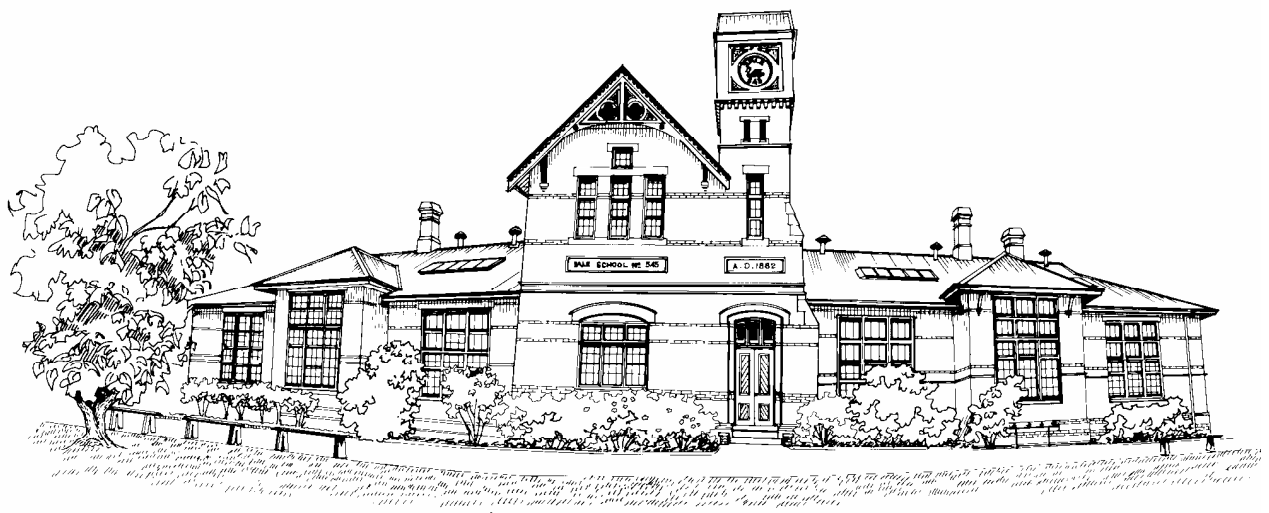


# SALE PRIMARY SCHOOL

NO. 545



# MEDICATION AND FIRST AID POLICY

# STUDENT HEALTH AND MEDICATION PROTOCOL

## Rationale:

- The Department of Education is responsible for providing first aid facilities and sufficient staff trained to an appropriate level of first aid
- Teachers are required to administer first aid, when necessary, within the limits of their skill, expertise and training.

## 1. First Aid Training

- There will be, minimally, staff trained in first aid timetabled as designated first aid officers each day at recess and lunchtime. Administration staff trained in first aid will care for students requiring first aid during other parts of the day.

## 2. First Aid Organisation

- Designated first aiders will on-duty each day to respond to accidents and emergencies.
- Duty first aid teachers will be listed on Yard Duty Roster schedule.
- Designated first aid co-ordinator will be responsible for the maintenance of the first aid cupboard and kits.(\* see appendix for recommended first aid kits) in the first aid room.
- First aid room will be furnished with a current first aid manual.
- In the case of injuries to the head and/or face, parents must be contacted by phone to indicate that an injury has taken place – even if the student is to return to class.
- A comprehensive alphabetical list of children and their medical conditions will be prominently placed in the sick bay. Copies of individual medical condition management plans (eg for diabetics, asthmatics, children taking medication for Attention Deficit Disorder, etc) will also be placed in the sick bay.

## 3. Sick Bay Routines

1. Whenever a child is in the sick bay - the sick bay light will be switched on.
2. Unless a child is sent to lie down for a few minutes (eg as a response to a slight headache) no child should be left unsupervised in the sick bay.
3. All minor first aid treatment should be entered on the first aid response form in the sick bay. All other accident and emergency response must be recorded on the official accident report form. This will be cosigned by the principal prior to recording on CASES.
4. **EVERY ATTEMPT SHOULD BE MADE TO CONTACT THE PARENTS/GUARDIANS BEFORE CALLING FOR MEDICAL ATTENTION EXCEPT IN AN EXTREME EMERGENCY. IN SERIOUS CASES, PARENTS/GUARDIANS MUST ALWAYS BE INFORMED AS QUICKLY AS POSSIBLE OF THEIR CHILD'S CONDITION AND OF THE ACTIONS TAKEN BY THE SCHOOL. PARENTS/GUARDIANS SHOULD BE INFORMED OF ANY FIRST AID TREATMENT THEIR CHILD HAS RECEIVED.**

#### **4. Blood Spills**

Equipment and procedures for dealing with blood spills:

- Equipment:
  - Bleach (Strength should be 10,000 parts per million. With a household bleach, this approximates one-quarter of a cup to one cup of water);
  - Disposable latex gloves;
  - Disposable towels;
  - Disposable plastic bag;
  - Hot water and detergent.
  
- Procedure:
  - Use gloves;
  - Saturate disposable towel in bleach;
  - Cover the spill with the towel;
  - Leave for ten minutes;
  - Place towel into disposable plastic bag;
  - Wash area with hot water and detergent;
  - Place gloves into plastic bag;
  - Seal bag and dispose of it;
  - Wash hands.

#### **5. Medical Conditions**

Many students attending school need medication to control illness such as asthma, epilepsy and conditions causing hyperactive behaviour.

Every student who has a medical condition or illness should have a written “Individual Medical Condition Management Plan.” - (\* copy attached)

#### **5. Student Medication Protocol**

1. All students who are to receive medication during school hours must have parental consent given before a member of staff can administer it. This consent must be in writing and must clearly outline the name of the medication, the dosage required and the time it is to be administered.
2. With the exception of Asthmatic Sprays (Ventolin, Respoln), which may be held by children trained in their use, no medication is to be in a child’s possession at school.
3. To assist teachers, medication should be in a container which gives the details of the name of the student, the name of the drug, the dose and the time it is given. Upon arrival at school all medication must be handed directly to the teacher responsible for administering it in order for it to be secured in the most appropriate place (eg. Staff fridge / lockable cabinet.) If medication for more than one day is supplied, it must be stored in a locked drawer/cupboard/filing cabinet or the staffroom refrigerator and be clearly labelled.
4. Upon administering any medication to a child, the staff member concerned must record all information on the Medication Dispersion Record Sheet (**Appendix 4**) which must be readily accessible within the classroom (eg. In the student roll folder or lockable cabinet with the medication.) This Medication Dispersion Record Sheet is a ‘legal document’ and must be retained at the school for at least 12 months. Staff members are responsible for including this

Medication Dispersion Record with other 'legal documents' (eg. Parent notes) when these are sent to the office at the end of each school year for archiving.

5. Classroom teachers must ensure that any medication administration is conveyed to Casual Relief Teachers (CRTs) in order for them to be aware of procedures.
6. At no time will staff dispense ASPRIN to children.
7. Other analgesics - eg paracetamol - will only be given with the permission of parents/guardians and be issued by the principal/bursar - who will keep a record and monitor student intake.
8. Whenever children are going on an excursion or camp - all medication - clearly labelled and with appropriate instructions - should be handed to the designated responsible teacher.
9. Substance prescribed for a particular student should be retained solely for that student. Only in a life threatening emergency - (eg asthma attack requiring immediate medication) - would consideration be given to any variation of this requirement.
10. Whenever there is any element of doubt as to the requirement for medication or the administration of medicine - the school will make every effort to first contact the parent and/or emergency contact.
11. The school shall provide staff with training in the use of an EPIPEN in case of it's use being required to treat an anaphalytic seizure of a student (who has provided this medication to the school).

## ASTHMA MANAGEMENT PLAN

Student's Name \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Class \_\_\_\_\_

Teacher's Name \_\_\_\_\_

Parent's / Guardian's Names \_\_\_\_\_

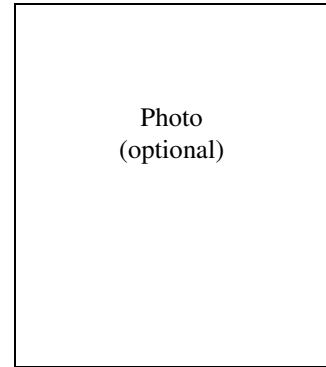
Phone Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Emergency contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Doctor's Name \_\_\_\_\_

Phone (BH) \_\_\_\_\_ Mobile/Pager \_\_\_\_\_

Ambulance Subscriber Yes/No (Subscriber No) \_\_\_\_\_ Medicare No \_\_\_\_\_



### SCHOOLS EMERGENCY ACTION PLAN

This section is to be completed by the student's doctor in consultation with their parent/guardian

1. What are the student's usual symptoms of asthma (✓)?  
 Wheezing  Tightness in chest  Coughing  Difficulty in breathing   
 Other (Please describe)

2. What are the student's signs / symptoms of worsening asthma?  
 Please describe

3. Please (✓) preferred **Emergency Action Plan**

Victorian Schools Asthma Policy for Emergency Treatment of an Asthma Attack  
 (Section 4.5.7.8. of the Department of Education Schools of the Future Reference Guide)

1. Sit the student down and remain calm to reassure the student
2. Without delay give 4 puffs of a Reliever inhaler (Ventolin, Respolin or Bricanyl), using a spacer (spacer technique - 1 puff/take 4 breaths from spacer, repeat until 4 puffs have been given)
3. Wait 4 minutes. If there is no improvement, give another 4 puffs, as per step 2.
4. If no improvement, call an ambulance (dial 000) immediately and state that "a student is having an asthma attack".
5. Continuously repeat steps 2 & 3 whilst waiting for the ambulance to arrive.

Student's Emergency Treatment (If different from above)

Medication	Dosage (eg 2 puffs)	Method (eg puffer and spacer)	How often (eg every 4 mins)

Additional comments

## USUAL ASTHMA MANAGEMENT PLAN

1. Is medication usually required at school?

No

Yes (if yes, please provide the following information)

Medication	Dosage	How often

2. Does the student need pre-exercise medication?

No

Yes (if yes, please provide the following information)

Medication \_\_\_\_\_ Dosage \_\_\_\_\_  
Under what circumstances? (eg cross country)

\_\_\_\_\_  
\_\_\_\_\_

3. Does the student require assistance / supervision from staff while taking medication?

No

Yes (if yes, please provide instructions)

Instructions

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Important

- Please notify any changes in writing
- A more detailed asthma management plan will be required for overnight school excursions and camps
- Other relevant information eg trigger factors, side effects from medication etc

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For further information about the Victorian School Asthma Policy and asthma management please contact Asthma Victoria on (03) 9326 7088 or Toll Free 1800 645 130

### Declaration

In the event of an asthma attack at school, I agree to my son/daughter/ward receiving the treatment described above. I also agree to pay all expenses incurred for any medical treatment deemed necessary.

Parent's / Guardian's Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Doctor's Comment s(if any) \_\_\_\_\_  
\_\_\_\_\_

Doctor's signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## **DISCARDED NEEDLES AND SYRINGES (HEALTH RISKS AND PRECAUTIONS)**

### **RISK OF INFECTION**

#### **HIV**

A person who is pricked or scratched with a discarded needle is at risk of being infected with HIV from blood in the needle. HIV doesn't live long outside the body. However, it is not possible to be certain how long ago the needle was used. There is also a risk of HIV transmission through the transfer of infected blood if a needle is shared.

#### **HEPATITIS B**

Similarly there is a possible risk of Hepatitis B infection. The virus that causes Hepatitis B is more infectious than HIV and remains alive and viable for up to 24 hours outside the body. There is also a risk of Hepatitis B transmission through the transfer of infected blood if a needle is shared.

#### **TETANUS**

A risk of tetanus infection exists only if the person has either not been vaccinated against tetanus or their vaccination is not up-to-date.

Tetanus spores live in the soil and may cause infection if they are transported into the body through skin punctured by a discarded needle.

#### **OTHER INFECTIONS**

With any wound there is the possibility of bacterial infection.

### **GUIDELINES FOR SAFE DISPOSAL**

- Avoid touching needle with fingers or hands. Students should report the finding to a designated staff member or other adult.
- The needle and syringe should be picked up by the blunt end away from the needle, preferably using gloves, brush and pan or barbecue tongs.
- Needle and syringe should be placed in a rigid plastic container with a well secured lid. The container must be leak proof, puncture proof and shatter proof.
- The container should be incinerated or disposed of through the municipal rubbish collection service.

### **NEEDLESTICK INJURY PROCEDURE**

A needlestick injury is an accidental jab with an infected needle or other sharp object.

- Encourage the wound to bleed by gentle squeezing it. Then wash in water and soap.
- Apply an antiseptic and sterile dressing.
- The injured person should be taken to his/her general practitioner for assessment and treatment and ensure that the circumstances of the injury are reported

**MEDICAL CONDITION - MANAGEMENT PLAN**

**NAME OF STUDENT**

**MEDICAL CONDITION**

**Student Details:**

Age:

Grade:

Home Telephone:

Business Telephone:

**Description of Condition:**

**Medical Treatment Required at School or While on School Activities:**

**Symptoms of Deterioration:**

**Medical treatment and action required if students condition deteriorates:**

**Emergency Contacts:**

	NAME	ADDRESS	TELEPHONE
1.			
2.			
	STUDENT'S DOCTOR		TELEPHONE

(LAST UPDATED \_\_\_\_\_ )

An extract from the Department of Education Gazette which specifies exclusion times for infectious diseases follows:

## Infectious Diseases

<i>Disease or Condition</i>	<i>Patient shall be excluded from school</i>	<i>Exclusion of Contacts</i>
Chickenpox	Until fully recovered or at least one week after the eruption first appears	Not excluded
Conjunctivitis	Until discharge from eyes has ceased (acute infectious)	Not excluded
Diphtheria	Until receipt of a medical certificate	Domiciliary contacts excluded until investigated by the medical officer of health or a health officer of the department and shown to be clear of the infection
Giardiasis (diarrhoea)	Until diarrhoea ceases	Not excluded
Hepatitis(infectious hepatitis)	Until receipt of a medical certificate of recovery from infection, or on subsidence of symptoms	Not excluded
Hepatitis B	Until recovered from acute attack	Not excluded
Impetigo(School sores)	Until sores have fully healed. The child may be allowed to return provided that appropriate treatment has commenced and that sores on exposed surfaces such as scalp, face, hands and legs are properly covered with occlusive dressings	Not excluded
Leprosy	Until receipt of a medical certificate of recovery from infection	Not excluded
Measles	Until at least 5 days from the appearance of rash or until receipt of a medical certificate of recovery from infection	Non-immunised contacts must be excluded for 13 days from the first day of appearance of rash in the last case unless immunised within 72 hours of first contact
Meningococcal infection	Until receipt of a medical certificate of recovery from infection	Domiciliary contacts must be excluded until they have been receiving appropriate chemotherapy for at least 48 hours
Mumps	Until fully recovered	Not excluded
Pediculosis(head lice)	Until appropriate treatment has commenced	Not excluded
Pertussis(whooping cough)	Until 2 weeks after the onset of illness and until receipt of a medical certificate of recovery from infection	Domiciliary contacts must be excluded from attending a children's services centre for 21 days after the last exposure to infection if the contacts have not previously had whooping cough or immunisation against whooping cough.
Poliomyelitis	Until at least 14 days after onset of illness or until receipt of a medical certificate of recovery from infection	Not excluded
Ringworm	Until appropriate treatment has commenced	Not excluded
Rotavirus (diarrhoea)	Until diarrhoea ceases	Not excluded
Rubella	Until fully recovered or at least 5 days after onset of rash	Not excluded
Scabies	Until appropriate treatment has commenced	Not excluded
Shiglla (diarrhoea)	Until diarrhoea ceases	Not excluded
Streptococcal infection(inc. Scarlet fever)	Until receipt of a medical certificate of recovery from infection	Not excluded
Trachoma	Until appropriate treatment has commenced	Not excluded
Tuberculosis	Until receipt of a medical certificate from a health officer of the department that the child is not considered to be infectious	Not excluded
Typhoid and Paratyphoid	Until receipt of a medical certificate of recovery from infection	Not excluded unless the medical officer of health or a health officer of the department considers exclusion to be necessary

## Appendix 1

### ASTHMA RESPONSE CARD

#### **Emergency treatment of an asthma attack**

If a student develops signs of what appears to be an asthma attack, appropriate care must be given immediately.

#### **Assessing the severity of an asthma attack.**

Asthma attacks can be:

- **Mild:** This involves coughing, a soft wheeze, minor difficulty in breathing and no difficulty speaking in sentences.
- **Moderate:** This involves a persistent cough, loud wheeze, obvious difficulty in breathing and able to speak in short sentences only.
- **Severe:** The student is often very distressed and anxious, gasping for breath, unable to speak more than a few words in one breath, pale and sweaty and may have blue lips.

**All students judged to be having a severe attack require emergency medical assistance.**

**Call an ambulance and carry out the steps listed while waiting for an ambulance to arrive.**

Regardless of whether an attack of asthma has been assessed as mild, moderate or severe, treatment must commence immediately. The danger in any acute asthma situation is delay. Delay may increase the severity of the attack and ultimately risks the student's life.

#### **Treating an asthma attack.**

If the student has an action plan follow the steps immediately. If no action plan is available the steps outlined should be taken immediately. These steps should be clearly displayed in the staff room so that all staff are well versed with them. They should also be written on a card in the first aid kit. The steps are:

- If the student's own bronchodilator puffer is not readily available, a bronchodilator puffer should be obtained from the first aid kit, or borrowed from another student or teacher, and given without delay. It does not matter if a different brand of bronchodilator is used.
- Sit the student down (as breathing is easier sitting rather than lying down) and provide reassurance. Remaining clam will also assist in reassuring the student.
- Without delay administer four puffs of bronchodilator via a spacer noting the following instructions:
  - Shake the asthma puffer, insert it into the spacer and fire a single puff into the spacer chamber.
  - Ask the student to breath in and out through the mouthpiece for four breaths (the student does not need to take their mouth away for each breath out as the mouthpiece contains a one-way valve).
  - Repeat immediately to administer a total of 4 puffs.
- Wait four minutes. If there is no improvement, repeat step 2 (third dot point above).
- If there is still no improvement, an ambulance should be called immediately (dial 000). State clearly that a student is having 'an asthma attack'. The ambulance service will always give priority to an asthma attack.
- Repeat steps 2 and 3 (third and fourth dot point above) continuously while waiting for an ambulance to arrive.
- Contact the student's parents/guardians and doctor immediately.

Even if the student has a complete recovery from the asthma attack, their parents/guardians or doctor should be notified of the incident.

If no spacer is available:

- Shake the puffer.
- Have the student hold the puffer either in the mouth, or slightly away from the open mouth.
- Either the student, or the staff member, should fire the puffer the moment the student begins to take a slow steady breath in (inhalation/inspiration). Ideally, the student should hold their breath for four seconds at full inspiration.
- Allow the student to take four normal breaths of air, then repeat the above procedure until four puffs of bronchodilator have been delivered.
- Wait four minutes. If there is no improvement, repeat the above steps.
- If there is still no improvement, call an ambulance immediately.
- Repeat the above steps continuously while waiting for the ambulance to arrive.

If at any time the student's condition suddenly worsens, call an ambulance immediately

#### Reference

Asthma Victoria, 69 Flemington Road, North Melbourne Vic 3051

Phone (03) 93267088 or 1800 645 130

Fax (03) 93267055

email [afv@asthma.org.au](mailto:afv@asthma.org.au)

internet [www.asthma.org.au](http://www.asthma.org.au)

## DIABETICS RESPONSE CARD

### **Treatment of Mild to Moderate “Hypo”**

Mild to moderate hypos can be treated by giving sugary foods or drinks by mouth. Parents/guardians should provide class room staff with their child’s preferred hypo kit, or an emergency store of jelly beans or glucose tablets.

The essentials in the treatment of mild to moderate hypos are to:

#### **1. Act swiftly.**

Sometimes a student will do a blood glucose measurement at school to confirm a hypo, however, it is important not to waste time. If in doubt, TREAT.

#### **2. Give rapidly absorbed carbohydrate. Any ONE of the following:**

- Jelly beans (4 large or 7 small)
- Fruit juice (1/3 to 1/2 glass or 125 - 200 ml)
- Sugary soft drink (1/3 to 1/2 can or 125 - 200 ml)
- Glucose tablets equivalent to 10 - 15 grams
- Sugar, honey, sweetened condensed milk or jam (2-3 teaspoons)

Repeat this treatment if there has been no response within 10 to 15 minutes.

**Note:** Often the student may be uncooperative during a hypo and two people may be required to help ensure the student takes the carbohydrate.

#### **3. Follow up by giving slowly absorbed carbohydrate.**

When recovery begins to occur (usually within 10 to 15 minutes) give slowly absorbed starchy carbohydrate foods (eg sandwich, biscuits - equivalent to 1 slice of bread or a piece of fruit). For very small children, 1/2 this amount is sufficient. These foods will provide a more sustained release of carbohydrates and maintain the blood glucose levels in the normal range.

#### **4. Supervise**

Do not leave anyone having a hypo alone. The student needs to be supervised to make sure the food or drink is actually consumed and someone needs to stay with the student until he/she has recovered. If symptoms improve, the student may return to normal activity in approx 15 minutes. If no improvement is apparent in this time, repeat the treatment. If symptoms remain, notify the parents/guardians or the school doctor or transfer to a hospital by ambulance.

#### **5. Notify parents/guardians**

Advise the parents about the hypo and do not allow unaccompanied travel home.

## **Treatment of a Severe ‘Hypo’**

Never put food or drink in the mouth of a person who is unconscious, convulsing or unable to swallow in case it is inhaled. The treatment for a severe hypo is either an injection of glucose into the vein (this can only be given by a doctor or a trained paramedic) or an injection of Glucagon given by doctors, paramedics, a school nurse or the parents.

### **In a severe hypo:**

- Lie the student on one side and protect from injury
- Perform usual first aid, checking the *airway*, *breathing* and *circulation* (the “ABC” of first aid). Check the mouth is clear to allow unobstructed breathing. Skin colour should remain pale to normal if the student is breathing properly.

**CALL AN AMBULANCE AND INFORM THE OPERATOR THAT THERE IS A DIABETIC EMERGENCY**

**DIAL 000**

## Appendix 3

### FIRST AID KIT CONTENTS

Although first aid cabinets normally will only be accessed by those staff with designated first aid responsibilities, all staff must be aware of their location in case of an emergency.

The cabinets should be easily recognisable and should not be locked. Any medications such as paracetamol and those supplied by parents/guardians should be stored separately in a locked cupboard or drawer.

First aid cupboards should contain the relevant type and quantity of supplies to suit the requirements of each school.

In general, a school first aid cupboard would contain:

- An up-to-date first aid book
- Dressings
  - All gauze swabs: 100 of 7.5cm x 7.5cm (divide into groups of five swabs and place in small individual plastic packets). These are for wound cleaning only.
  - Sterile wound dressings, individually packed: Eight small, four medium, four large.
  - Combine dressing, for bleeding and/or major wounds. As this can be purchased on in large rolls, it is suggested that non-adhesive sanitary pads (cut in half for small dressings) be used.
  - Sterile non-adhesive dressings in individual packets; small, for covering burns or 'wet' wounds; large, for wounds such as large grazes.
  - Eye pads, individually packed.
- Adhesive dressings:
  - Non-allergenic paper-type adhesive tape: One of 2.5cm for holding dressings on the face and neck and for students with sensitive skin. It does not hold well on other parts of the body.
  - Adhesive first aid dressings and strips, for covering small wounds and grazes.
  - Butterfly closures.
  - Elasticised plasters, preferably hypoallergenic.
- Bandages:
  - Four triangle, for slings and bandages.
  - Crepe bandages: Two of 2.5 cm, two of 5cm, six of 7.5cm and two of 10cm. These may be used to hold dressings in place or for support.
- Lotions and ointments
  - Cuts and abrasions should be cleaned under running water. Antiseptics are not recommended.
  - Any sun screen, with a sun protection factor of approximately 15+.
  - A sterile eye solution. Use the whole bottle each time.
- Asthma management equipment.

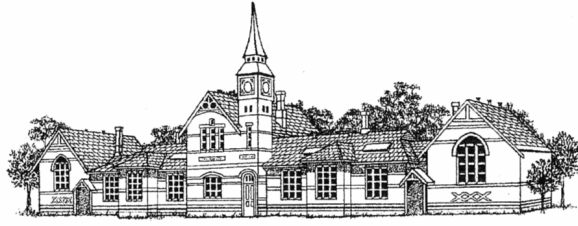
Other equipment

- Disposable plastic gloves. There are essential for all kits, particularly for treating blood spills.
- Cotton buds, for applying creams and lotions and for cleaning wounds.
- One medicine measure for use with prescribed medications.
- Disposable cups.
- One pair of scissors (medium size).
- One splinter tweezers and one splinter forceps.
- One teaspoon.
- Disposable hand towels.
- Nail brush.

- Torch, to measure eye pupil reaction (pen type is best).
- Two gel packs, kept in the refrigerator, for 'bangs, bumps and bruises'.
- Adhesive sanitary pads, as a backup for personal supplies.
- Wooden splints for fractured limbs (in case of ambulance delay).
- Six broad bandages and safety pins.
- Blanket and sheet.
- Germicidal soap.
- One box of paper tissues.
- Chux or similar for wiping up blood spills.
- Small plastic rubbish bags for used swabs.
- Ice cream containers for vomit.

First aid kits should be available for all groups that leave the school on excursions. The content of these kits will be dependent on the nature of the activities, the number of students and staff and the location of the excursion.





SALE PRIMARY SCHOOL  
No. 545

## Medication Dispersion Policy

- All students who are to receive medication during school hours must have parental consent given before a member of staff can administer it. This consent must be in writing and must clearly outline the name of the medication, the dosage required and the time it is to be administered.
- Upon arrival at school all medication must be handed directly to the teacher responsible for administering it in order for it to be secured in the most appropriate place (eg. Staff fridge / lockable cabinet.)
- Upon administering any medication to a child, the staff member concerned must record all information on the Medication Dispersion Record Sheet (see attached) which must be readily accessible within the classroom (eg. In the student roll folder or lockable cabinet with the medication.)
- In the event of a child receiving medication daily and regularly classroom teachers can enter the student's name once, the date can indicate the whole week, the time, medication and dosage will be consistent and they need only initial the signature box on each occasion.
- Classroom teachers must ensure that any medication administration is conveyed to Casual Relief Teachers (CRTs) in order for them to be aware of procedures.
- This Medication Dispersion Record Sheet is a 'legal document' and must be retained at the school for at least 12 months. Staff members are responsible for including this Medication Dispersion Record with other 'legal documents' (eg. Parent notes) when these are sent to the office at the end of each school year for archiving.