MEDICAL WEFARE OF STUDENTS POLICY

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1. Summary

1.1 The welfare of students is paramount for all CECG schools. A student's parents/carers are best placed to support their health and wellbeing but schools must have appropriate procedures and qualified staff to care for students' medical welfare during school hours. This policy outlines obligations and procedures to support students who have ongoing healthcare needs, and those who have shorter-term medical issues such as injury or illness.

1.2 This policy applies to all Catholic Education, Archdiocese of Canberra and Goulburn (CECG) workers and students in CECG schools.

1.3 Children and workers in CECG Early Learning Centres and school-aged care are covered by the ELC and SAC First Aid, Incident, Injury, Trauma and Serious Illness Policy.

2. Medical Welfare of Students Policy

2.1 A student's parents/carers are best placed to support their health and wellbeing but schools must have appropriate procedures and qualified staff to care for students' medical welfare during school hours.

2.2 Parents/carers are responsible for informing schools of any medical issues, and ensuring students do not attend school if their health requires it. CECG policy is that students who are injured or unwell should be cared for at home by a parent or carer. If a student is unwell or injured at school, the school will contact parents/carers to request they pick up the student, unless the school considers the student can be provided adequate care at school.

2.3 Schools must keep up to date and medically endorsed individual response plans for any children or young people with diabetes, anaphylaxis, epilepsy, and asthma. Schools should also keep medically endorsed individual response plans for any students with ongoing healthcare conditions that require intervention or could lead to medical emergencies. CECG recommends the Individual Response Plan template or condition-specific response plans (linked in the CECG template).

2.4 Schools must develop procedures for responding to injuries or illnesses that require First Aid or other medical treatment. See Appendix 1 for elements that local first aid procedures should include. The school's first aid procedures must be prominently displayed for all staff.

2.5 If a student is unwell or injured at school, workers with relevant first aid training must provide reasonable first aid and determine whether further medical attention is required.

3. First Aid

CECG school workers must telephone emergency services on 000 if a student requires emergency medical attention.

3.1 Every school must have a designated First Aid officer.

3.2 All school employees who work with students must complete CPR, anaphylaxis, epilepsy, diabetes, and asthma training annually.

3.3 Every school must have a minimum of 2 staff members or ten percent of employees who work with children (whichever is larger) with current first aid training. First Aid training must be updated at least every three years. This is a minimum requirement, and schools may provide

training to a larger proportion of employees who work with children depending on their needs and risks.

3.4 When considering the appropriate number of staff, schools should consider whether their student population has higher risks that require more qualified first aid staff. Schools should also consider the mandatory first aid requirements for excursions, set out in the CECG Event and Activity Policy, which include one or more first-aid qualified staff for every excursion and event.

3.5 Employees with relevant first aid-training must assist students who have health support needs by:

- Providing reasonable first aid (including emergency care) when children or young people become unwell.
- Administering prescribed medications and health care procedures, in line with written authorisation from parents and medical practitioners.

3.6 Every school must have First Aid kits that are readily accessible, regularly maintained, and sufficient for their needs. A member of the staff must be appointed to take charge of the kit (e.g. the First Aid officer). First aid kits must be clearly identified and well maintained.

3.7 All first aid kits should include pressure immobilisation bandages (also known as compression bandages) for the treatment of snake bites, particularly in schools at higher risk of snake encounters.

3.8 Schools may obtain further guidance from Safe Work Australia's publication "First Aid in the Workplace: Code of Practice".

3.9 If a student suffers a suspected concussion, the school must apply the procedures in **Appendix 2**.

4. Students who are unwell at School

4.1 Schools will contact parents to request that they pick up students who are unwell or injured at school, unless the school considers the student can be provided adequate care at school.

4.2 CECG notes that a parent/carer may decline to pick up unwell or injured students. The school has a legal duty of care to the student, other students, and staff and all efforts should be made to convey the need to pick up an unwell or injured student. The views of the student should be taken into account, but the school is responsible for determining the best course of action.

4.3 If parents/carers are unable or unwilling to collect their child, and the student's health can be cared for with reasonable first aid, the Principal may negotiate an appropriate arrangement for temporary care of the student. The arrangement and the decision not to pick up the student should by confirmed in writing with the parent. If the school cannot reasonably care for the child, it may be appropriate to contact emergency or non-emergency medical assistance (e.g. the student's regular doctor).

5. Individual Response Plans

5.1 An Individual Response Plan must be developed for any student:

- diagnosed with severe asthma, type 1 diabetes, epilepsy or anaphylaxis
- diagnosed as being at risk of an emergency, or
- who requires ongoing administration of health care procedures.

5.2 The Individual Response Plan must:

- be approved by a qualified medical practitioner
- specify the student's specific health care needs
- describe agreed actions to meet these needs
- include emergency phone numbers for ambulance, the parent and an emergency contact
- include the phone number of the student's medical practitioner(s)
- include attachments as relevant such as:
  - an emergency care/response plan
  - a statement of the agreed responsibilities of different people involved in support
  - a schedule for the administration of prescribed medication
  - a schedule for the administration of health care procedures
  - an authorisation to contact the necessary medical personnel

5.3 Relevant CECG workers should be trained in the administration of individual medical response plans, or administration of prescribed medication and/or health care procedures, if the worker may be involved in the administration.

5.4 It is particularly important that relevant workers are informed regarding students diagnosed with a condition that might require an emergency response.

5.5 If a student requires an individual medical response plans but a current one is not in place, the school will inform parents that a plan completed and signed by a medical practitioner must be completed and returned to the school within 21 days. Up until that time, the student may continue to attend school but the parents will be responsible for providing all medical intervention whilst the child is at school (in a designated room when required). If a medical plan signed by a medical practitioner is not in place within 21 days, the student cannot attend school until one is received. The school will follow all mandatory requirements regarding recording and reporting lack of attendance and duty of care.

5.6 The school should undertake a risk assessment and ensure that they have strategies in place to deal with any issues that arise (e.g., parent not available to deliver insulin, child suffers adverse reaction etc.) while waiting for the individual medical response plans to arrive at school.

6. Administering Medications and Health Care Procedures

6.1 Parents must provide a Medication Authorisation to authorise the school to administer medication. The request should be updated at least annually, or as required (e.g. if medication changes). Requests must be accompanied by current individual medical advice or plan by the student's medical practitioner (see appendices for a template that may be provided to doctors).

6.2 Parents must supply any appropriate medical equipment.

6.3 All medication must be supplied to the school in the container in which it was supplied by the pharmacy. It must be clearly labelled with:

- the child's name
- the drug's name
- the dosage and frequency to be given, and
- the prescribing doctor's name and phone number.

6.4 Only designated workers with relevant first aid training should administer medications and first aid in schools. Alternative arrangements may involve parents/guardians if suitable staff are not available to administer the medication.

6.5 Administering medication requires a 'five rights' check. This means checking:

1. Right student – check student identity
2. Right drug – check drug label
3. Right dose – check individual plan and dosage
4. Right route – check individual plan (e.g. swallowed, applied to skin, via gastrostomy, eye drop etc)
5. Right time – check individual plan

6.6 Medication must always be checked by the person administering it. Medical care plans may indicate medication that must be checked by two people before administration (e.g. Schedule 2 medications under the Poisons Standard).

6.7 The CECG Wellbeing team should be notified of medical plans that include high-risk medication (e.g. Compass notification when uploading the individual plan, or email for schools not on Compass).

6.8 All medicine stored on the school premises must be kept in a suitable locked cupboard, or locked refrigerator if refrigeration is required.

6.9 Where practical, staff may work in teams so that drugs are administered in the presence of another adult.

6.10 Schools must record all medication dispensed in the Compass First Aid Module or Medication Administration Record and retain the records in line with the Record Keeping Policy. The record should include:

- the student's name
- the date and time medicine was administered,
- the substance administered and dosage amount, and
- the name of person administering the medication and the person checking.

6.11 In primary schools, it is the responsibility of staff with relevant training and the class teacher to ensure that all students attend at the appropriate time and place for their medication. In secondary schools it is reasonable to expect most students to present themselves at the appropriate time and place for their medication but this must be monitored. Supervision may be arranged where a student self-administers prescribed medication.

7. Dispensing Analgesic Substances

7.1 Schools do not dispense analgesic substances for pain relief without prior approval from the parent or guardian.

7.2 Parents should complete a Request to Dispense Medicine form if the school is asked to administer analgesics to a student. Where it would be unreasonable to obtain written permission, oral permission may be obtained over the phone from a parent or guardian to administer paracetamol. A record must be kept of any medication dispensed at school.

7.3 Aspirin or a medication containing aspirin may be harmful to the recipient and must only be administered in cases when written authorisation by the student's doctor states that aspirin has been prescribed for a specific condition.

8. Dispensing Asthma Medication

8.1 All staff must be aware of the information available from the Asthma Foundation on the management of asthma in schools. (http://www.asthmafoundation.org.au/)

8.2 Staff allow students with asthma to carry and self-administer inhaler medication, and can provide supervision. Supervision can be arranged or mandated in the individual medical response plan.

8.3 A bronchodilator puffer is carried in the school's first aid kit(s).

8.4 Schools must maintain a register of students with asthma.

9. Definitions

9.1 **First Aid**: The initial administration of treatment in the case of illness or accidents that may need to be actioned prior to the involvement of a doctor or full medical care being obtained.

9.2 **Anaphylaxis**: An acute multi-system severe type I hypersensitivity allergic reaction and is a severe, whole-body allergic reaction. The most severe form of allergic reaction.

9.3 **Cardiopulmonary Resuscitation (CPR)**: The technique which combines expired air resuscitation and external chest compressions for a victim whose breathing and heart have stopped or are severely impeded.

9.4 **First Aid Qualifications**: Qualifications gained as part of a certified course in First Aid run by a recognised provider such as Red Cross or St John's Ambulance.

9.5 **Asthma**: Asthma is a chronic inflammatory lung disease that inflames and narrows the person's airways making it hard for them to breathe. This can be triggered by exposure to such substances as dust, pollens, animals, tobacco smoke and exercise.

9.6 **Diabetes**: Diabetes (mellitus) is a condition in which there is too much glucose in the blood caused by the body not being able to make enough insulin to counteract it, or the insulin the body makes does not work properly in controlling the glucose level in the blood.

9.7 **Epilepsy**: Epilepsy is a disruption in brain function that results in recurrent seizures or fits. This does not affect the person's ability and intelligence to take part in normal activities.

10. Related Documents and Legislation

10.1 Related CECG Documents:

- Individual Response Plan
- Medication Authorisation
  Medication Administration Record
- Management of Infectious Diseases in Schools Policy
- School Events and Activities Policy
- School Sports Policy

11. Contact

11.1 For support or further questions relating to this policy, contact the School and Family Services team.

12. Appendix 1 – Local First Aid Procedures

Local First Aid Procedures should cover at least the following elements. This example is intended as a useful model and can be completed and printed to support local school first aid response by staff with first-aid training. Any changes should not impose lesser standards – e.g. downgrade examples of major injury/illness to moderate. Italics indicate particular areas for schools to consider and keep/update/delete as required.

Roles and Responsibilities

Staff members responsible for sick/injured students (either specific positions and/or a class of staff such as 'all staff with anaphylaxis training' or 'all staff with current first aid training'). For example:

- First Aid Officer: *Position or name, and responsibilities.*
- *Any other staff in charge of medical welfare decisions, such as contacting parents*, or *specific medical welfare issues such as concussion coordinator (see Appendix 2), any person in charge of managing health care plans.*

General Assessment and Response

General steps for assessing injury or illness and whether parents must be informed and/or pickup should be requested. For example:

- Provide immediate first aid, if required.
- Assess if the injury/illness is minor, moderate, or major and apply necessary response, in addition to student health care plan (if any):

Minor	**Moderate**	**Major**
Rest as required. Parent notification optional. Student may return to class/play ground when ready.	Provide first aid. Notify parents as soon as practical. Request pickup unless student can be adequately cared for at school. Monitor comfort and condition until pickup, or staff determine student is ready to return to class/playground.	Provide first aid. Contact emergency services if required. Inform parents immediately and require pickup. Provide constant supervision.

- Record injuries/illnesses either in COMPASS module or elsewhere for schools not on Compass, and notify appropriate parties (e.g. Principal; Assistant Principal; CECG WHS team for all WHS incidents). *School to confirm any notification rules it requires e.g. The Principal/Assistant Principal should always be notified if parents are contacted.*
- Assess whether the incident requires additional action under relevant CECG policies, such as WHS Incident Management and Reporting Guide; Management of Infectious Diseases in Schools Policy, Reportable Conduct Policies (ACT or NSW), or critical incident policies, and complete as required.
- Follow-up process by *school to determine – e.g. first aid officer/class teacher*:

Minor	**Moderate**	**Serious**
Check how the student is feeling at their next attendance.	Check how the student is feeling at their next attendance. Follow-up with parents optional.	Follow-up with parents within 24-48 hours to enquire about student condition and any support that may be required.

Specific Assessment and Response issues:

Steps or considerations for any specific types of injury or illness (if any). For example:

- The school considers any head injury to be at least 'moderate', even if there is no identified concussion and appears to be no first aid required.
- *Other as required/useful for the school, and any specific student needs or risks.*

Definitions:

- **Minor injury/illness**: No or only minor first aid (e.g. band-aid) seems to be required and the student does not present significant discomfort or pain. Examples might include minor falls or collisions or minor nausea.
- **Moderate injury/illness**: First aid is required within the school's capacity to provide and the student presents moderate discomfort or pain manageable by short rest, analgesic (if approved by parent/carer), or medication plan. Examples might include falls or collisions with small scrapes or bruises but no identified risk of fracture, any collision to the head, nausea or headache, or a significant but manageable asthma attack.
- **Serious injury/illness:** First aid is required and the event involves significant risk of harm to the student or other students, or significant discomfort to the unwell student. Examples might include identified risk of fractures or broken bones, vomiting, suspected concussion, injuries involving bleeding, anaphylaxis response or life-threatening asthma attack.

13. Appendix 2 - Concussion Procedures

Principals must ensure that students who have suffered concussion injuries are cleared by a medical practitioner prior to participating in sport and physical activity.
Principals must ensure that students who have suffered a suspected concussion injury on the day of participation do not participate in the sport or physical activity.

Concussion – When in Doubt - Sit Out

Concussion is an injury to the brain caused by sudden strong movement of the brain against the skull. Concussion may occur in almost every sport and/or physical activity. This may be caused by collision with another person or object that involves a direct or indirect force to the head, face, neck or elsewhere with a force transmitted to the head. A student does not have to be knocked unconscious to have a concussion.
Recognising a suspected concussion at the time of injury is extremely important to ensure correct management and to prevent further injury. Parents and players should be encouraged to report any history of previous concussions to coaches, officials, teachers, trainers and administrators

Concussion Management – The 5R's

Recognise - Know the signs/symptoms of a concussion.
Remove - Immediately remove the student from the activity if suspected of having a concussion.
Report - Communication between everyone is essential. School to parents, parents to school and parents to community coaches.
Referral - Students suspected of having a concussion must be referred to a medical practitioner. **Rest** Students with a concussion need rest from physical and mental activities.
Return – Prior to returning to activity a written clearance must be provided by a health care professional. A gradual return to activity (learn and or plan) is encouraged.

Recognising Concussion

Everyone including students/players parents, teachers /coaches, officials and trainers are responsible for recognising and reporting students/players with visual signs of a head injury or who report/exhibit concussion symptoms.
Watch for when a player collides with:

- another player
- a piece of equipment
- the ground

Visual Signs

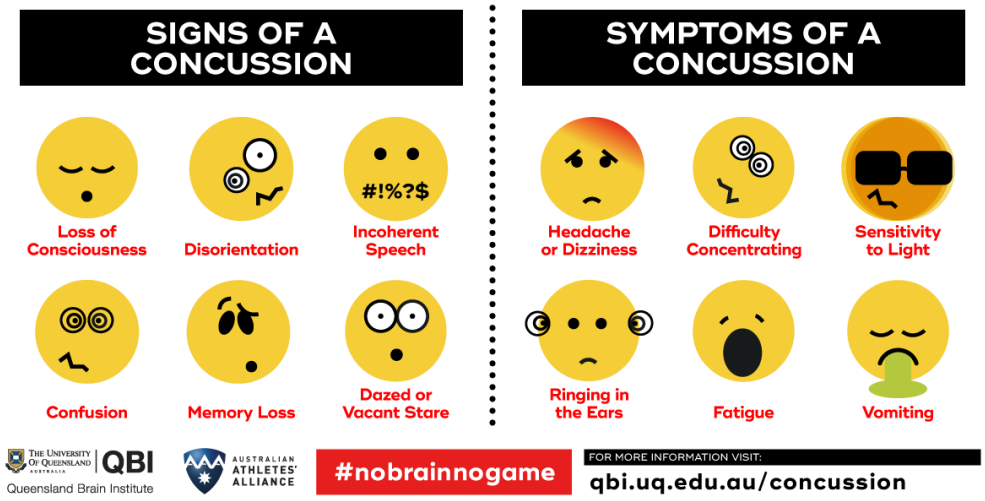
Participants who suffer an impact to the head, face, neck or body may demonstrate visual signs of a concussion. These could be:

- Lying motionless on the playing surface
- Getting up slowly after impact
- Confusion, unable to respond appropriately to questions
- Having a blank or vacant stare
- Having balance or coordination problems
- Memory impairment

Symptoms

Symptoms that suggest a concussion include:

- Headache or "feeling pressure in the head"
- Seizures or convulsion
- Losing consciousness
- Slurred speech
- Ongoing vomiting
- Blurry or double vision
- Sensitivity to light and/or noise
- Excessive drowsiness, fatigue or low energy
- Worsening headache
- Neck pain
- Difficulty concentrating and /or remembering
- Trouble walking
- Confusion – "feeling like being in a fog"
- Weakness or numbness



A student who displays or exhibits any of the above symptoms should stop participating immediately and be removed from the activity.

Memory Assessment

For students more than 12 years old, the questions listed on the Concussion Recognition Tool 5(CRT5) can be used to recognise a suspected concussion.

An incorrect response to any of the questions indicates the player may have sustained a concussion and therefore should be removed from the activity immediately. The questions may include:

- What venue are we at today?
  - Which half is it now?
  - Who scored last in the game?

- Who did you play last week?

Depending on the situation it may be appropriate to modify the questions such as:

- What month is it?
- What is the date today?
- What is the day of the week?
- What year is it?

Red Flags

In some instances a student may exhibit signs or symptoms of a severe head or spinal injury. These should be considered "Red Flags". They would include:

- Neck Pain or tenderness
- Double Vision
- Weakness or tingling/burning in arms or legs
- Severe increasing headaches
- Seizure or convulsion
- Loss of consciousness
- Deteriorating consciousness
- Vomiting
- Increasing restless, agitation or aggression

If a student is suspected of sustaining a severe head or spinal injury **an ambulance should be called immediately**.

Removal

Any student with a suspected concussion must be removed from the activity. This will enable the student to be properly assessed. Any such student must not be allowed to resume participation on the same day unless cleared by a medical practitioner.

Students with a suspected concussion should:

- Be removed from participation immediately
- Be monitored and not left alone for at least 1 – 2 hours
- Not take prescription medications, including aspirin, anti-inflammatory medications, sedative medications or pain relieving medications
- Not be sent home by themselves
- Not drive a motor vehicle
- Be referred for appropriate medical assessment

Report

Report suspected concussion that the school informs the parents/caregivers of the requirements relating to concussion. Parents/caregivers should also inform the school if their child has suffered a concussion or a suspected concussion.

Referral

Any student with concussion or suspected concussion will require a medical assessment by a medical practitioner. Parents/caregivers must be informed of the concussion/suspected concussion the required rest and supervision strategies and the need to seek medical assessment/advice.

Any student that is removed from an activity due a suspected concussion must not resume the activity for at least 48 hours.

Rest

Rest is the most important strategy in recovering from concussion. It is recommended that the rest period should be for 24 – 48 hours. Rest means that the student should not undertake any activity that provokes symptoms. The rest period should continue until all symptoms and signs of concussion have disappeared.

Return

The priority when managing concussion in children should be returning to school and learning ahead of return to play.

A student who has suffered a concussion should follow a graduated return to play protocol. They should increase their exercise progressively, as long as they remain symptom-free, following the stages outlined below

As with the return to learn strategies the management of concussion and return to play is a shared responsibility between the student, parents/caregivers, school and medical practitioner. Communication is essential and all information should be shared.

Sports Medicine Australia Suggested Schedule – Return to Activity following 24-48 hours of rest

Stage	Activity	Goal of each stage
1. Daily activities while remaining symptom free	Daily activities that do not provoke symptoms	Gradually reintroduce work or school activities
2. Light aerobic exercise	Walking, swimming or stationary cycling at a slow to medium pace. No strength or weight training	Increase heart rate
3. Sport specific exercise	Running drills in football or skating drills in ice hockey. No activities with head impact	Add movement
4. Non-contact training drills	Hader training drills, eg passing etc. Start progressive strength or weight training after receiving medical clearance	Exercise, coordination and mental load
5. Full contact training	Normal training activities	Restore confidence & assess skills by teacher/coach
6. **Return to play**	Normal game plan	