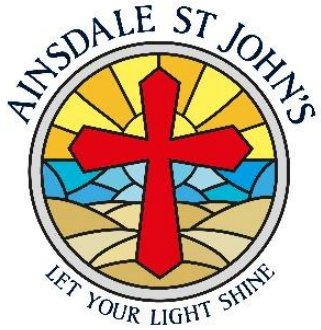

Supporting Pupils with Medical Conditions

Statement of intent

At Ainsdale St John's CE Primary School, our vision is "Let your light shine" (Matthew 5:16). We Aspire to Shine for Jesus through our values of Courage, Community and Compassion.

Every child with a medical condition – whether physical or mental – should feel safe, valued and included, and have full access to education, PE, educational visits, residentials, play, wraparound activities and the wider life of the school. We listen to children and families and work with healthcare professionals to provide individual, proportionate support.

Some pupils with medical conditions are disabled within the meaning of the Equality Act 2010 and must receive reasonable adjustments. Some also have SEND or an education, health and care (EHC) plan. These duties operate alongside, rather than instead of, our arrangements under this policy.

1. Legal framework and related policies

This policy has regard to section 100 of the Children and Families Act 2014; the Equality Act 2010; the Education Act 1996 (including section 19); relevant health and safety and medicines law; and the SEND framework.

Relevant DfE guidance includes Supporting pupils at school with medical conditions (2015, current as at October 2026), Allergy safety in schools (2026), Arranging education for children who cannot attend school because of health needs (2023), First aid in schools, early years and further education, and statutory SEND guidance.

Read alongside the school's separate published Allergy Safety Policy, SEND and Inclusion Policy, First Aid Policy, Safeguarding and Child Protection Policy, Attendance Policy, Educational Visits procedures, Supporting Children with Health Needs / alternative provision arrangements, Complaints Policy, and relevant LDST procedures.

2. Roles and responsibilities

LDST has the statutory duty to ensure suitable arrangements are in place. The Local Governing Body oversees implementation within delegated responsibilities and seeks assurance that the policy works effectively, is accessible to staff and families, and is reviewed regularly.

The headteacher is accountable for day-to-day implementation and for ensuring that the SENDCo/Inclusion Lead arranges plans, staff briefings, medication records, training and regular checks. Sufficient competent cover must be available, including for emergencies, trips and wraparound provision.

Teachers and other staff must understand the needs of pupils they work with, know how to summon help, act promptly in emergencies and follow relevant individual healthcare plans (IHPs). Staff may be asked to provide medical support but cannot be required to administer medicines; appropriately trained and willing staff must be identified and contingency arrangements made.

Parents/carers should notify school promptly of conditions and changes, provide medication and current clinical information where needed, maintain emergency contacts and contribute to IHPs. The school must not place responsibility for arranging school-day medical care solely on parents.

Children are invited, according to age and understanding, to explain what helps them, report symptoms and help shape plans. They are never expected to manage a condition beyond their demonstrated capability.

School nurses, specialist teams and other healthcare professionals should advise on individual needs, clinical procedures and staff competency as appropriate. The school will liaise with the local authority, NHS Cheshire and Merseyside Integrated Care Board and commissioned services when necessary.

3. Admissions and transition

No child will be refused admission or prevented from taking up a place simply because arrangements for a medical condition have not yet been made. Early planning will be undertaken with families, previous settings and relevant healthcare professionals. Any exceptional short-term safety issue will be assessed individually and lawfully, with urgent action to put support in place.

For September entrants, transition planning should start before admission; for mid-year admissions or new conditions, interim safe arrangements should begin without delay, with a fuller plan normally prepared within two weeks where practicable. School will not wait for a formal diagnosis where support is clearly needed.

4. Notification and assessment of need

Families may inform the class teacher or school office, who will notify the designated coordinator promptly. Staff noticing a possible medical need will escalate it in the same way. The coordinator will seek the child's and family's views, available clinical advice and information about daily routines, emergency risks and education impacts.

The headteacher will decide, in consultation with relevant parties, whether an IHP is needed; decisions will be individual, evidence-informed and recorded. A plan may be required for conditions which fluctuate, carry emergency risk or need complex or regular support. An IHP is not required automatically for every minor or short-term condition.

5. Individual healthcare plans (IHPs)

An IHP will be developed collaboratively by the school, parents/carers, child where appropriate and relevant healthcare professionals. It will be accessible to staff who need it, while respecting the child's confidentiality and data protection rights.

- Condition, symptoms, triggers, early warning signs and emergency signs; the child's views and how they communicate distress.
- Medication and treatments: dose, route, timing, storage, side effects, monitoring, consent and action if missed or refused.
- Agreed adjustments in lessons, attendance, PE, food/drink, toileting, rest, pastoral support, examinations where relevant, trips and residentials.
- Named staff and deputies, required training and competency sign-off, information sharing, access to medication/equipment and emergency contacts.

• Specific emergency response, when to call 999, how to use prescribed rescue medication, and who accompanies the child if transferred to hospital.

• Review date, trigger for early revision and links to any EHC plan, specialist emergency care plan or separate allergy plan.

IHPs will be reviewed at least annually and promptly after changes in treatment, an incident or near miss, or significant changes in needs. Staff will be briefed on updates before they are expected to implement them.

6. Staff training, competence and cover

All staff receive induction and appropriate awareness of this policy, emergency escalation, access to plans and relevant allergy arrangements. Staff performing clinical procedures or administering specialist medication must have condition-specific training and, where appropriate, competency confirmed by an appropriate healthcare professional. First-aid training alone is not sufficient for specialist procedures.

A current training register will record names, procedures, training dates, expiry/review dates and assessors. The coordinator checks cover for absences, lunch, break, clubs, Rise and Shine Club, supply staff and off-site activities. Parents can provide essential practical knowledge but will not act as sole trainers for clinical procedures.

7. Medicines: consent, administration and storage

Medicines will be given at school when failing to do so would adversely affect a pupil's health or attendance. Prescribed medication should normally be administered in line with the prescriber's instructions and written parent/carer agreement; medicines must be in date, labelled and supplied in original packaging with instructions, except insulin pens/pumps and other clinically appropriate devices.

A medicine administration form will record the medicine, dose, route, frequency, any relevant time constraints and parental consent. Staff will check the correct pupil, medicine, dose, time and route, and record immediately what was administered, when and by whom, including a declined, missed or incorrect dose and subsequent action. Parents will be told about significant concerns or errors promptly.

Non-prescription medicines, including paracetamol, must follow the Trust/school medicines procedure, with prior written parental consent, suitable age/dose checks, confirmation of any earlier dose and clear records. Telephone confirmation may supplement but must not routinely replace written consent. Aspirin must not be given to pupils under 16 unless prescribed by a doctor.

Medication and devices must be stored securely but remain promptly accessible. Emergency inhalers, glucose treatments, AAIs and other rescue medicines must never be locked away in a way that delays access. Controlled drugs require secure storage and records in line with applicable requirements; a competent child may possess their own prescribed controlled drug where lawful and agreed.

Staff will not force a child to take medication. The IHP will explain refusal arrangements and when to contact parents or clinical services. Unused medicines will normally be returned to parents for safe disposal; sharps must be disposed of safely.

8. Self-management, dignity and personal care

Where assessment shows that a child can safely manage medication or equipment, independence will be encouraged and recorded in their IHP. Pupils will have immediate access to inhalers, glucose monitoring and other equipment as needed, with discreet adult supervision proportionate to age and competence.

School will respect privacy, manage intimate/personal care sensitively, enable appropriate toilet, food, water and rest breaks and avoid unnecessary restrictions on participation. Medical needs must not result in shame, punishment or loss of educational opportunity.

9. Allergies, anaphylaxis and asthma

ASJ must maintain and publish a separate Allergy Safety Policy under the DfE's 2026 statutory guidance. This medical conditions policy should be read alongside it. The separate policy will cover identification of allergens and risks, whole-staff allergy training, suitable IHPs, communication with catering and wraparound staff, emergency responses, near misses and at least annual review.

Children at risk of anaphylaxis must have an individual emergency plan and accessible prescribed adrenaline auto-injectors (AAIs). Staff must know where devices are, how to respond immediately to suspected anaphylaxis, and to call 999. The school will confirm arrangements for any permitted spare emergency AAIs, checks of expiry dates and safe access on trips in its Allergy Safety Policy.

Children with asthma must be able to access their prescribed reliever inhaler promptly and be supported in using it. The school will document inhaler arrangements, emergency action and any legally permitted spare emergency inhaler arrangements.

10. Records, confidentiality and learning from incidents

School will maintain accurate records of parental consent, medicines received, stock/expiry checks, administration, training, IHP reviews, incidents and near misses. Medical information will be shared only with those who need it to keep the child safe and support learning; confidential information will be stored in accordance with data protection and Trust retention arrangements.

The headteacher/coordinator will review significant incidents and near misses promptly, involve the family and relevant professionals, consider safeguarding and reporting duties, amend risk assessments and share learning with appropriate staff. Serious incidents will be escalated under Trust procedures.

11. Emergency procedures, first aid and AED

Where an emergency is suspected, staff will provide the immediate response specified in the child's IHP or applicable emergency guidance, summon first aid assistance, call 999 when indicated and notify parents as soon as reasonably practicable. Staff must not delay emergency treatment while seeking parental permission.

A staff member will remain with a pupil awaiting an ambulance and, where practicable, accompany them until a parent/carer takes over. Information about treatment provided and medicines administered will be given to emergency responders.

The school has an automated external defibrillator (AED), in the main entrance. Staff will know the location and emergency response arrangements; AED voice instructions should be followed, alongside cardiopulmonary resuscitation and emergency-service directions.

12. Attendance, education during illness and reintegration

Pupils will be supported to attend school and receive reasonable adjustments, including phased returns and flexible arrangements where clinically appropriate. Children will not routinely be sent home or placed on reduced timetables because of medical needs without individual assessment and proper safeguards.

Where it becomes clear a child is likely to miss 15 school days or more, consecutively or cumulatively, because of health needs and cannot receive suitable education in school, ASJ will engage Sefton Council promptly about its section 19 education duties. The school will not wait until the fifteenth day before seeking advice or support.

The class teacher, SENDCo and relevant professionals will coordinate appropriate learning, contact with peers and a planned reintegration, considering wellbeing and curriculum gaps. Any education arranged by the local authority should be coordinated with the home school.

13. Educational visits, PE, clubs and wraparound care

Participation is the default. Staff will plan reasonable adjustments and proportionate risk assessments for curriculum activities, sports, swimming, the ASJ Journey off-site visits, residentials and Rise and Shine Club. Plans include medication availability, trained adult cover, emergency communication, transport, food/allergen issues and overnight requirements where relevant.

Families and healthcare professionals will be consulted when needed. Exclusion from an activity must not be based on generalised assumptions about a condition and should occur only where there is strong individual evidence that safe participation cannot reasonably be achieved.

14. Supply teachers and other adults

Supply teachers, visiting staff, volunteers and club leaders will receive the minimum necessary information on pupil medical needs, emergency plans, medicine access and whom to contact. Relevant staff will be confident in how support operates before taking responsibility for children.

15. Complaints and escalation

Concerns should be raised promptly with the class teacher or headteacher so that urgent safety matters can be addressed immediately. Unresolved concerns may be pursued through the school/LDST Complaints Procedure. Parents may also seek independent advice about disability discrimination and other relevant legal routes.

16. Home-to-school transport

The local authority is responsible for assessing eligibility for statutory home-to-school travel assistance. ASJ will work with families and the local authority to share necessary information and coordinate transport-related medical plans, with appropriate confidentiality safeguards.

17. Monitoring, review and publication

The headteacher will review implementation, including IHP, medicine checks, staff competence and incidents. The policy will be reviewed at least annually, or sooner following revised guidance or a material change in school provision. It will be made available to staff and parents on the school website once approved.

Official guidance consulted

DfE – Supporting pupils at school with medical conditions: https://www.gov.uk/government/publications/supporting-pupils-at-school-with-medical-conditions--3

DfE – Allergy safety in schools (July 2026): https://www.gov.uk/government/publications/allergy-safety-in-schools

DfE – Education for children with health needs who cannot attend school: https://www.gov.uk/government/publications/education-for-children-with-health-needs-who-cannot-attend-school

DfE – Supporting pupils with medical conditions consultation outcome (July 2026): https://www.gov.uk/government/consultations/proposal-on-support-for-pupils-with-medical-conditions-at-school