SHANKLEA EYFS

Illness and Exclusions Policy and Procedure

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Illness and Exclusions Policy and Procedure

Managing children with allergies, or who are sick or infectious

(Including reporting notifiable diseases)

Policy statement

We provide care for healthy children and promote health through identifying allergies and preventing contact with allergenic substances and through preventing cross infection of viruses and bacterial infections.

EYFS Key themes and commitments

1.2 Inclusive practice

1.4 Health and well-being

2.4 Key person

3.2 Supporting every child

Procedures for children with known allergies

- When parents start their children at the setting they are asked if their child suffers from any known allergies. This is recorded on the registration form. Parents are also requested to give permission for their child to be taken to hospital in the event of requiring emergency treatment.

If a child has an allergy, a Healthcare Plan is completed to detail the following:

- The allergen (i.e. the substance, material or living creature the child is allergic to such as nuts, eggs, bee stings, cats etc).
- The nature of the allergic reactions e.g. anaphylactic shock reaction, including rash, reddening of skin, swelling, breathing problems etc.
- What to do in case of allergic reactions, any medication used and how it is to be used (e.g. Epipen).
- Control measures – such as how the child can be prevented from contact with the allergen.
- Review.
- The healthcare Plan is kept in the main school office and a copy is displayed where staff can see it.
- Parents and medical specialists train staff in how to administer special medication in the event of an allergic reaction.
- Generally, no nuts or nut products are used within the setting.
- School cooks are informed of any food allergies.

- Parents are asked that no nut or nut products are brought in packed lunches or for example to a party.

At all times the administration of medication must be compliant with the Welfare Requirements of the Early Years Foundation Stage and follow procedures based on advice given in *Managing Medicines in Schools and Early Years Settings* (DfES 2005)

Oral Medication

Asthma inhalers are now regarded as "oral medication" by insurers and so documents do not need to be forwarded to your insurance provider.

- Oral medications must be prescribed by a GP or have manufacturer's instructions clearly written on them.
- The setting must be provided with clear written instructions on how to administer such medication.
- All risk assessment procedures need to be adhered to for the correct storage and administration of the medication.
- The setting must have the parents or guardians prior written consent. This consent is kept on file.

For life saving medication & invasive treatments - adrenaline injections (Epipens) for anaphylactic shock reactions (caused by allergies to nuts, eggs etc) or invasive treatments such as rectal administration of Diazepam (for epilepsy).

The setting must have:

- a letter from the child's GP/consultant stating the child's condition and what medication if any is to be administered;
- written consent from the parent or guardian allowing staff to administer medication; and
- proof of training in the administration of such medication by the child's GP, a district nurse, children's' nurse specialist or a community paediatric nurse.

Key person for special needs children - children requiring help with tubes to help them with everyday living e.g. breathing apparatus, to take nourishment, colostomy bags etc.

- Prior written consent from the child's parent or guardian to give treatment and/or medication prescribed by the child's GP.
- Key person to have the relevant medical training/experience, which may include those who have received appropriate instructions from parents or guardians, or who have qualifications.

Procedure for children who are sick or infectious

- If children appear unwell during the day – have a temperature, sickness, diarrhoea or pains, particularly in the head or stomach – the EYFS staff member calls the parents and asks them to collect the child, or send a known carer to collect on their behalf.
- If a child has a temperature, they are kept cool, by removing top clothing, sponging their heads with cool water, but kept away from draughts.
- Temperature is taken using a 'fever scan' kept near to the first aid box.
- In extreme cases of emergency the child should be taken to the nearest hospital and the parent informed.
- Parents are asked to take their child to the doctor before returning them to the setting; the setting can refuse admittance to children who have a temperature, sickness and diarrhoea or a contagious infection or disease.
- Where children have been prescribed antibiotics, parents are asked to keep them at home for 48 hours before returning to the setting.
- After diarrhoea, parents are asked to keep children home for 48 hours or until a formed stool is passed.
- The setting has a list of excludable diseases and current exclusion times detailed below.

Disease	Incubation	Infectivity	Exclude Until	Comments
Adenovirus gastroenteritis	8-10 days	6-16 days	48 hours from last episode of diarrhoea or vomiting.	Exclude for 48 hours longer in children who are unable to maintain good personal hygiene.
Chickenpox	11-20 days	Up to 4 days before (usually only 1 day) to 5 days after. Cases often transmit before appearance of rash.	5 days from start of skin eruption.	Traditionally excluded until all lesions are crusted but no transmission recorded after day 5. Contacts with a weak immune system need prevention.

Campylobacter	1-10 days	Patients probably not infectious if treated and diarrhoea has resolved.	24 hours from last episode of diarrhoea.	Exclude for 48 hours longer in children who are unable to maintain good personal hygiene.
Conjunctivitis	3-29 days Mean = 8	While active (direct contact). Infective up to 2 weeks.	None.	Transmission more likely in young children by direct contact - very few data.
Fifth disease (slapped cheek)	13-18 days	30% in families. 10-60% in schools.	None.	Avoid infection in pregnant women and people with a weak immune system.
Glandular fever	33-49 days	At least 2 months.	None.	None.
Hand, foot and mouth disease	3-5 days	Up to 50% in homes and nurseries.	None - good hygiene helps.	Stool excretion continues for some weeks. Avoid infection in pregnant women.
Head lice	n/a	While harbouring lice.	None.	Note need for treatment of cases and contacts shown to have head lice.
Hepatitis A	15-50 days	From 2 weeks before to 1-2 weeks after jaundice onset.	Exclude until 7 days after onset of jaundice (or 7 days after symptom onset if no jaundice).	Good hygiene needs emphasising.

Herpes simplex virus (cold sores)	1-6 days	While lesions are moist.	None.	Highly infectious, especially amongst young children. Avoid kissing.
Impetigo	Skin carriage 2-33 days before development of impetigo (streptococci).	High (streptococci). Low (staphylococci). (Variable infectivity depending on causative bacteria.)	Until lesions healed or crusted or 48 hours after starting antibiotic treatment.	None.
Measles*	6-19 days	Highly contagious in non-immune population. A few days before to 6-18 days after onset of rash.	4 days from onset of rash.	Check immunisation. Risk of serious infection in people with a weak immune system (give preventative treatment).
Mumps*	15-24 days	10-29 days. Moderately infective in non-immunised population.	5 days from onset of swelling.	Outbreaks reported in vaccinated secondary school children.
Ringworm	Varies	Until lesions resolve.	Exclusion not usually required.	Good hygiene helps.
Rubella*	13-20 days	1 week before to approximately 4 days after onset of rash.	6 days from onset of rash.	Check all female contacts are immune.
Scabies	Varies	Until mites and eggs are dead.	Can return after first treatment.	Risk of transmission is low in schools but outbreaks do occur. Close contacts

				should also be treated.
Scarlet fever*	1-3 days	Moderate within families. Low elsewhere. Infective first 3 days of treatment.	24 hours after starting antibiotic treatment.	Moderate within families. Low elsewhere.
Threadworms	n/a	Until all worms are dead.	None.	Good hygiene helps. Case and family contacts should be treated.
Tuberculosis*	n/a	Until 14th day of treatment.	Variable.	See 2nd Reference below.
Warts and Verrucas	n/a	None.	None.	Care needed with verrucas in swimming pools, gymnasiums and changing rooms.
Whooping cough*	7-10 days	Mainly early catarrhal stage, but until 4 weeks after onset of cough paroxysms. Shorten to 7 days if given antibiotics.	5 days from commencing antibiotic treatment; otherwise 21 days from onset of illness.	Check immunisation of contacts. Highly infectious in non-immune populations.

Note: * = a notifiable disease (required by law to be reported to government authorities).

Reporting of 'notifiable diseases'

- If a child or adult is diagnosed suffering from a notifiable disease under the Public Health (Infectious Diseases) Regulations 1988, the GP will report this to the Health Protection Agency.
- When the Nursery becomes aware, or is formally informed of the notifiable disease, the head, deputy head or Nursery leader will inform Ofsted and act on any advice given by the Health Protection Agency.

HIV/AIDS/Hepatitis procedure

- HIV virus, like other viruses such as Hepatitis, (A, B and C) are spread through body fluids. Hygiene precautions for dealing with body fluids are the same for all children and adults.
- Single use vinyl gloves and aprons are worn when changing children's nappies, pants and clothing that are soiled with blood, urine, faeces or vomit.
- Protective rubber gloves are used for cleaning/sluicing clothing after changing.
- Soiled clothing is rinsed and either bagged for parents to collect or laundered in the nursery.
- Spills of blood, urine, faeces or vomit are cleared using mild disinfectant solution and mops; cloths used are disposed of with the clinical waste.
- Tables and other furniture, furnishings or toys affected by blood, urine, faeces or vomit are cleaned using a disinfectant.

Nits and head lice

- Nits and head lice are not an excludable condition, although in exceptional cases a parent may be asked to keep the child away until the infestation has cleared.
- On identifying cases of head lice, all parents are informed by letter and asked to treat their child and all the family if they are found to have head lice.

Further guidance

Managing Medicines in Schools and Early Years Settings (DfES 2005)
http://publications.teachernet.gov.uk/eOrderingDownload/1448-2005PDF-EN-02.pdf