3 Health policy

Alongside associated procedures this policy was adopted by St George's Childcare

Signed

Name ADRIAN CROUCH

Position CHAIR

Date. 21 FEBRUARY 2022

Aim

Our provision is a suitable, clean, and safe place for children to be cared for, where they can grow and learn. They meet all statutory requirements for promoting health and hygiene and fulfil the criteria for meeting the relevant Early Years Foundation Stage Safeguarding and Welfare requirements.

Objectives

We promote health through:

- ensuring emergency and first aid treatment is given where necessary
- ensuring that medicine necessary to maintain health is given correctly and in accordance with legal requirements
- identifying allergies and preventing contact with the allergenic substance
- identifying food ingredients that contain recognised allergens
- promoting health through taking necessary steps to prevent the spread of infection and taking appropriate action when children are ill
- promoting healthy lifestyle choices through diet and exercise
- supporting parents right to choose complementary therapies
- pandemic flu planning or illness outbreak management as per DfE and World Health Organisation (WHO) guidance

Legal references

Medicines Act (1968)

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

Control of Substances Hazardous to Health (COSHH) Regulations (2002)

Health and Safety (First Aid) Regulations 1981

Food Information Regulations 2014

Policies & Procedures for the EYFS 2021 (Early Years Alliance 2021)

3.5 (a) Managing a suspected case of Coronavirus

The main symptoms of coronavirus are:

- a high temperature
- a new continuous cough – this means coughing a lot, for more than an hour, or three or more coughing episodes in 24 hours
- a loss of change to smell or taste – this means they cannot smell or taste anything, or things smell or taste different to normal

Please refer to the latest government guidance on next-steps-for-living-with-COVID. If it is suspected that a child has COVID, staff do not attempt to diagnose or make assumptions about symptoms presented. They should immediately respond and take action as detailed in this procedure. This includes asking parents/carers to seek further advice from a medical practitioner who may/or may not advise that the symptoms meet the criteria for testing. In which case if the child appears well and displays no further suspect symptoms, they can return to the setting within the timescale advised by the medical practitioner.

The focus on coronavirus must not detract from staff being alert to the signs and symptoms linked to other serious illness as detailed below:

What to do if a child seems very unwell

Children and babies will still get illnesses that can make them very unwell quickly. It is important to get seek medical help and to contact the child's parents immediately.

Call 999 if a child:

- has a stiff neck
- has a rash that does not fade when you press a glass against it
- is bothered by light
- has a seizure or fit for the first time
- has unusually cold hands
- has pale, blotchy, blue or grey skin
- has a weak, high-pitched cry that is not like their usual cry
- is extremely agitated (does not stop crying) or is confused
- finds it hard to breathe
- has a soft spot on their head that curves outwards
- is not responding like they normally do

Being prepared

- All staff are aware of this procedure and their responsibility if a child becomes unwell with coronavirus symptoms at the setting.
- Staff are instructed in how to remove and dispose of PPE equipment safely – this includes aprons and gloves worn during routine care procedures. We display the NHS guide to putting on and removing PPE.

If a child becomes unwell

- If a child is displaying any of the symptoms of coronavirus. The manager/deputy calls their parents to collect them immediately. Current guidance states that: '*If a child or young person has a positive COVID-19 test result they should stay at home and where possible avoid contact with other people for 3 days after the day they took the test. The risk of passing the infection on to others is much lower after 3 days, if they feel well and do not have a high temperature. Children and young people who usually attend an education or childcare setting and who live with someone who has a positive COVID-19 test result should continue to attend as normal'.*
- We will maintain contact with the parent(s) of the child who was sent home, and ensure they know that their child is entitled to a test and encourage them to get their child tested. To access testing parents should use the 111 online coronavirus service.
- We will ask the parent(s) to let us know the outcome as soon as possible.
- If the test result is positive we will inform all other parents that a child has tested positive and remind them to be aware of the symptoms to look out for.
- We will inform our local authority if a child, or staff member in the setting tests positive for coronavirus.
- We will also inform Ofsted as coronavirus is now classified as a Notifiable Disease.

3.05b Infection control

Good practice infection control is paramount in early years settings. Young children's immune systems are still developing, and they are therefore more susceptible to illness.

Prevention

- Minimise contact with individuals who are unwell by ensuring that those who have symptoms of an infectious illness do not attend settings and stay at home for the recommended exclusion time (see below UKHSA link).
- Always clean hands thoroughly, and more often than usual where there is an infection outbreak.
- Ensure good respiratory hygiene amongst children and staff by promoting 'catch it, bin it, kill it' approach.
- Where necessary, for instance, where there is an infection outbreak, wear appropriate PPE.

Response to an infection outbreak

- Manage confirmed cases of a contagious illness by following the guidance from the UK Health Security Agency (UKHSA)

Informing others

Early years providers have a duty to inform Ofsted of any serious accidents, illnesses or injuries as follows:

- anything that requires resuscitation
- admittance to hospital for more than 24 hours
- a broken bone or fracture
- dislocation of any major joint, such as the shoulder, knee, hip or elbow
- any loss of consciousness
- severe breathing difficulties, including asphyxia
- anything leading to hypothermia or heat-induced illness

In some circumstances this may include a confirmed case of a Notifiable Disease in their setting, if it meets the criteria defined by Ofsted above. Please note that it is not the responsibility of the setting to diagnose a notifiable disease. This can only be done by a clinician (GP or Doctor). If a child is displaying symptoms that indicate they may be suffering from a notifiable disease, parents must be advised to seek a medical diagnosis, which will then be 'notified' to the relevant body. Once a diagnosis is confirmed, the setting may be contacted by the UKHSA, or may wish to contact them for further advice.

Health procedures

3.1 Accidents and emergency treatment

Person responsible for checking and stocking first aid box: *Kate Foulkes*

The setting provides care for children and promotes health by ensuring emergency and first aid treatment is given as required. There are also procedures for managing food allergies in Food safety and nutrition.

- Parents consent to emergency medical treatment consent on registration.
- At least one person who has a current paediatric first aid (PFS) certificate is always on the premises and available when children are present who regularly update their training; First Aid certificates are renewed at least every three years.
- All members of staff know the location of First Aid boxes, the contents of which are in line with St John's Ambulance recommendations as follows:
  - 20 individually wrapped sterile plasters (assorted sizes)
  - 2 sterile eye pads
  - 4 individually wrapped triangular bandages (preferably sterile)
  - 6 safety pins
  - 2 large, individually wrapped, sterile, un-medicated wound dressings
  - 6 medium, individually wrapped, sterile, un-medicated wound dressings
  - a pair of disposable gloves
  - adhesive tape
  - a plastic face shield (optional)
- No other item is stored in a First Aid box.
- Single use gloves are also kept near to (not in) the box, as well as a thermometer.
- There is a named person in the setting who is responsible for checking and replenishing the First Aid Box contents.
- For minor injuries and accidents, First Aid treatment is given by a qualified first aider; the event is recorded on a child's accident form. Parents may have a photo-copy of the accident form on request.
- In the event of minor injuries or accidents, parents are informed when they collect their child, unless the child is unduly upset or members of staff have any concerns about the injury. In which case they will contact the parent for clarification of what they would like to do, i.e. collect the child or take them home and seek further advice from NHS 111.

- In the event of a head injury parents are informed immediately and a head injury information sheet is supplied

Serious accidents or injuries

- An ambulance is called for children requiring emergency treatment.
- First aid is given until the ambulance arrives on scene. If at any point it is suspected that the child has died, Death of a child on site procedure is implemented and the police are called immediately.
- Parents or carers are contacted and informed of what has happened and where their child is being taken to.

Recording and reporting

- In the event of a serious accident, injury, or serious illness, the designated person notifies the designated officer using Confidential safeguarding incident report form as soon as possible.
- The manager is consulted before a RIDDOR report is filed.
- If required, a RIDDOR form is completed; one copy is sent to the parent, one for the child's file and one for the local authority Health and Safety Officer.
- The directors are notified by the setting manager of any serious accident or injury to, or serious illness of, or the death of, any child whilst in their care in order to be able to notify Ofsted and any advice given will be acted upon. Notification to Ofsted is made as soon as is reasonably practicable and always within 14 days of the incident occurring. The designated person will, after consultation with the directors, inform local child protection agencies of these events

3.2 Administration of medicine

Key persons are responsible for administering medication to their key children; ensuring consent forms are completed, medicines stored correctly, and records kept.

Administering medicines during the child's session will only be done if necessary.

When a child is prescribed a new medicine we ask that parents keep them at home for 48 hours to ensure no adverse effect, and to give it time to take effect. The manager must check the insurance policy document to be clear about what conditions must be reported to the insurance provider.

Consent for administering medicine

- Only a person with parental responsibility (PR), or a foster carer may give consent. A childminder, grandparent, parent's partner who does not have PR, cannot give consent.
- When bringing in medicine, the parent informs their key person/back up key person, or senior childcare leader if the key person is not available.
- Staff who receive the medication, check it is in date and prescribed specifically for the current condition. It must be in the original container (not decanted into a separate bottle). It must be labelled with the child's name and original pharmacist's label.
- Medication dispensed by a hospital pharmacy will not have the child's details on the label but should have a dispensing label. Staff must check with parents and record the circumstance of the events and hospital instructions as relayed to them by the parents.
- Members of staff who receive the medication ask the parent to sign a consent form stating the following information. No medication is given without these details:
  - full name of child and date of birth
  - name of medication and strength
  - who prescribed it
  - dosage to be given
  - how the medication should be stored and expiry date
  - a note of any possible side effects that may be expected
  - signature and printed name of parent and date

Storage of medicines

All medicines are stored safely.

- The key person is responsible for ensuring medicine is handed back at the end of the day to the parent.
- For some conditions, medication for an individual child may be kept at the setting. A healthcare plan form must be completed. Key persons check that it is in date and return any out-of-date medication to the parent.
- Parents do not access where medication is stored, to reduce the possibility of a mix-up with medication for another child, or staff not knowing there has been a change.

Record of administering medicines

A record of medicines administered is kept in a file in the child's room.

The medicine record:

- name of child
- name and strength of medication
- the date and time of dose
- dose given and method
- signed by key person and witness
- verified by parent signature at the end of the day

A witness signs the medicine record to verify that they have witnessed medication being given correctly according to the procedures here.

- No child may self-administer. If children are capable of understanding when they need medication, e.g., for asthma, they are encouraged to tell their key person what they need. This does not replace staff vigilance in knowing and responding.
- The medication records are monitored to look at the frequency of medication being given. For example, a high incidence of antibiotics being prescribed for a number of children at similar times may indicate a need for better infection control.

Children with long term medical conditions requiring ongoing medication

- A care plan is carried out for children that require ongoing medication. This is the responsibility of the setting manager and key person. Other medical or social care personnel may be involved in the risk assessment.
- Parents contribute to care plan. They are shown around the setting, understand routines and activities and discuss any risk factor for their child.

- For some medical conditions, key staff will require basic training to understand it and know how medication is administered.
- The care plan includes any activity that may give cause for concern regarding an individual child's health needs.
- The care plan form is completed fully with the parent; outlining the key person's role and what information is shared with other staff who care for the child.

Managing medicines on trips and outings

- Children are accompanied by their key person, or other staff member who is fully informed about their needs and medication.
- Medication is taken in a plastic box labelled with the child's name, name of medication, and a record of administration is completed.
- If a child on medication has to be taken to hospital, the child's medication is taken clearly labelled as above.

Staff taking medication

Staff taking medication must inform their manager. The medication must be stored securely in staff lockers or a secure area away from the children. The manager must be made aware of any contra-indications for the medicine so that they can risk assess and take appropriate action as required. Staff have a care plan in place as needed.

3.2a Administration of non-prescribed medication

Non prescribed medication can include over the counter medicines and creams which can be purchased from a pharmacy, health shop and supermarkets.

Non prescribed medication must only be administered to a child with written permission for that particular medication from a parent or carer.

Members of staff who receive the medication must ask a parent to sign a consent form stating the following information:

- Full name and date of birth of child
- Name of medication and strength
- Time of last given dose
- Time next dose due

The medication must be in the original packaging with details of dose allowed and the age that the medication can be used for.

Staff can only give a child non prescribed medication that has been checked for:

- A parent signed a consent form
- The medication is in date
- The medication is sold as appropriate for the age of the child
- The dose allowed for the child's age is clearly stated

Staff will record all medication given and inform parents on the same day, completing a medicine form and administrating medication with a witness.

Staff will never give more than the suggested dose on the packaging.

3.3 Health care plan

Please note that this form must be used alongside the individual child's registration form which contains emergency parental contact and other personal details.

Name of Child	
Date of Birth	
Child's address	
Contact information for family or main carers	
1.Name	
Relationship to child	
Contact numbers	
2. Name	
Relationship to child	
Contact numbers	
Medical diagnosis, condition or allergy	
Clinic or Hospital contact	
Name	
Phone no.	
GP/Doctor	
Name	
Phone No.	

Describe medical needs and give details of symptoms
Risk assessment completed? If no, please state why? If yes please include details here Date completed:
Daily care requirements e.g. before meals/going outdoors
Describe what constitutes an emergency for the child and what actions are to be taken if this occurs
Name/s of staff responsible for an emergency situation with this child

Parent/carer and person completing this form must sign below to indicate that the information in this plan is accurate and the parent/carer agrees for any relevant procedures to be carried out

Parent's name	Signature	Date
Key person's name	Signature	Date
Setting Manager's name	Signature	Date

For children requiring lifesaving or invasive medication and/or care, for example, rectal diazepam, adrenaline injectors, Epipens, Anapens, JextPens, maintaining breathing apparatus, changing colostomy or feeding tubes, approval must be received from the child's GP/consultant, as follows:

I have read the information in this Individual Health Plan and have found it to be accurate.

Name of GP/consultant:		Date:	
Signature:			

Review completed (at least every six months)

Parent's name	Signature	Date
Key person's name	Signature	Date
Setting manager's name	Signature	Date

Copies circulated to:

Parents

Child's personal records (with registration form)

GP/Consultant – if required

3.4 Life-saving medication and invasive treatments

Life-saving medication and invasive treatments may include adrenaline injections (Epipens) for anaphylactic shock reactions (caused by allergies to nuts, eggs etc) or invasive treatment such as rectal administration of Diazepam (for epilepsy).

- The key person responsible for the intimate care of children who require life-saving medication or invasive treatment will undertake their duties in a professional manner having due regard to the procedures listed above.
- The child's welfare is paramount, and their experience of intimate and personal care should be positive. Every child is treated as an individual and care is given gently and sensitively; no child should be attended to in a way that causes distress or pain.
- The key person works in close partnership with parents/carers and other professionals to share information and provide continuity of care.
- Children with complex and/or long-term health conditions have a health care plan in place which takes into account the principles and best practice guidance given here.
- Key persons have appropriate training for administration of treatment and are aware of infection control best practice, for example, using personal protective equipment (PPE).
- Key persons speak directly to the child, explaining what they are doing as appropriate to the child's age and level of comprehension.
- Children's right to privacy and modesty is respected. Another practitioner is usually present during the process.

Record keeping

For a child who requires invasive treatment the following must be in place from the outset:

- 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 parents allowing members of staff to administer medication
- 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
- a healthcare plan

A record is made in the child's file of the intimate/invasive treatment each time it is given.

Physiotherapy

- Children who require physiotherapy whilst attending the setting should have this carried out by a trained physiotherapist.
- If it is agreed in the health care plan that the key person should undertake part of the physiotherapy regime then the required technique must be demonstrated by the physiotherapist personally; written guidance must also be given and reviewed regularly. The physiotherapist should observe the practitioner applying the technique in the first instance.

Safeguarding/child protection

- Practitioners recognise that children with SEND are particularly vulnerable to all types of abuse, therefore the safeguarding procedures are followed rigorously.
- If a practitioner has any concerns about physical changes noted during a procedure, for example unexplained marks or bruising then the concerns are discussed with the designated person for safeguarding and the relevant procedure is followed.

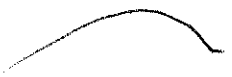
Treatments such as inhalers or Epi-pens must be immediately accessible in an emergency.

3.5 Baby and child massage

It is recognised that massage is beneficial for babies and young children, promoting relaxation of mind and body, as well as other benefits. The best people to massage babies and young children are their parents and opportunity to learn to do this should be available. While children can benefit from this in day care, concerns about children's personal safety mean that it should only be done under strict conditions.

If babies and young children are massaged in the setting the following conditions are met:

- Members of staff carrying out massage are qualified or have had some training by a qualified person and are aware of contra-indications (a medical condition that may restrict or prevent a treatment being carried out).
- Parental consent is obtained and contra-indications checked and signed by parents. Any contra-indications would mean a child is not to be massaged unless the parents gain agreement from a GP.
- Massage sessions are planned, organised and supervised so that they fit into the daily routine.
- Massage carried out by a single member of staff is never undertaken away from the group.
- Babies remain clothed in vest and nappy; young children wear vest and shorts.
- Rooms are warm and draught free; noise is at a minimum; rest period is a good time.
- Massage only takes place on hands, arms, shoulders, neck, head, feet and lower legs.
- Children's consent for massage is sought and their preferences are respected.
- Young children can be taught to massage each other's hands, feet and heads.
- Massage is empowering and educative; it should be undertaken in conjunction with educating children about body awareness, 'good and bad touches', recognition of tension; development of their own sensitivity to touch.
- Confirmation is received from the insurance provider to ensure these activities can take place.



3.6 Sickness

- If a child appears unwell during the day, or, for example has a raised temperature, sickness, diarrhoea and or pain, particularly in the head or stomach then the key person calls the parents once they have informed a manager and asks them to collect the child or send a known carer to collect on their behalf.
- If a child has a raised temperature, they are kept cool by removing top clothing, sponging their heads with cool water and kept away from draughts.
- A child's temperature is taken and checked regularly with an ear thermometer.
- If a baby's temperature does not go down, and is worryingly high, then Calpol may be given after gaining written consent on the child's permissions form and verbal consent where possible from the parent where possible. This is to reduce the risk of febrile convulsions, particularly for babies under 2 years old. Parents sign the medication record when they collect their child.**
- In an emergency an ambulance is called, and the parents are informed.
- Parents are advised to seek medical advice before returning them to the setting; the setting can refuse admittance to children who have a raised temperature, sickness and diarrhoea or a contagious infection or disease.
- Where children have been prescribed antibiotics for an infectious illness or complaint, parents are asked to keep them at home for 48 hours.
- After diarrhoea or vomiting, parents are asked to keep children home for 48 hours following the last episode.
- Diarrhoea is defined by the government health protection in childcare facilities information, as 3 or more liquid or semi-liquid stools in a 24-hour period. Our staff will use their discretion to decide if it is appropriate to send a child home earlier, for example if there is an outbreak of a sickness bug in the room.

www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities/chapter-9-managing-specific-infectious-diseases#diarrhoea-and-vomiting-gastroenteritis

- Some activities such as sand and water play, and self-serve snack will be suspended for the duration of any outbreak.
- The setting has information about excludable diseases and exclusion times.
- If there is an outbreak of an infection (affects more than 3-4 children) the manager keeps a record of the numbers and duration of each event.
- The manager has a list of notifiable diseases and contacts Public Health England (PHE) and Ofsted in the event of an outbreak.

- If staff suspect that a child who falls ill whilst in their care is suffering from a serious disease that may have been contracted abroad such as Ebola, immediate medical assessment is required. The setting manager or deputy calls NHS111 and informs parents.

HIV/AIDS 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 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 bagged for parents to collect.
- Spills of blood, urine, faeces or vomit are cleared using mild disinfectant solution and mops; cloths used are disposed of with clinical waste.
- Tables and other furniture or toys affected by blood, urine, faeces or vomit are cleaned using a disinfectant.
- Baby mouthing toys are kept clean and plastic toys cleaned in sterilising solution regularly.

Nits and head lice

- Nits and head lice are not an excludable condition; although in exceptional cases parents may be asked to keep the child away from the setting until the infestation has cleared.
- On identifying cases of head lice, all parents are informed and asked to treat their child and all the family, using current recommended treatments methods if they are found.

****Paracetamol based medicines (e.g. Calpol)**

The use of paracetamol-based medicine may not be agreed in all cases. A setting cannot take bottles of non-prescription medicine from parents to hold on a 'just in case' basis, unless there is an immediate reason for doing so. Settings do not normally keep such medicine on the premises as they are not allowed to 'prescribe'. However, given the risks to very young babies of high temperatures, insurers may allow minor infringement of the regulations as the risk of not administering may be greater. Ofsted is normally in agreement with this. In all cases, parents of children under two years must sign to say they agree to the setting administering paracetamol-based medicine in the case of high temperature on the basis that they are on their way to collect. Such medicine should never be used to reduce temperature so that a child can stay in the care of the setting for a normal day.

Whilst the brand name Calpol is referenced, there are other products which are paracetamol or Ibuprofen based pain and fever relief such as Nurofen for children over 3 months.

Guidance on infection control in schools and other childcare settings (Public Health Agency)
https://www.publichealth.hscni.net/sites/default/files/Guidance_on_infection_control_in%20schools_poster.pdf

Guidance on infection control in schools and other childcare settings

HSC Public Health Agency

March 2017

Prevent the spread of infections by ensuring: routine immunisation, high standards of personal hygiene and practice, particularly handwashing, and maintaining a clean environment. Please contact the Public Health Agency **Health Protection Duty Room (Duty Room) on 0300 555 0119** or visit www.publichealth.hscni.net or www.gov.uk/government/organisations/Public-health-england if you would like any further advice or information, including the latest guidance. Children with rashes should be considered infectious and assessed by their doctor.

Rashes and skin infections	Recommended period to be kept away from school, nursery or childminders	Comments
Athlete's foot	None	Athlete's foot is not a serious condition. Treatment is recommended
Chickenpox*	Until all vesicles have crusted over	See: Vulnerable children and female staff – pregnancy
Cold sores, (Herpes simplex)	None	Avoid kissing and contact with the sores. Cold sores are generally mild and self-limiting
German measles (rubella)*	Four days from onset of rash (as per "Green Book")	Preventable by immunisation (MMR x 2 doses). See: Female staff – pregnancy
Hand, foot and mouth	None	Contact the Duty Room if a large number of children are affected. Exclusion may be considered in some circumstances
Impetigo	Until lesions are crusted and healed, or 48 hours after commencing antibiotic treatment	Antibiotic treatment speeds healing and reduces the infectious period
Measles*	Four days from onset of rash	Preventable by vaccination (MMR x 2). See: Vulnerable children and female staff – pregnancy
Molluscum contagiosum	None	A self-limiting condition
Ringworm	Exclusion not usually required	Treatment is required
Roseola (infantum)	None	None
Scabies	Child can return after first treatment	Household and close contacts require treatment
Scarlet fever*	Child can return 24 hours after commencing appropriate antibiotic treatment	Antibiotic treatment recommended for the affected child. If more than one child has scarlet fever contact PHA Duty Room for further advice
[redacted]cheek (fifth [redacted] or parvovirus B19)	None once rash has developed	See: Vulnerable children and female staff – pregnancy
Shingles	Exclude only if rash is weeping and cannot be covered	Can cause chickenpox in those who are not immune i.e. have not had chickenpox. It is spread by very close contact and touch. If further information is required, contact the Duty Room. SEE: Vulnerable Children and Female Staff – Pregnancy
Warts and verrucae	None	Verrucae should be covered in swimming pools, gymnasiums and changing rooms

Diarrhoea and vomiting illness	Recommended period to be kept away from school, nursery or childminders	Comments
Diarrhoea and/or vomiting	48 hours from last episode of diarrhoea or vomiting	
E. coli O157 VTEC*	Should be excluded for 48 hours from the last episode of diarrhoea	Further exclusion is required for young children under five and those who have difficulty in adhering to hygiene practices
Typhoid* [and paratyphoid*] (enteric fever)	Further exclusion may be required for some children until they are no longer excreting	Children in these categories should be excluded until there is evidence of microbiological clearance. This guidance may also apply to some contacts of cases who may require microbiological clearance
Shigella* (dysentery)		Please consult the Duty Room for further advice
Cryptosporidiosis*	Exclude for 48 hours from the last episode of diarrhoea	Exclusion from swimming is advisable for two weeks after the diarrhoea has settled

Respiratory infections	Recommended period to be kept away from school, nursery or childminders	Comments
Flu (influenza)	Until recovered	See: Vulnerable children
Tuberculosis*	Always consult the Duty Room	Requires prolonged close contact for spread
Whooping cough* (pertussis)	48 hours from commencing antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment	Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks. The Duty Room will organise any contact tracing necessary

[redacted]ions	Recommended period to be kept away from school, nursery or childminders	Comments
Conjunctivitis	None	If an outbreak/cluster occurs, consult the Duty Room
Diphtheria *	Exclusion is essential. Always consult with the Duty Room	Family contacts must be excluded until cleared to return by the Duty Room. Preventable by vaccination. The Duty Room will organise any contact tracing necessary
Glandular fever	None	
Head lice	None	Treatment is recommended only in cases where live lice have been seen
Hepatitis A*	Exclude until seven days after onset of jaundice (or seven days after symptom onset if no jaundice)	The duty room will advise on any vaccination or other control measure that are needed for close contacts of a single case of hepatitis A and for suspected outbreaks.
Hepatitis B*, C, HIV/AIDS	None	Hepatitis B and C and HIV are bloodborne viruses that are not infectious through casual contact. For cleaning of body fluid spills, SEE: Good Hygiene Practice
Meningococcal meningitis*/ septicaemia*	Until recovered	Some forms of meningococcal disease are preventable by vaccination (see immunisation schedule). There is no reason to exclude siblings or other close contacts of a case. In case of an outbreak, it may be necessary to provide antibiotics with or without meningococcal vaccination to close contacts. The Duty Room will advise on any action needed.
Meningitis* due to other bacteria	Until recovered	Hib and pneumococcal meningitis are preventable by vaccination. There is no reason to exclude siblings or other close contacts of a case. The Duty Room will give advice on any action needed
Meningitis viral*	None	Milder illness. There is no reason to exclude siblings and other close contacts of a case. Contact tracing is not required
MRSA	None	Good hygiene, in particular handwashing and environmental cleaning, are important to minimise any danger of spread. If further information is required, contact the Duty Room
Mumps*	Exclude child for five days after onset of swelling	Preventable by vaccination (MMR x 2 doses)
Threadworms	None	Treatment is recommended for the child and household contacts
Tonsillitis	None	There are many causes, but most cases are due to viruses and do not need an antibiotic

* **denotes a notifiable disease.** It is a statutory requirement that doctors report a notifiable disease to the Director of Public Health via the Duty Room.

Outbreaks: if a school, nursery or childminder suspects an outbreak of infectious disease, they should inform the Duty Room.

Good hygiene practice

Handwashing is one of the most important ways of controlling the spread of infections, especially those that cause diarrhoea and vomiting, and respiratory disease. The recommended method is the use of liquid soap, warm water and paper towels. Always wash hands after using the toilet, before eating or handling food, and after handling animals. Cover all cuts and abrasions with waterproof dressings.

Coughing and sneezing easily spread infections. Children and adults should be encouraged to cover their mouth and nose with a tissue. Wash hands after using or disposing of tissues. Spitting should be discouraged.

Personal protective equipment (PPE). Disposable non-powdered vinyl or latex-free CE-marked gloves and disposable plastic aprons must be worn where there is a risk of splashing or contamination with blood/body fluids (for example, nappy or pad changing). Goggles should also be available for use if there is a risk of splashing to the face. Correct PPE should be used when handling cleaning chemicals.

Cleaning of the environment, including toys and equipment, should be frequent, thorough and follow national guidance. For example, use colour-coded equipment, follow Control of Substances Hazardous to Health (COSHH) regulations and correct decontamination of cleaning equipment. Monitor cleaning contracts and ensure cleaners are appropriately trained with access to PPE.

Cleaning of blood and body fluid spillages. All spillages of blood, faeces, saliva, vomit, nasal and eye discharges should be cleaned up immediately (always wear PPE). When spillages occur, clean using a product that combines both a detergent and a disinfectant. Use as per manufacturer's instructions and ensure it is effective against bacteria and viruses and suitable for use on the affected surface. Never use mops for cleaning up blood and body fluid spillages – use disposable paper towels and discard clinical waste as described below. A spillage kit should be available for blood spills.

Laundry should be dealt with in a separate dedicated facility. Soiled linen should be washed separately at the hottest wash the fabric will tolerate. Wear PPE when handling soiled linen. Children's soiled clothing should be bagged to go home, never rinsed by hand.

Clinical waste. Always segregate domestic and clinical waste, in accordance with local policy. Used nappies/pads, gloves, aprons and soiled dressings should be stored in correct clinical waste bags in foot-operated bins. All clinical waste must be removed by a registered waste contractor. All clinical waste bags should be less than two-thirds full and stored in a dedicated, secure area while awaiting collection.

Sharps, eg needles, should be discarded straight into a sharps bin conforming to BS 7320 and UN 3291 standards. Sharps bins must be kept off the floor (preferably wall-mounted) and out of reach of children.

Sharps injuries and bites

If skin is broken as a result of a used needle injury or bite, encourage the wound to bleed/wash thoroughly using soap and water. Contact GP or occupational health or go to A&E immediately. Ensure local policy is in place for staff to follow. Contact the Duty Room for advice, if unsure.

Animals

Animals may carry infections, so wash hands after handling animals. Health and Safety Executive for Northern Ireland (HSENI) guidelines for protecting the health and safety of children should be followed.

Animals in school (permanent or visiting). Ensure animals' living quarters are kept clean and away from food areas. Waste should be disposed of regularly, and litter boxes not accessible to children. Children should not play with animals unsupervised. Hand-hygiene should be supervised after contact with animals and the area where visiting animals have been kept should be thoroughly cleaned after use. Veterinary advice should be sought on animal welfare and animal health issues and the suitability of the animal as a pet. Reptiles are not suitable as pets in schools and nurseries, as all species carry salmonella.

Visits to farms. For more information see https://www.hseni.gov.uk/publications/preventing-or-controlling-ill-health-animal-contact-visitor-attractions

Vulnerable children

Some medical conditions make children vulnerable to infections that would rarely be serious in most children, these include those being treated for leukaemia or other cancers, on high doses of steroids and with conditions that seriously reduce immunity. Schools and nurseries and childminders will normally have been made aware of such children. These children are particularly vulnerable to chickenpox, measles and parvovirus B19 and, if exposed to either of these, the parent/carer should be informed promptly and further medical advice sought. It may be advisable for these children to have additional immunisations, for example pneumococcal and influenza. This guidance is designed to give general advice to schools and childcare settings. Some vulnerable children may need further precautions to be taken, which should be discussed with the parent or carer in conjunction with their medical team and school health.

Female staff* – pregnancy

If a pregnant woman develops a rash or is in direct contact with someone with a potentially infectious rash, this should be investigated by a doctor who can contact the duty room for further advice. The greatest risk to pregnant women from such infections comes from their own child/children, rather than the workplace.

- Chickenpox can affect the pregnancy if a woman has not already had the infection. Report exposure to midwife and GP at any stage of pregnancy. The GP and antenatal carer will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.
- German measles (rubella). If a pregnant woman comes into contact with german measles she should inform her GP and antenatal carer immediately to ensure investigation. The infection may affect the developing baby if the woman is not immune and is exposed in early pregnancy.
- Slapped cheek disease (fifth disease or parvovirus B19) can occasionally affect an unborn child. If exposed early in pregnancy (before 20 weeks), inform whoever is giving antenatal care as this must be investigated promptly.
- Measles during pregnancy can result in early delivery or even loss of the baby. If a pregnant woman is exposed she should immediately inform whoever is giving antenatal care to ensure investigation.
- All female staff born after 1970 working with young children are advised to ensure they have had two doses of MMR vaccine.

*The above advice also applies to pregnant students.

Immunisations

Immunisation status should always be checked at school entry and at the time of any vaccination. Parents should be encouraged to have their child immunised and any immunisation missed or further catch-up doses organised through the child's GP.

For the most up-to-date immunisation advice and current schedule visit www.publichealth.hscni.net or the school health service can advise on the latest national immunisation schedule.

When to immunise	Diseases vaccine protects against	How it is given
2 months old	Diphtheria, tetanus, pertussis (whooping cough), polio and Hib	One injection
	Pneumococcal infection	One injection
	Rotavirus	Orally
	Meningococcal B infection	One injection
3 months old	Diphtheria, tetanus, pertussis, polio and Hib	One injection
	Rotavirus	Orally
4 months old	Diphtheria, tetanus, pertussis, polio and Hib	One injection
	Pneumococcal infection	One injection
	Meningococcal B infection	One injection
Just after the first birthday	Measles, mumps and rubella	One injection
	Pneumococcal infection	One injection
	Hib and meningococcal C infection	One injection
	Meningococcal B infection	One injection
Every year from 2 years old up to P7	Influenza	Nasal spray or injection
3 years and 4 months old	Diphtheria, tetanus, pertussis and polio	One injection
	Measles, mumps and rubella	One injection
Girls 12 to 13 years old	Cervical cancer caused by human papillomavirus types 16 and 18 and genital warts caused by types 6 and 11	Two injections over six months
14 to 18 years old	Tetanus, diphtheria and polio	One injection
	Meningococcal infection ACWY	One injection

This is the Immunisation Schedule as of July 2016. Children who present with certain risk factors may require additional immunisations. Always consult the most updated version of the "Green Book" for the latest immunisation schedule on www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book#the-green-book

From October 2017 children will receive hepatitis B vaccine at 2, 3, and 4 months of age in combination with the diphtheria, tetanus, pertussis, polio and Hib vaccine.

Staff immunisations. All staff should undergo a full occupational health check prior to employment; this includes ensuring they are up to date with immunisations, including two doses of MMR.

Original material was produced by the Health Protection Agency and this version adapted by the Public Health Agency,
12-22 Linenhall Street, Belfast, BT2 8BS.
Tel: 0300 555 0114.
www.publichealth.hscni.net
Information produced with the assistance of the Royal College of Paediatrics and Child Health and Public Health England.

3.7 Oral health

The setting provides care for children and promotes health through promoting oral health and hygiene, encouraging healthy eating, healthy snacks and tooth brushing.

- Fresh drinking water is always available and easily accessible.
- Sugary drinks are not served.
- In partnership with parents, babies are introduced to an open free-flowing cup at 6 months and from 12 months are discouraged from using a bottle.
- Only water and milk are served with morning and afternoon snacks.
- Children are offered healthy nutritious snacks with no added sugar.
- Parents are discouraged from sending in confectionary as a snack or treat.

Pacifiers/dummies

- Parents are *advised* to stop using dummies/pacifiers once their child is 12 months old.
- Dummies that are damaged are disposed of and parents are told that this has happened

Further guidance

Infant & Toddler Forum: Ten Steps for Healthy Toddlers

www.infantandtoddlerforum.org/toddlers-to-preschool/healthy-eating/ten-steps-for-healthy-toddlers/

3.8 Mental health and wellbeing

Poor mental health has a huge impact on individual employees, their colleagues, and employers, from high staff turnover, sickness, to decreased motivation and lost productivity.

Employers have a legal duty to manage risks to the health and safety of their employees. At St George's childcare, believe the mental health and wellbeing of our employees is key to our success and sustainability and a positive environment benefits our employees and the children and their families, who attend the setting.

St George's childcare is committed to the protection and promotion of the wellbeing of all its employees and to promoting a culture of positive mental health by

- encouraging all employees to support each other
- having a management team which is open, approachable, and aware of mental health issues
- making available outside support and training where required

Key Principles

At St George's childcare, we will support:

- Effective communication and training to raise awareness and understanding about mental health and wellbeing
- Dealing with issues effectively and preventing discrimination
- Reducing stigma around anxiety and mental health
- Managers implementing an open-door policy and being non-judgmental and offering proactive support
- Managers treating everybody fairly and with respect
- Workloads being monitored to ensure staff are not overloaded or under utilised
- Promoting opportunities for employees to enhance their professional development
- Managers identifying and remedying factors that may contribute to negative mental wellbeing
- Managers implementing and following all our policies

Responsibility of staff

The childcare managers and the board have a crucial role to play in ensuring that St George's is a safe and encouraging space to talk about mental health. Whilst managers will make every effort to support the mental health and wellbeing of the staff team, every member of staff can be responsible for their own mental health by looking out for early signs and taking care of themselves, physically as well as mentally, and by:

- Taking advantage of the office open door policy to chat about any concerns at any time.
- Speaking to a manager to make them aware of any wellbeing concerns regarding themselves or a team member.
- Helping create a culture where everyone feels responsible for looking out for colleagues who may have mental health issues.

Every member of staff is responsible for the impact they have on others, noting that:

- Negative language has a negative impact on the emotional landscape and the way we think and communicate.
- Laughter can change a mood and improve relationships with others
- Whilst problems will arise and mistakes will be made, blame and accusations will not be effective tools to promote mental wellbeing
- Communication is key, so staff need to read items such as the staff weekly news, staff room notice boards and attend staff meetings for news and ideas.
- Managers can signpost staff to external and local organisations for professional support. Staff can seek appropriate help through their GP or the NHS where necessary.

A happy and thriving working environment encourages not only children's learning and development but also practitioners' mental health and wellbeing. Colleagues who reduce the adverse impact of stress by working together, making happiness, laughter, and respect for others a part of every day, will help build job satisfaction, help develop coping strategies and will enable staff to feel supported and valued and invested in the great work that is done at St Georges supporting our children and their families.

Note: This policy should be used alongside other policies as necessary, including sickness and absence, valuing diversity, and promoting inclusion. It is important to remember confidentiality is of paramount importance for those experiencing mental health difficulties and problems. However, staff must be aware in certain circumstances, where an individual is deemed at risk, this policy will take second place to our safeguarding policies.

Public Health England

Protecting and improving the nation's health

Guidance on infection control in schools and other childcare settings

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through advocacy, partnerships, world-class science, knowledge and intelligence, and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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This document is available in other formats on request. Please email publications@phe.gov.uk

Contents

1. Introduction

The document provides guidance for schools and other childcare settings, such as nurseries, on infection control issues.

It is an updated version of guidance that was produced in 2010.

Prevent the spread of infections by ensuring:

- routine immunisation
- high standards of personal hygiene and practice, particularly handwashing
- maintaining a clean environment

For further information and advice visit www.gov.uk/phe or contact your local health PHE centre. See Appendix 1 for contact details.

2. Rashes and skin infections

Children with rashes should be considered infectious and assessed by their doctor.

Infection or complaint	Recommended period to be kept away from school, nursery or childminders	Comments
Athlete's foot	None	Athlete's foot is not a serious condition. Treatment is recommended
Chickenpox	Until all vesicles have crusted over	*See: Vulnerable Children and Female Staff – Pregnancy*
Cold sores, (Herpes simplex)	None	Avoid kissing and contact with the sores. Cold sores are generally mild and self-limiting
German measles (rubella)*	Four days from onset of rash (as per "Green Book")	Preventable by immunisation (MMR x2 doses). *See: Female Staff – Pregnancy*
Hand, foot and mouth	None	Contact your local HPT if a large number of children are affected. Exclusion may be considered in some circumstances
Impetigo	Until lesions are crusted and healed, or 48 hours after starting antibiotic treatment	Antibiotic treatment speeds healing and reduces the infectious period
Measles*	Four days from onset of rash	Preventable by vaccination (MMR x2). *See: Vulnerable Children and Female Staff – Pregnancy*
Molluscum contagiosum	None	A self-limiting condition
Ringworm	Exclusion not usually required	Treatment is required
Roseola (infantum)	None	None
Scabies	Child can return after first treatment	Household and close contacts require treatment
Scarlet fever*	Child can return 24 hours after starting appropriate antibiotic treatment	Antibiotic treatment is recommended for the affected child

Slapped cheek/fifth disease. Parvovirus B19	None (once rash has developed)	*See: Vulnerable Children and Female Staff – Pregnancy*
Shingles	Exclude only if rash is weeping and cannot be covered	Can cause chickenpox in those who are not immune, ie have not had chickenpox. It is spread by very close contact and touch. If further information is required, contact your local PHE centre. *See: Vulnerable Children and Female Staff – Pregnancy*
Warts and verrucae	None	Verrucae should be covered in swimming pools, gymnasiums and changing rooms

3. Diarrhoea and vomiting illness

Infection or complaint	**Recommended period to be kept away from school, nursery or childminders**	**Comments**
Diarrhoea and/or vomiting	48 hours from last episode of diarrhoea or vomiting	
E. coli O157 VTEC Typhoid* [and paratyphoid*] (enteric fever) Shigella (dysentery)	Should be excluded for 48 hours from the last episode of diarrhoea. Further exclusion may be required for some children until they are no longer excreting	Further exclusion is required for children aged five years or younger and those who have difficulty in adhering to hygiene practices. Children in these categories should be excluded until there is evidence of microbiological clearance. This guidance may also apply to some contacts who may also require microbiological clearance. Please consult your local PHE centre for further advice
Cryptosporidiosis	Exclude for 48 hours from the last episode of diarrhoea	Exclusion from swimming is advisable for two weeks after the diarrhoea has settled

4. Respiratory infections

Infection or complaint	Recommended period to be kept away from school, nursery or childminders	Comments
Flu (influenza)	Until recovered	*See: Vulnerable Children*
Tuberculosis*	Always consult your local PHE centre	Requires prolonged close contact for spread
Whooping cough* (pertussis)	Five days from starting antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment	Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks. Your local PHE centre will organise any contact tracing necessary

5. Other infections

Infection or complaint	Recommended period to be kept away from school, nursery or child minders	Comments
Conjunctivitis	None	If an outbreak/cluster occurs, consult your local PHE centre
Diphtheria *	Exclusion is essential. Always consult with your local HPT	Family contacts must be excluded until cleared to return by your local PHE centre. Preventable by vaccination. Your local PHE centre will organise any contact tracing necessary
Glandular fever	None	
Head lice	None	Treatment is recommended only in cases where live lice have been seen
Hepatitis A*	Exclude until seven days after onset of jaundice (or seven days after symptom onset if no jaundice)	In an outbreak of hepatitis A, your local PHE centre will advise on control measures

Hepatitis B*, C*, HIV/AIDS	None	Hepatitis B and C and HIV are bloodborne viruses that are not infectious through casual contact. For cleaning of body fluid spills *see: Good Hygiene Practice*
Meningococcal meningitis*/ septicaemia*	Until recovered	Meningitis C is preventable by vaccination There is no reason to exclude siblings or other close contacts of a case. In case of an outbreak, it may be necessary to provide antibiotics with or without meningococcal vaccination to close school contacts. Your local PHE centre will advise on any action is needed
Meningitis* due to other bacteria	Until recovered	Hib and pneumococcal meningitis are preventable by vaccination. There is no reason to exclude siblings or other close contacts of a case. Your local PHE centre will give advice on any action needed
Meningitis viral*	None	Milder illness. There is no reason to exclude siblings and other close contacts of a case. Contact tracing is not required
MRSA	None	Good hygiene, in particular handwashing and environmental cleaning, are important to minimise any danger of spread. If further information is required, contact your local PHE centre
Mumps*	Exclude child for five days after onset of swelling	Preventable by vaccination (MMR x2 doses)
Threadworms	None	Treatment is recommended for the child and household contacts
Tonsillitis	None	There are many causes, but most cases are due to viruses and do not need an antibiotic

* denotes a notifiable disease. It is a statutory requirement that doctors report a notifiable disease to the proper officer of the local authority (usually a consultant in communicable disease control). In addition, organisations may be required via locally agreed arrangements to inform their local PHE centre. Regulating bodies (for example, Office for Standards in Education (OFSTED)/Commission for Social Care Inspection (CSCI)) may wish to be informed – please refer to local policy.

Outbreaks: if an outbreak of infectious disease is suspected, please contact your local PHE centre.

6. Good hygiene practice

Handwashing

Handwashing is one of the most important ways of controlling the spread of infections, especially those that cause diarrhoea and vomiting, and respiratory disease. The recommended method is the use of liquid soap, warm water and paper towels. Always wash hands after using the toilet, before eating or handling food, and after handling animals. Cover all cuts and abrasions with waterproof dressings.

Coughing and sneezing

Coughing and sneezing easily spread infections. Children and adults should be encouraged to cover their mouth and nose with a tissue. Wash hands after using or disposing of tissues. Spitting should be discouraged.

Personal protective equipment (PPE)

Disposable non-powdered vinyl or latex-free CE-marked gloves and disposable plastic aprons must be worn where there is a risk of splashing or contamination with blood/body fluids (for example, nappy or pad changing). Goggles should also be available for use if there is a risk of splashing to the face. Correct PPE should be used when handling cleaning chemicals.

Cleaning of the environment

Cleaning of the environment, including toys and equipment, should be frequent, thorough and follow national guidance. For example, use colour-coded equipment, COSHH and correct decontamination of cleaning equipment. Monitor cleaning contracts and ensure cleaners are appropriately trained with access to PPE.

Cleaning of blood and body fluid spillages

All spillages of blood, faeces, saliva, vomit, nasal and eye discharges should be cleaned up immediately (always wear PPE). When spillages occur, clean using a product that combines both a detergent and a disinfectant. Use as per manufacturer's instructions and ensure it is effective against bacteria and viruses and suitable for use on the affected surface. Never use mops for cleaning up blood and body fluid spillages – use disposable paper towels and discard clinical waste as described below. A spillage kit should be available for blood spills.

Laundry

Laundry should be dealt with in a separate dedicated facility. Soiled linen should be washed separately at the hottest wash the fabric will tolerate. Wear PPE when handling soiled linen. Children's soiled clothing should be bagged to go home, never rinsed by hand.

Clinical waste

Always segregate domestic and clinical waste, in accordance with local policy. Used nappies/pads, gloves, aprons and soiled dressings should be stored in correct clinical waste bags in foot-operated bins. All clinical waste must be removed by a registered waste contractor. All clinical waste bags should be less than two-thirds full and stored in a dedicated, secure area while awaiting collection.

Sharps disposal

Sharps should be discarded straight into a sharps bin conforming to BS 7320 and UN 3291 standards. Sharps bins must be kept off the floor (preferably wall-mounted) and out of reach of children.

Sharps injuries and bites

If skin is broken, encourage the wound to bleed/ wash thoroughly using soap and water. Contact GP or occupational health or go to A&E immediately. Ensure local policy is in place for staff to follow. Contact your local HPT for advice, if unsure.

Animals

Animals may carry infections, so hands must be washed after handling any animals. Health and Safety Executive (HSE) guidelines for protecting the health and safety of children should be followed.

Animals in school (permanent or visiting)

Ensure animals' living quarters are kept clean and away from food areas. Waste should be disposed of regularly, and litter boxes not accessible to children. Children should not play with animals unsupervised. Veterinary advice should be sought on animal welfare and animal health issues and the suitability of the animal as a pet. Reptiles are not suitable as pets in schools and nurseries, as all species carry salmonella.

Visits to farms

Please contact your local environmental health department, which will provide you with help and advice when you are planning a visit to a farm or similar establishment. For more information see http://www.face-online.org.uk/resources/preventing-or-controlling-ill-health-from-animal-contact-at-visitor-attractions-industry-code-of-practice

Vulnerable children

Some medical conditions make children vulnerable to infections that would rarely be serious in most children, these include those being treated for leukaemia or other cancers, on high doses of steroids and with conditions that seriously reduce immunity. Schools and nurseries and childminders will normally have been made aware of such children. These children are particularly vulnerable to chickenpox, measles or parvovirus B19 and, if exposed to either of these, the parent/carer should be informed promptly and further medical advice sought. It may be advisable for these children to have additional immunisations, for example pneumococcal and influenza.

Female staff – pregnancy

If a pregnant woman develops a rash or is in direct contact with someone with a potentially infectious rash, this should be investigated according to PHE guidelines by a doctor. The greatest risk to pregnant women from such infections comes from their own child/children, rather than the workplace. Some specific risks are:

- chickenpox can affect the pregnancy if a woman has not already had the infection. Report exposure to midwife and GP at any stage of exposure. The GP and antenatal carer will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles
- German measles (rubella). If a pregnant woman comes into contact with german measles she should inform her GP and antenatal carer immediately to ensure investigation. The infection may affect the developing baby if the woman is not immune and is exposed in early pregnancy
- slapped cheek disease (parvovirus B19) can occasionally affect an unborn child. If exposed early in pregnancy (before 20 weeks), inform whoever is giving antenatal care as this must be investigated promptly
- measles during pregnancy can result in early delivery or even loss of the baby. If a pregnant woman is exposed she should immediately inform whoever is giving antenatal care to ensure investigation

This advice also applies to pregnant students.

7. Immunisations

Immunisation status should always be checked at school entry and at the time of any vaccination. Parents should be encouraged to have their child immunised and any immunisation missed or further catch-up doses organised through the child's GP. For the most up-to-date immunisation advice see the NHS Choices website at www.nhs.uk or the school health service can advise on the latest national immunisation schedule.

Immunisation schedule

Two months old	Diphtheria, tetanus, pertussis, polio and Hib (DTaP/IPV/Hib) Pneumococcal (PCV13) Rotavirus vaccine	One injection One injection Given orally
Three months old	Diphtheria, tetanus, pertussis, polio and Hib (DTaP/IPV/Hib) Meningitis C (Men C) Rotavirus vaccine	One injection One injection Given orally
Four months old	Diphtheria, tetanus, pertussis, polio and Hib (DTaP/IPV/Hib) Pneumococcal (PCV13)	One injection One injection
Between 12-13 months old	Hib/meningitis C Measles, mumps and rubella (MMR) Pneumococcal (PCV13)	One injection One injection One injection
Two, three and four years old	Influenza (from September)	Nasal spray or one injection
Three years and four months old or soon after	Diphtheria, tetanus, pertussis, polio (DTaP/IPV or dTaP/IPV) Measles, mumps and rubella (MMR)	One injection One injection
Girls aged 12 to 13 years	Cervical cancer caused by human papilloma virus types 16 and 18. HPV vaccine	Two injections given 6-24 months apart
Around 14 years old	Tetanus, diphtheria, and polio (Td/IPV)	One injection
	Meningococcal C (Men C)	One injection

This is the complete routine immunisation schedule. Children who present with certain risk factors may require additional immunisations. Some areas have local policies – check with your local PHE centre.

Staff immunisations – all staff should undergo a full occupational health check before starting employment; this includes ensuring they are up to date with immunisations, including MMR.

Appendix 1. PHE centre contact details

North of England

Cheshire and Merseyside PHE Centre
5th Floor
Rail House
Lord Nelson Street
Liverpool L1 1JF
Tel: 0344 225 1295

Cumbria and Lancashire PHE Centre
1st Floor, York House
Ackhurst Business Park
Foxhole Road
Chorley PR7 1NY
Tel: 0344 225 0602

Greater Manchester PHE Centre
5th Floor
3 Piccadilly Place
London Road
Manchester M1 3BN
Tel: 0344 225 0562

North East PHE Centre
Floor 2 Citygate
Gallowgate
Newcastle-upon-Tyne NE1 4WH
Tel: 0300 303 8596

Yorkshire and the Humber PHE Centre
Blenheim House
West One
Duncombe Street
Leeds LS1 4PL
Tel: 0113 386 0300

Midlands and East of England

Anglia and Essex PHE Centre
Eastbrook
Shaftesbury Road
Cambridge CB2 8DF
Tel: 0303 444 6690

East Midlands PHE Centre
Institute of Population Health
Nottingham City Hospital
Hucknall Road
Nottingham NG5 1QP
Tel: 0344 225 4524

South Midlands and Hertfordshire PHE Centre
Beacon House
Dunhams Lane
Letchworth Garden City
Herts SG6 1BE
Tel: 0300 303 8537

West Midlands PHE Centre
6th Floor
5 St Philip's Place
Birmingham B3 2PW
Tel: 0344 225 3560

South of England

Avon, Gloucestershire and Wiltshire PHE Centre
2 Rivergate
Temple Quay
Bristol BS1 6EH
Tel: 0300 303 8162

Devon, Cornwall and Somerset PHE Centre
Richmond Court
Emperor Way
Exeter Business Park
Exeter
Devon EX1 3QS
Tel: 0344 225 3557

Kent, Surrey and Sussex PHE Centre
County Hall North
Chart Way
Horsham
West Sussex RH12 1XA
Tel: 0844 225 3861

Thames Valley PHE Centre
Chilton
Oxfordshire
OX11 0RQ
Tel: 0345 279 9879

Wessex PHE Centre
Unit 8, Fulcrum 2
Solent Way
Fareham
Hampshire PO15 7FN
Tel: 0345 055 2022

London

London integrated region and PHE Centre
151 Buckingham Palace Road
London SW1W 9SZ
Tel: 020 7811 7000/7001