Appendix 1

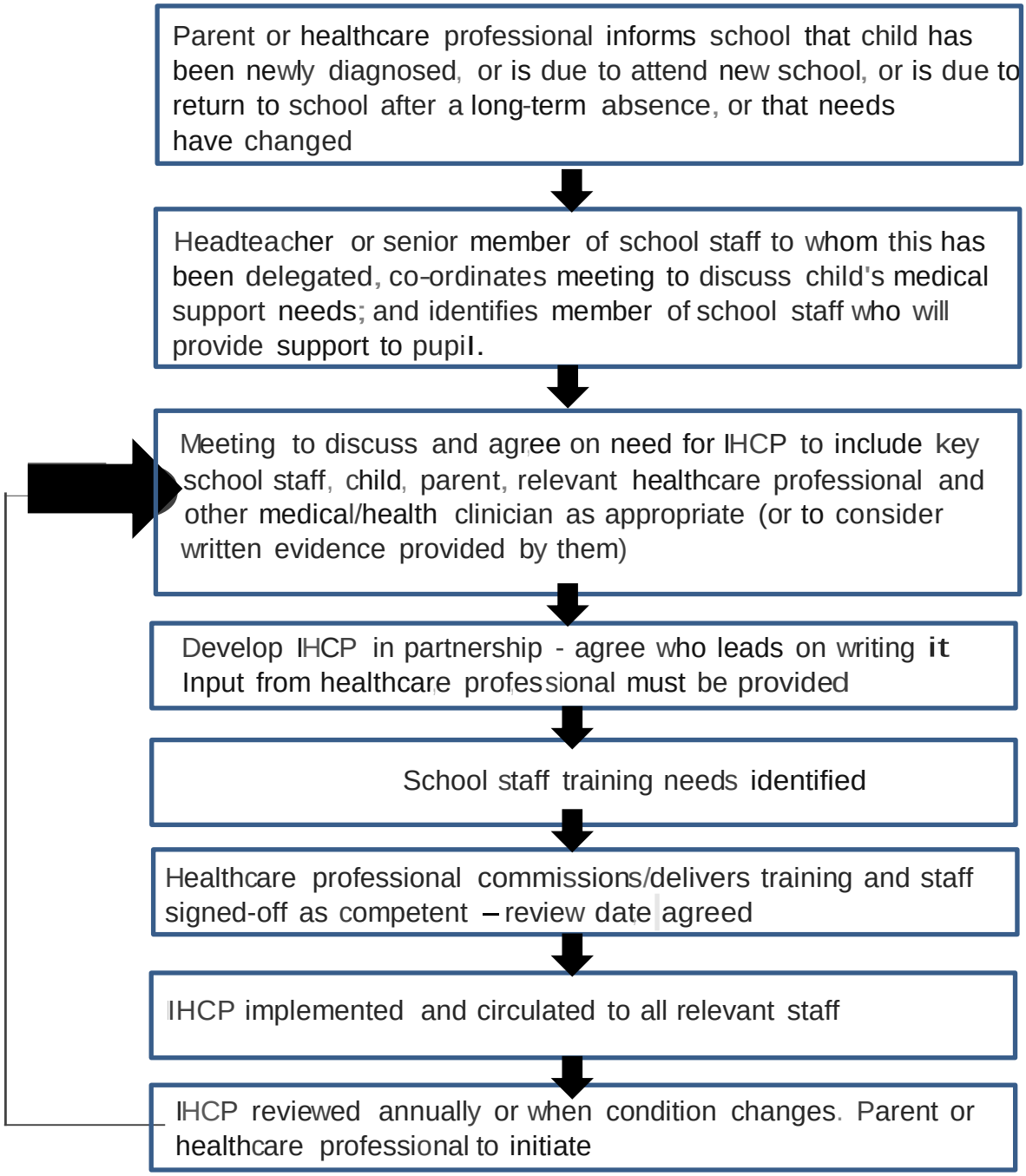
West Sussex County Council

Care Plan Templates

Supporting pupils with medical conditions

December 2021

Model process for developing individual healthcare plans



Template 1: individual healthcare plan (IHCP)

Attach photograph here

Name of school/setting	
Child's name	
Group/class/form	
Date of birth	
Child's address	
Medical diagnosis or condition	
Date	
Review date	

Family Contact Information

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

Clinic/Hospital Contact

Name	
Phone no.	

G.P.

Name	
Phone no.	

Who is responsible for providing support in school	

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

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

Daily care requirements

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

Arrangements for school visits/trips etc

Other information

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

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

Plan developed with

Staff training needed/undertaken – who, what, when

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

Copies to:

Template 2: Individual protocol for Mild Asthma

Please complete the questions below, sign this form and return without delay.

CHILD'S NAME……..

D.O.B. ……..…

Class ……

School use attach photo here

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

1. Does your child need an inhaler in school? Yes/No (delete as appropriate)

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?

……

4. It is advised that pupils have a spare inhaler in school. Spare inhalers may be required in the event that the first inhaler runs out is lost or forgotten. Inhalers must be clearly labelled with your child's name and must be replaced before they reach their expiry date. The school will also keep a salbutamol inhaler for emergency use.

Please delete as appropriate:

- My child carries their own inhaler <u>YES/NO</u>
- My child REQUIRES/DOES NOT REQUIRE a spacer and I have provided this to the school office
- I am aware I am responsible for supplying the school with in date inhaler(s)/spacer for school use and will supply this/these as soon as possible. <u>YES/NO</u>

5. Does your child need a blue inhaler before doing exercise/PE? If so, how many puffs?

……

6. Do you give consent for the following treatment to be given to your child as recognised by Asthma Specialists in an emergency? - Yes/No (delete as appropriate)

- Give **6 puffs of the 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 the blue inhaler via a spacer**
- Reassess after 5 minutes
- **If their symptoms are not relieved with 10 puffs of blue inhaler then this should be viewed as a serious attack:**
- **CALL AN AMBULANCE and CALL PARENT**
- **While waiting for an ambulance continue to give 10 puffs of the reliever inhaler every few minutes**

Please sign below to confirm you agree the following:

- I agree to ensure that my child has in-date inhalers and a spacer (if prescribed) in school.
- 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.

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

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

Parental Update (only to be completed if your child no longer has asthma) My child …….. 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:

	Provided by parent/school	Location (delete as appropriate)	Expiry date	Date of phone call requesting new inhaler	Date of letter (attach copy)
1st inhaler		With pupil/In classroom			
2nd inhaler Advised		In office/first aid room			
Spacer (if required)					
Record any further follow up with the parent/carer:					

Template 3 : Individual protocol for Antihistamine as an initial treatment protocol for mild allergic reaction

CHILD'S NAME……....

D.O.B. ……

Class ……

School use attach photo here

Nature of Allergy:

……

……

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

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**

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

- **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 I give my consent to the school to administer the schools supply of anti-histamine as part of my child's treatment for anaphylaxis. I confirm I have administer this medication in the past without adverse effect.

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

Individual protocol for using Antihistamine (e.g. Piriton)

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.

Template 4 : Individual protocol for an Emerade adrenaline auto injector

CHILD'S NAME……....

D.O.B. ……

Class ……

School use attach photo here

Nature of Allergy:

……

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name:
Phone No:
Address:

MEDICATION **Emerade**
Name on Emerade & expiry date: ……

- **It is the parents 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 …… 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.**

- **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

Individual protocol for……..……using an EMERADE (Adrenaline auto injector)

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: 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.

Template 5 : Individual protocol for an Epipen adrenaline auto injector

CHILD'S NAME……....

D.O.B. ……

Class ……

School use attach photo here

Nature of Allergy:

……

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

GP
Name:
Phone No:
Address:

Clinic/ Hospital Contact
Name
Phone No:
Address:

MEDICATION EPIPEN

Name on EPIPEN & Expiry date: ……..

- **It is the parents 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 ……. 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.**

- **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

Individual protocol for using an Epipen (Adrenaline Auto injector)

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: 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.

Template 6 : Individual protocol for an Jext pen adrenline auto injector

CHILD'S NAME……....

D.O.B. ……

Class ……

School use attach photo here

Nature of Allergy:

……

Contact Information

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

If I am unavailable please contact:

Name					Relationship to pupil			
Phone numbers	Work		Home		Mobile		Other	

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 …… 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.**

- **I give my consent for the school to administer my child's Jext pen 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

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.

Template 7: model letter inviting parents to contribute to individual healthcare plan development

Dear Parent/Guardian

DEVELOPING AN INDIVIDUAL HEALTHCARE PLAN FOR YOUR CHILD

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

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

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

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

Yours sincerely

Template 8: Example letter to send to parent/guardian who has not provided an in-date inhaler or auto injector.
Please amend as necessary for the individual circumstances.

Dear (Name of parent)

Following today's phone call regarding (name of pupil)'s asthma inhaler/adrenaline auto injector, I am very concerned that in date medication has not been provided. You have confirmed on the Individual Protocol that (name of pupil) requires an inhaler in school and you have agreed to provide the medication. Please ensure that the following are provided without delay:

- an inhaler/ adrenaline auto injector
- a spacer

If (name of pupil) no longer requires an inhaler/auto injector, please inform the school in writing as soon as possible.

Please be aware that in the absence of in date medication, should (name of pupil) suffer an attack, and you have given your consent staff will administer the schools reliever inhaler/adrenaline auto injector. However if you have not given consent for the school reliever inhaler/adrenaline auto injector to be administered staff will not be able to follow suitable emergency procedures. They will be reliant on calling 999 and awaiting the Emergency Services.

Yours sincerely

Protocol for the administration of Paracetamol

- Paracetamol can be administered to children of any age, dose must be suitable for their age and weight
- Verbal parental consent must be gained at the time of administration to administer paracetamol, if before 12 noon. If the parents cannot be contacted paracetamol cannot be administered. Conversation with parent/guardian must be recorded in writing.
- If paracetamol is administered at any time during the school day parents will be informed of the time of administration and dosage.
- The school will keep records of the administration of paracetamol as for prescribed medication.
- Pupils must not bring paracetamol (or other types of painkillers) to school for self-administration.

Use with caution:

- Liver problems
- Kidney problems
- Long term malnutrition
- Long term dehydration
- Epilepsy

SIDE EFFECTS:

- Allergic reaction rash, swelling difficulty breathing
- Low blood pressure and a fast heartbeat
- Blood disorders
- Liver and kidney damage (overdose)

Do not administer if the pupil is also taking any of the following drugs:

- Metoclopramide (relieves sickness and indigestion)
- Carbamazepine (treats a number of conditions including epilepsy)
- Phenobarbital or phenytoin (used to control seizures)
- Lixisenatide – used to treat type 2 diabetes)
- Imatinib – used to treat leukaemia
- Other drugs containing paracetamol e.g. Lemsip, Sudofed, Feminax

IF YOU SUSPECT AN OVERDOSE CALL 999 IMMEDIATELY only 4 dose in 24 hours

Protocol for the administration of Ibuprofen

- Ibuprofen can ONLY be administered to pupils AGE 12 and OVER and dose must be suitable for their age and weight for period pain, migraine and pain symptoms that include inflammation/swelling e.g. joint pain, sprains;
- Verbal parental consent must be gained at the time of administration to administer ibuprofen. If the parents cannot be contacted ibuprofen cannot be administered. Conversation with parent/guardian must be recorded in writing.
- If parents confirm they have administered Ibuprofen in the morning then the school CANNOT ADMINISTER ANOTHER DOSE that day.
- If Ibuprofen is administered at any time during the school day parents will be informed of the time of administration and dosage.
- The school will keep records of the administration of Ibuprofen as for prescribed medication.
- Pupils must not bring Ibuprofen (or other types of painkillers) to school for self-administration.

DO NOT ADMINISTER TO ASTHMATICS

Use with caution:

- Kidney or liver problems
- Stomach ulcer
- Heart problems
- Lupus
- Crohn's disease or ulcerative colitis
- High blood pressure
- Stroke

SIDE EFFECTS

- nausea or vomiting constipation or diarrhoea
- indigestion or abdominal pain headache or dizziness
- bloating (fluid retention)
- raised blood pressure
- allergic reaction e.g. rash
- worsening asthma
- kidney failure
- black stools /blood in stool

Do not administer if the pupil is also taking any of the following drugs:

- Other Non-steroidal anti-inflammatory drugs (NSAID's) should not take more than one NSAID at a time
- Anti-depressants
- Beta blockers to treat high blood pressure/migraines
- Diuretics – to remove excess fluid in the body

IF YOU SUSPECT AN OVERDOSE CALL 999 IMMEDIATELY only 3 doses in 24 hours