Southway Junior School
Southway
Burgess Hill
West Sussex
RH15 9SU

Headteacher: Mrs V Smith

Tel. 01444 233824
email: parentline@southwayjunior.co.uk
website: www.southwayjunior.co.uk

APPENDIX 2

Form 1 - Individual Healthcare Plan (IHCP)

Attach photograph here

Name of school	
Child's name	
Year Group/Class	
Date of birth	
Child's address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information

Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	
Name	
Relationship to child	
Phone no. (work)	
(home)	
(mobile)	

Clinic/Hospital Contact

Name	
Phone no	

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GP Name	
GP Phone no	

Who is responsible for providing support in school	

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

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

Daily care requirements

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

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Arrangements for school visits/trips etc

Other information

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

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

Plan developed with

Staff training needed/undertaken – who, what, when

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

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is stopped. I agree that my child's medical information can be shared with school staff responsible for their care.

_____ _____

Signed by parent or guardian Print name

_____ _____

Date Review date

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Dear Parent/Carer

Form 2 - Asthma Information Form

In order to keep our records up to date regarding your child's asthma, please complete the questions below and return to the school office.

CHILD'S NAME: …….. **Age:** ……. **Class:** ……

Please indicate whether your child's asthma is: Mild ☐ Severe ☐

1. Does your child need an inhaler in school? Yes * ☐ No ☐

* Please provide inhalers with this form – see note below.

2. Please provide information on your child's current treatment (include the name, type of inhaler, the dose and how many puffs). Do they have a spacer?

……

……

3. What triggers your child's asthma?

……

……

It is essential that your child has **two** inhalers in school. The spare inhaler may be required in the event that the first inhaler runs out, is lost or forgotten. **Inhalers must be sent in to the school office and in the original packaging bearing the dispensing label showing your child's name. It is the responsibility of the parent/carer to ensure that inhalers are replaced before they reach their expiry date**.

* I agree to ensure that my child has two in-date inhalers and spacers (if prescribed) in school. I understand that in the event of this not being the case my child will be unable to participate in sporting activities or out of school events.

Please tick the appropriate statements:

☐ My child has an in-date inhaler for use in class. Expiry date:……

☐ I have provided the school with a second in-date inhaler for my child to be held in the school medical room. Expiry date: ……

☐ My child requires a spacer and I have provided these to the school medical room.

☐ My child does not require a spacer.

☐ I need to obtain an inhaler(s) / spacer for school use and will supply this/these as soon as possible.

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4. Does your child need to use their blue inhaler before doing exercise / PE? If so, how many puffs?

……

5. I give consent for the following treatment, as recognised by Asthma Specialists, to be given to my child in an emergency?

- Give **6 puffs of their blue inhaler via a spacer**
- Reassess after 5 minutes
- If the child still feels wheezy or appears to be breathless they should have a further **4 puffs of their blue inhaler**
- Reassess after 5 minutes
- **If their symptoms are not relieved with 10 puffs of their blue inhaler then this should be viewed as a serious attack:**
- **CALL AN AMBULANCE and then CALL PARENT**
  - **While waiting for the ambulance continue to give 10 puffs of the blue reliever inhaler every few minutes.**

6. Should a situation occur when my child is unable to access their own in-date inhaler, i.e., emergency evacuation, I authorise use of the school's emergency inhaler.

I give consent for the school to administer my child's inhaler in accordance with the emergency treatment detailed above. I agree that the school can administer the school emergency salbutamol inhaler if required. I agree that my child's medical information can be shared with school staff responsible for their care and that I will ensure that my child has in-date inhalers/spacers in school.

Signed: …… **Date**: ……
I am the person with parental responsibility

Print Name: ……

Please remember to inform the school if there are any changes in your child's treatment or condition.

Parental Update (only to be completed if your child no longer has asthma) My child …….. Class …… no longer has asthma and therefore no longer requires an inhaler in school or on school visits.	
Signed …… *I am the person with parental responsibility*	Date……

For office use only:

	Yes / No	Location	Expiry date	Date of phone call requesting inhaler	Date of letter (attach copy)
1st inhaler		Classroom			
2nd inhaler		Medical Room			
Spacer (if required)					
Record any further follow up with the parent/carer:					

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Form 3 - Individual protocol for Antihistamine as an initial treatment protocol for mild allergic reaction

CHILD'S NAME:
D.O.B:
Class:

Nature of Allergy:

Contact Information

Name			**Relationship to pupil**		
Phone numbers	**Work**		**Mobile**		

If I am unavailable, please contact:

Name			**Relationship to pupil**		
Phone numbers	**Work**		**Mobile**		

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name:
Phone No:
Address:

MEDICATION – Antihistamine

Name of antihistamine:
Expiry Date:

- **It is the parents responsibility to ensure the Antihistamine has not expired and to provide a new bottle when reaches its expiry date.**
- **It is the schools responsibility to ensure this care plan is reviewed and parents inform the school of any changes in condition or treatment.**

Dosage & Method: **As prescribed on the container.**

Agreed by: School Representative Date:

I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education, and I give my consent to the school to administer anti-histamine as part of my child's treatment for anaphylaxis. I confirm I have administered this medication in the past without adverse effect.

Signed: Print name: Date:
I am the person with parental responsibility

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Individual protocol for using Antihistamine

Symptoms may include:

- Itchy skin
- Sneezing, itchy eyes, watery eyes, facial swelling (does not include lips/mouth)
- Rash anywhere on body

Stay Calm

Reassure

Give Antihistamine delegated person responsible to administer antihistamine, as per instructions on prescribed bottle

Observe patient and monitor symptoms

Inform parent/guardian to collect

from school

If symptoms progress and there is any difficulty in swallowing/speaking /breathing/ cold and clammy
Dial 999
A = Airway
B = Breathing
C = Circulation

If child is prescribed an adrenaline auto injector administer it - follow instructions on protocol

If symptoms progress Dial 999 - Telephone for an ambulance

You need to say: "I have a child in anaphylactic shock".
Give school details:
Give details: Pupils name has a severe allergy and what has happened.
DO NOT PUT THE PHONE DOWN UNTIL YOU ARE SURE ALL THE NECESSARY INFORMATION HAS BEEN GIVEN
Someone to wait by the school gate to direct the ambulance staff straight to the child.

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Form 4 - Individual protocol for an EpiPen adrenaline auto injector

CHILD'S NAME:
D.O.B:
Class:

Nature of Allergy:

Contact Information

Name			**Relationship to pupil**	
Phone numbers	**Work**		**Mobile**	

If I am unavailable, please contact:

Name			**Relationship to pupil**	
Phone numbers	**Work**		**Mobile**	

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name:
Phone No:
Address:

MEDICATION **EpiPen**
Name of medication: EpiPen
Expiry date:

- **It is the parent's responsibility to supply 2 EpiPen auto injectors and to ensure they have not expired**

Dosage & Method: **1 DOSE INTO UPPER OUTER THIGH**

- **The school staff will take all reasonable steps to ensure my child does not eat any food items unless they have been prepared / approved by parents**
- **It is the schools responsibility to ensure this care plan is reviewed**

Agreed by: School Representative Date:

- **I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education and inform the school of changes in condition or treatment.**
- **I give my consent for the school to administer my child's EpiPen or the school held adrenaline auto-injector (if my child's pen is lost/forgotten or malfunctions) to be administered in an emergency as detailed in this plan.**

Signed: Print name: Date:
I am the person with parental responsibility

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Individual protocol for using an EpiPen (Adrenaline Autoinjector)

Symptoms may include:

- Difficulty in swallowing / speaking / breathing
- Wheezy / irregular breathing / excessive coughing
- Hoarseness
- Nettle rash (hives) anywhere on body
- Sense of impending doom
- Swelling of throat and mouth
- Abdominal pain, nausea & vomiting
- Feeling of weakness (BP drops)
- Collapse & unconsciousness
- Cold and clammy

Stay Calm

Reassure

One member of staff to Dial 999

REMEMBER

A = AIRWAY
B = BREATHING
C = CIRCULATION

Give EPIPEN first then dial 999 Administer EpiPen in the upper outer thigh

Remove grey safety cap
Hold EpiPen with black tip downwards against thigh jab firmly.
Hold EpiPen in place for 10 seconds
Can be given through clothing, but not very thick clothing.
Note time of injection given
If no improvement give 2nd EPIPEN 5 minutes later

Call Parents

Reassure

Telephoning for an ambulance

You need to say: "I have a child in anaphylactic shock".

Give school details:

Give details: Child's name has a severe allergy and what has happened.

DO NOT PUT THE PHONE DOWN UNTIL YOU ARE SURE ALL THE NECESSARY INFORMATION HAS BEEN GIVEN

Someone to wait by the school gate to direct the ambulance staff straight to the child.

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Form 5 - Individual protocol for a Jext pen adrenline auto injector

CHILD'S NAME:
D.O.B:
Class:

Nature of Allergy:

Contact Information

Name			**Relationship to pupil**		
Phone numbers	**Work**		**Mobile**		

If I am unavailable, please contact:

Name			**Relationship to pupil**		
Phone numbers	**Work**		**Mobile**		

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name:
Phone No:
Address:

MEDICATION **JEXT**

Name on JEXT & expiry date:

- **It is the parents responsibility to supply 2 JEXT pen auto injectors and to ensure they have not expired**

Dosage & Method: **1 DOSE INTO UPPER OUTER THIGH**

- **The school staff will take all reasonable steps to ensure my child does not eat any food items unless they have been prepared / approved by parents**
- **It is the schools responsibility to ensure this care plan is reviewed and parents inform the school of any changes in condition or treatment.**

Agreed by: School Representative Date:

- **I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education and inform the school of changes in condition or treatment.**
- **I give my consent for the school to administer my child's Jext or the school held adrenaline auto-injector (if my child's pen is lost/forgotten or malfunctions) to be administered in an emergency as detailed in this plan.**

Signed: Print name: Date:
I am the person with parental responsibility

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Individual protocol for using a JEXT Pen (Adrenaline Autoinjector)

Symptoms may include:

- Difficulty in swallowing / speaking / breathing
- Wheezy / irregular breathing / excessive coughing
- Hoarseness
- Nettle rash (hives) anywhere on body
- Sense of impending doom
- Swelling of throat and mouth
- Abdominal pain, nausea & vomiting
- Feeling of weakness (BP drops)
- Collapse & unconsciousness
- Cold and clammy

Stay Calm

Reassure ……

One member of staff to Dial 999

REMEMBER

A = AIRWAY
B = BREATHING
C = CIRCULATION

Give JEXT pen first
Then call 999
Administer in the upper thigh

Remove yellow cap, place black tip against upper outer thigh, push injector firmly into thigh until it clicks.

Hold in JEXT Pen in place for 10 seconds.

Can be given through clothing, but not very thick clothing

Note time of injection given

If no improvement give 2nd JEXT Pen 5 minutes later

Call Parents

Reassure

……

Telephoning for an ambulance

You need to say: "I have a child in anaphylactic shock".

Give school details:

Give details: Childs name has a severe allergy and what has happened.

DO NOT PUT THE PHONE DOWN UNTIL YOU ARE SURE ALL THE NECESSARY INFORMATION HAS BEEN GIVEN

Someone to wait by the school gate to direct the ambulance staff straight to the child.

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Form 6 - Individual protocol for an Emerade adrenaline auto injector

CHILD'S NAME:
D.O.B:
Class:

Nature of Allergy:

Contact Information

Name			**Relationship to pupil**	
Phone numbers	**Work**		**Mobile**	

If I am unavailable, please contact:

Name			**Relationship to pupil**	
Phone numbers	**Work**		**Mobile**	

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name:
Phone No:
Address:

MEDICATION **Emerade**
Name of medication: Emerade
Expiry date:

- **It is the parent's responsibility to supply 2 Emerade auto injectors and to ensure they have not expired**

Dosage & Method: **1 DOSE INTO UPPER OUTER THIGH**

- **The school staff will take all reasonable steps to ensure my child does not eat any food items unless they have been prepared / approved by parents**
- **It is the schools responsibility to ensure this care plan is reviewed**

Agreed by: School Representative Date:

- **I agree that the medical information contained in this plan may be shared with individuals involved with my child's care and education and inform the school of changes in condition or treatment.**
- **I give my consent for the school to administer my child's Emerade or the school held adrenaline auto-injector (if my child's pen is lost/forgotten or malfunctions) to be administered in an emergency as detailed in this plan.**

Signed: Print name: Date:
I am the person with parental responsibility

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Individual protocol for using an Emerade (Adrenaline Autoinjector)

Symptoms may include:

- Difficulty in swallowing / speaking / breathing
- Wheezy / irregular breathing / excessive coughing
- Hoarseness
- Nettle rash (hives) anywhere on body
- Sense of impending doom
- Swelling of throat and mouth
- Abdominal pain, nausea & vomiting
- Feeling of weakness (BP drops)
- Collapse & unconsciousness
- Cold and clammy

Stay Calm

Reassure

One member of staff to Dial 999

REMEMBER

A = AIRWAY
B = BREATHING
C = CIRCULATION

Give EMERADE first then dial 999 Administer Emerade in the upper outer thigh

Remove cap protecting the needle
Hold Emerade against upper outer thigh and press it against patients leg. You will hear a click when the adrenaline is injected.
Hold Emerade in place for 10 seconds.
Can be given through clothing, but not very thick clothing.
Note time injection given.

If no improvement give 2nd EMERADE 5 minutes later

Call Parents

Reassure

Telephoning for an ambulance

You need to say: "I have a child in anaphylactic shock".
Give school details:
Give details: Child's name has a severe allergy and what has happened.

DO NOT PUT THE PHONE DOWN UNTIL YOU ARE SURE ALL THE NECESSARY INFORMATION HAS BEEN GIVEN

Someone to wait by the school gate to direct the ambulance staff straight to the child.