinks. Infection can also be spread when the affected person vomits. This is because aerosols can spread the organism directly to others and contaminate the environment. A person will be infectious while symptoms remain.		
Hand, foot and mouth disease Hand, foot and mouth disease is a common viral illness in childhood. It is generally a mild illness caused by an enterovirus. Spread is by direct contact with the secretions of the infected person (including faeces) or by aerosol spread such as coughing and sneezing. Younger children are more at risk because they tend to play closely with their peers. There is a slight risk to pregnant staff, and they may wish to avoid close contact with an affected child. Women who develop any rash symptoms during pregnancy should seek advice from their general practitioner or midwife.	The child may develop a fever, reduced appetite and generally feel unwell. One or 2 days later a rash may develop with blisters, on hands, feet, insides of their cheeks, gums and on the sides of the tongue. Not all cases have symptoms. The incubation period is 3 to 5 days. Persons affected are most infectious during the first week of the illness. The illness is usually mild and clears up by itself in 7 to 10 days. If the child or staff member develops the rare additional symptoms of high fever, headache, stiff neck, back pain, or other complications then they should seek prompt medical advice.	Exclusion of a well pupil is not required. If a child is feeling unwell, they should stay at home and return to education or childcare setting as soon as they are feeling better, there is no need to stay off until the blisters have all healed.
Head lice Head lice and nits are common in young children and their families. Head lice are spread by direct head-to-head contact and therefore tend to be more common in children because of the way they play. They cannot jump, fly or swim. Itching and scratching occurs 2 to 3 weeks after coming into contact with someone who has head lice.	Head lice are tiny insects that only live on humans. The eggs are grey or brown and about the size of a pinhead which stick to the hair, close to the scalp. The eggs hatch in 7 to 10 days. Empty eggshells (nits) are white and shiny and are found further along the hair shaft as they grow out.	No exclusion is needed but we ask that you treat head lice as soon as you spot them. We also ask that you check your child's hair on a weekly basis.
Impetigo Impetigo is a bacterial skin infection that mainly affects infants and young children. It is very infectious and appears most commonly as reddish sores on the face. It may be a primary	The sores can develop anywhere on the body but tend to occur as reddish sores on the face, especially around the nose and mouth and on the hands and feet. After about a week, the sores	Child excluded until all sores or blisters are crusted over or 48 hours after commencing antibiotic treatment.

infection or a complication of an existing skin condition such as eczema, scabies or insect bites. Impetigo can easily spread to other parts of the affected person's body or to other people such as through direct physical contact, or by sharing towels, flannels or eating and drinking utensils.	burst and leave golden brown crusts. It can sometimes be painful and itchy. The incubation period is between 4 to 10 days.	
Measles Measles is a highly infectious viral infection. The (measles, mumps and rubella) MMR vaccine is the safest and most effective way to protect against measles. People need 2 doses of MMR to be protected against measles, mumps and rubella. Measles is highly infectious and transmitted via airborne or droplet spread, or direct contact with nasal or throat secretions of infected persons.	Symptoms include a runny nose; cough; conjunctivitis (sore, itchy, watery, red and sticky eyes); high fever and small white spots (Koplik spots) inside the cheeks. Around day 3 of the illness, a rash of flat red or brown blotches appear, beginning on the face, behind the ears and spreading over the body. The incubation period is between 10 to 12 days but can vary from 7 to 21 days.	4 days from onset of rash and individual is well enough.
Respiratory infections, including coronavirus (COVID-19) Respiratory infections are common in children and young people, particularly during the winter months. Symptoms can be caused by [several respiratory infections] https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19) including the common cold, COVID-19, flu, and respiratory syncytial virus (RSV). Respiratory infections can spread easily between people. Sneezing, coughing, singing and talking may spread respiratory droplets from an infected person to someone close by. Droplets from the mouth or nose may also contaminate hands, eating and drinking utensils, toys or other items and spread to those who may use or touch them, particularly if they then touch their nose or mouth.	Children with respiratory infections can experience a range of symptoms including a runny nose, high temperature (38C or more), cough and sore throat. It is not possible to tell which germ someone is infected with based on symptoms alone. Some children aged under 2 years, especially those with a heart condition or born prematurely, and very young infants, are at increased risk of hospitalisation from RSV.	Children with mild symptoms such as a runny nose, sore throat, or mild cough, who are otherwise well, can continue to attend their education or childcare setting. Children and young people who are unwell and have a high temperature should stay at home and where possible avoid contact with other people. They can go back to education or childcare setting when they no longer have a high temperature and they are well enough. If a child or young person has a positive COVID-19 test result, they should try to stay at home and avoid contact with other people for 3 days after the day they took the test, if they can. After 3 days, if they feel well and do not have a high temperature, the risk of passing the infection on to others is much lower. This is because children and young people tend to be infectious to other people for less time than adults. Children and young people who usually attend an education or childcare setting and who live with someone who has a positive COVID-19 test result should continue to attend as normal.
Slapped cheek syndrome (parvovirus B19) Slapped cheek syndrome is caused by a virus called parvovirus B19. The virus spreads to other people, surfaces or	Slapped check syndrome (also called fifth disease or parvovirus B19) is common in children and should get better on its own. It is rarer in adults but can be more serious.	The child can attend as long as they are well in themselves. Children do not have to stay away from school after the rash appears.

objects by coughing or sneezing near them.	The illness may only consist of a mild feverish illness, which escapes notice, but in others a rash appears after a few days. The rose-red rash makes the cheeks appear bright red, hence the name 'slapped cheek syndrome'. The rash may spread to the rest of the body but unlike many other rashes it rarely involves the palms and soles. The child begins to feel better as the rash appears. The rash usually peaks after a week and then fades. The rash is unusual in that for some months afterwards, a warm bath, sunlight, heat or fever will trigger a recurrence of the bright red cheeks and the rash itself. The virus can affect an unborn baby in the first 20 weeks of pregnancy. If a woman is exposed early in pregnancy (before 20 weeks) she should seek prompt advice from whoever is providing her antenatal care.	
Scarlet Fever Scarlet fever is highly infectious and is spread by close contact with someone carrying the bacteria. The incubation period is 2 to 5 days. Coughing, sneezing, singing and talking may spread respiratory droplets from an infected person to someone close by. Droplets from the mouth or nose may also contaminate hands, eating and drinking utensils, toys or other items and spread to others that use or touch them, particularly if they then touch their nose or mouth.	Symptoms vary but in severe cases there may be high fever, difficulty swallowing and tender enlarged lymph nodes. The rash develops on the first day of fever, it is red, generalised, pinhead in size and gives the skin a sandpaper-like texture and the tongue has a strawberry-like appearance. The scarlet fever rash may be confused with measles. The fever lasts 24 to 48 hours. Scarlet fever is usually a mild illness but is rarely complicated by ear infections, rheumatic fever that affects the heart, and kidney problems.	Individual can return 24 hours after commencing the 1st dose of antibiotics. If no antibiotics are taken, the child can spread the infection for 2 to 3 weeks after the symptoms start. Therefore, children are asked to stay away from school for this period.
Threadworms Threadworm infection is an intestinal infection and is very common in childhood. They are tiny worms in stools and can spread easily.	Worms may be seen in stools or around a child's bottom. They look like pieces of white thread.	None needed but Pharmacies can advise on treatment.

Re-infection is common and infectious eggs are also spread to others directly on fingers or indirectly on bedding, clothing and environmental dust. Regular hand washing, laundry and regular cleaning can help reduce the risk of infection and re-infection.	Symptoms include extreme itching around the anus or vagina, particularly at night. They can also cause children to be irritable and wake up during the night.	
Whooping cough Whooping cough (pertussis) is a bacterial infection of the lungs and breathing tubes. It spreads very easily and can sometimes cause serious problems. It's important for babies and children to get vaccinated against it.	The first signs of whooping cough are similar to a cold, such as a runny nose and sore throat (a high temperature is uncommon). After about a week, individuals: will get coughing bouts that last for a few minutes and are worse at night may make a "whoop" sound – a gasp for breath between coughs (young babies and some adults may not "whoop") may have difficulty breathing after a coughing bout and may turn blue or grey (young infants) may bring up a thick mucus, which can make you vomit may become very red in the face (more common in adults) The cough may last for several weeks or months.	Stay off school, work or nursery until 48 hours after starting antibiotics, or 3 weeks after symptoms started if you've not had antibiotics.