# Supporting Pupils with Medical Conditions Policy

# St Luke's Primary School

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| **Approved by:** | Governing Board | **Date:** | September 2026 |
| **Next review date:** | September 2027 | | |

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### 1. Aims

This policy aims to ensure that:

- Pupils, staff and parents understand how our school will support pupils with medical conditions
- Pupils with medical conditions are properly supported to allow them to access the same education as other pupils, including school trips and sporting activities

The governing board will implement this policy by:

- Making sure sufficient staff are suitably trained
- Making staff aware of pupil's condition, where appropriate
- Making sure there are cover arrangements to ensure someone is always available to support pupils with medical conditions
- Providing supply teachers with appropriate information about the policy and relevant pupils
- Developing and monitoring individual healthcare plans (IHPs)

**The named person with responsibility for making sure that this policy is implemented is the Head Teacher**

### 2. Legislation and statutory responsibilities

This policy meets the requirements under Section 100 of the Children and Families Act 2014, which places a duty on governing boards to make arrangements for supporting pupils at their school with medical conditions.

It is also based on the Department for Education's statutory guidance: Supporting pupils at school with medical conditions.

### 3. Roles and responsibilities

## 3.1 The governing board

The governing board has ultimate responsibility to make arrangements to support pupils with medical conditions. The governing board will ensure that sufficient staff have received suitable training and are competent before they are responsible for supporting children with medical conditions.

### 3.2 The Head Teacher

The Head Teacher will:

- Make sure all staff are aware of this policy and understand their role in its implementation
- Ensure that there is a sufficient number of trained staff available to implement this policy and deliver against all individual healthcare plans (IHPs), including in contingency and emergency situations
- Take overall responsibility for ensuring the development of IHPs
- Make sure that school staff are appropriately insured and aware that they are insured to support pupils in this way
- Ensure that systems are in place for obtaining information about a child's medical needs and that this information is kept up to date

### 3.3 Staff

Supporting pupils with medical conditions during school hours is not the sole responsibility of one person. Any member of staff may be asked to provide support to pupils with medical conditions, although they will not be required to do so. This includes the administration of medicines.

Those staff who take on the responsibility to support pupils with medical conditions will receive sufficient and suitable training and will achieve the necessary level of competency before doing so.

Teachers will take into account the needs of pupils with medical conditions that they teach. All staff will know what to do and respond accordingly when they become aware that a pupil with a medical condition needs help.

The First Aid Lead will contact the school nursing service in the case of any pupil who has a medical condition that may require support at school, but who has not yet been brought to the attention of the school nurse

The First Aid Lead will reach out to others, such as parents and healthcare professionals, for advice and guidance on how to support our pupils

### 3.4 Parents

Parents will:

- Provide the school with sufficient and up-to-date information about their child's medical needs
- Be involved in the development and review of their child's IHP and may be involved in its drafting
- Carry out any action they have agreed to as part of the implementation of the IHP e.g. provide medicines and equipment

### 3.5 Pupils

Pupils with medical conditions will often be best placed to provide information about how their condition affects them. Pupils should be fully involved in discussions about their medical support needs and contribute as much as possible to the development of their IHPs. They are also expected to comply with their IHPs.

### 3.6 School nurses and other healthcare professionals

Our school nursing service will notify the school when a pupil has been identified as having a medical condition that will require support in school. This will be before the pupil starts school, wherever possible.

Healthcare professionals, such as GPs and pediatricians, will liaise with the school nurse and notify them of any pupils identified as having a medical condition.

#### 4. Equal opportunities

Our school is clear about the need to actively support pupils with medical conditions to participate in school trips and visits, or in sporting activities, and not prevent them from doing so.

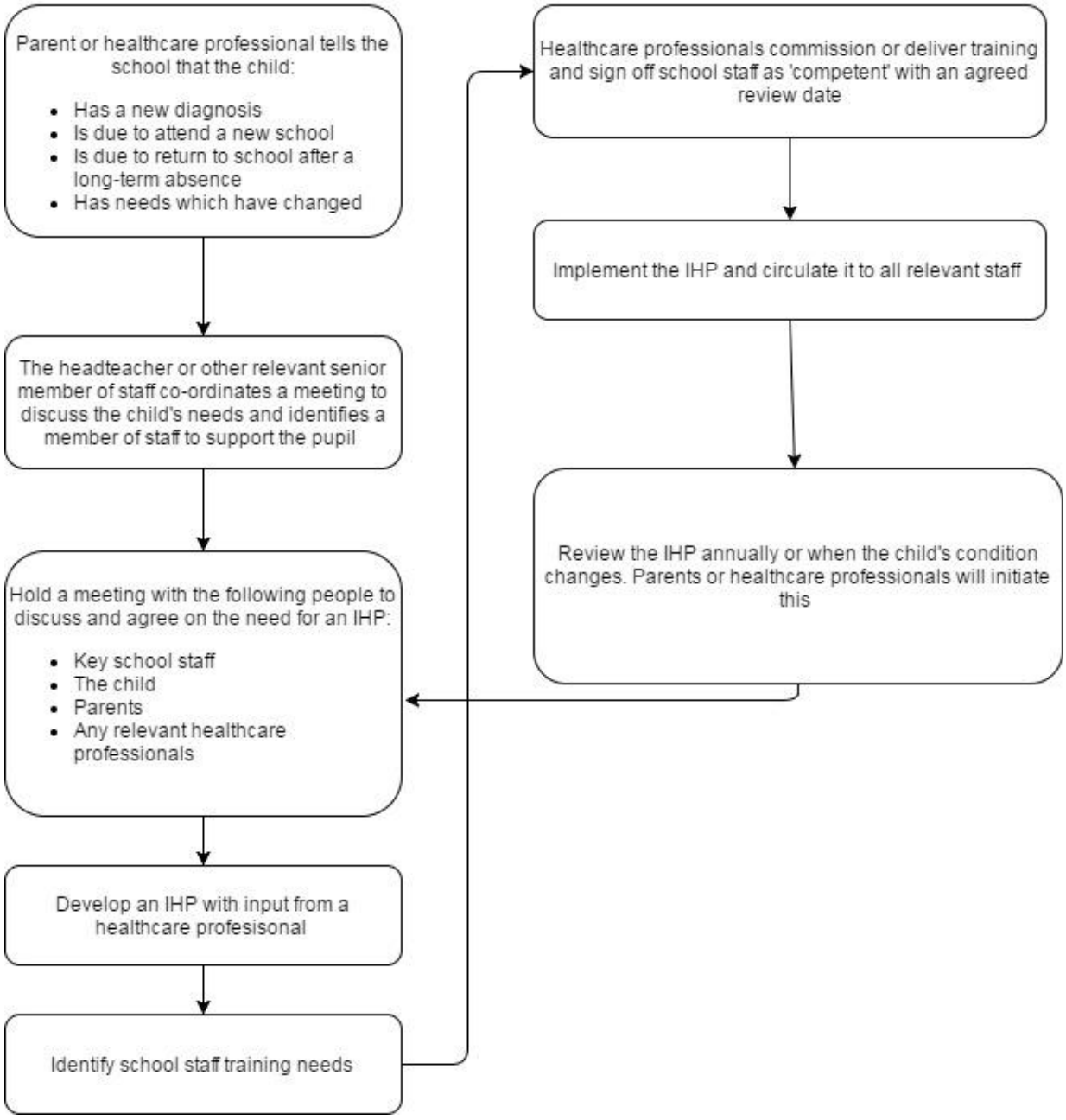
The school will consider what reasonable adjustments need to be made to enable these pupils to participate fully and safely on school trips, visits and sporting activities.

Risk assessments will be carried out so that planning arrangements take account of any steps needed to ensure that pupils with medical conditions are included. In doing so, pupils, their parents and any relevant healthcare professionals will be consulted.

**5. Being notified that a child has a medical condition**

When the school is notified that a pupil has a medical condition, the process outlined below will be followed to decide whether the pupil requires an IHP.

The school will make every effort to ensure that arrangements are put into place within 2 weeks, or by the beginning of the relevant term for pupils who are new to our school.




**6. Individual healthcare plans**

Although the Head Teacher has overall responsibility for ensuring the development of IHPs for pupils with medical conditions, this has been delegated to the First Aid Lead and SENCO. They will seek out the input of others as required.

Plans will be reviewed at least annually, or earlier if there is evidence that the pupil's needs have changed.

Plans will be developed with the pupil's best interests in mind and will set out:

- What needs to be done
- When
- By whom

Not all pupils with a medical condition will require an IHP. It will be agreed with a healthcare professional and the parents when an IHP would be inappropriate or disproportionate. This will be based on evidence. If there is not a consensus, the Head Teacher will make the final decision.

Plans will be drawn up in partnership with the school, parents and a relevant healthcare professional, such as the school nurse, specialist or pediatrician, who can best advise on the pupil's specific needs. The pupil will be involved wherever appropriate.

IHPs will be linked to, or become part of, any statement of special educational needs (SEN) or education, health and care (EHC) plan. If a pupil has SEN but does not have a statement or EHC plan, the SEN will be mentioned in the IHP.

The level of detail in the plan will depend on the complexity of the child's condition and how much support is needed. The First Aid Lead and SENCO in conjunction with the Head Teacher, School Nurse and parents, as appropriate, will consider the following when deciding what information to record on IHPs:

- The medical condition, its triggers, signs, symptoms and treatments
- The pupil's resulting needs, including medication (dose, side effects and storage) and other treatments, time, facilities, equipment, testing, access to food and drink where this is used to manage their condition, dietary requirements and environmental issues, e.g. crowded corridors, travel time between lessons
- Specific support for the pupil's educational, social and emotional needs. For example, how absences will be managed, requirements for extra time to complete exams, use of rest periods or additional support in catching up with lessons, counselling sessions
- The level of support needed, including in emergencies. If a pupil is self-managing their medication, this will be clearly stated with appropriate arrangements for monitoring
- Who will provide this support, their training needs, expectations of their role and confirmation of proficiency to provide support for the pupil's medical condition from a healthcare professional, and cover arrangements for when they are unavailable
- Who in the school needs to be aware of the pupil's condition and the support required
- Arrangements for written permission from parents and the Lead First Aider acting on behalf of the headteacher for medication to be administered by a member of staff, or self-administered by the pupil during school hours
- Separate arrangements or procedures required for school trips or other school activities outside of the normal school timetable that will ensure the pupil can participate, e.g. risk assessments
- Where confidentiality issues are raised by the parent/pupil, the designated individuals to be entrusted with information about the pupil's condition
- What to do in an emergency, including who to contact, and contingency arrangements

**7. Managing medicines**

At St. Luke's we recognize that there are two types of medicines that may need to be used in school:

1. Medicines that are not available over the counter; these must clearly show that they have been prescribed by a doctor and the school will require parental consent to administer it to the child;
2. Medicines that are available over the counter in shops or chemists – and for these to be given to a child, the parents must provide parental consent.

We will hold some prescription medicines in school to be administered in the event of an emergency when it would be detrimental to the pupil's health or school attendance not to do so however we will have sought parental consent in advance in case that eventuality arises e.g. inhalers or adrenalin pens.

**The only exception to this is where the medicine has been prescribed to the pupil without the knowledge of the parents.**

Pupils under 16 will not be given medicine containing aspirin unless prescribed by a doctor.

Anyone giving a pupil any medication (for example, for pain relief) will first check maximum dosages and when the previous dosage was taken. Parents will always be informed.

The school will only accept medicines that are:

- In-date

- Labelled if a prescribed medicine
- Calpol that is given to the school and forms are signed by a parent.
- Provided in the original container, as dispensed by the pharmacist/shop, and include instructions for administration, dosage and storage

The school will accept insulin that is inside an insulin pen or pump rather than its original container, but it must be in date.

All medicines will be stored safely. Medication will be held centrally and pupils will able to access them immediately with appropriate staff members. Medicines and devices such as asthma inhalers, blood glucose testing meters and adrenaline pens will always be readily available to pupils and not locked away.

Medicines will be returned to parents to arrange for safe disposal when no longer required.

### 7.1 Controlled drugs

Controlled drugs are prescription medicines that are controlled under the Misuse of Drugs Regulations 2001 and subsequent amendments, such as morphine or methadone.

A pupil who has been prescribed a controlled drug may have it in their possession if they are competent to do so, but they must not pass it to another pupil to use. All other controlled drugs are kept in a secure cupboard in the First Aid Room and only named staff have access.

Controlled drugs will be easily accessible in an emergency and a record of any doses used and the amount held will be kept.

### 7.2 Pupils managing their own needs

Pupils who are competent will be encouraged to take responsibility for managing their own medicines and procedures. This will be discussed with parents and it will be reflected in their IHPs. In such situations pupils will be expected to ensure that the member of staff updating the medication book is present when they are administering their medicine.

Pupils will be allowed to carry their own medicines and relevant devices wherever possible. Staff will not force a pupil to take a medicine or carry out a necessary procedure if they refuse, but will follow the procedure agreed in the IHP and inform parents so that an alternative option can be considered, if necessary.

### 7.3 Unacceptable practice

School staff should use their discretion and judge each case individually with reference to the pupil's IHP, but it is generally not acceptable to:

- Prevent pupils from easily accessing their inhalers and medication, and administering their medication when and where necessary
- Assume that every pupil with the same condition requires the same treatment
- Ignore the views of the pupil or their parents
- Ignore medical evidence or opinion (although this may be challenged)
- Send children with medical conditions home frequently for reasons associated with their medical condition or prevent them from staying for normal school activities, including lunch, unless this is specified in their IHPs
- If the pupil becomes ill, send them to the school office or medical room unaccompanied or with someone unsuitable
- Penalise pupils for their attendance record if their absences are related to their medical condition, e.g. hospital appointments
- Prevent pupils from drinking, eating or taking toilet or other breaks whenever they need to in order to manage their medical condition effectively
- Require parents, or otherwise make them feel obliged, to attend school to administer medication or provide medical support to their pupil, including with toileting issues. No parent should have to give up working because the school is failing to support their child's medical needs
- Prevent pupils from participating, or create unnecessary barriers to pupils participating in any aspect of school life, including school trips, e.g. by requiring parents to accompany their child
- Administer, or ask pupils to administer, medicine in school toilets

## 8. Emergency procedures

Staff will follow the school's normal emergency procedures (for example, calling 999). All pupils' IHPs will clearly set out what constitutes an emergency and will explain what to do.

If a pupil needs to be taken to hospital, staff will stay with the pupil until the parent arrives or accompany the pupil to hospital by ambulance.

## 9. Training

Staff who are responsible for supporting pupils with medical needs will receive suitable and sufficient training to do so.

The training will be identified during the development or review of IHPs. Staff who provide support to pupils with medical conditions will be included in meetings where this is discussed.

The relevant healthcare professionals will lead on identifying the type and level of training required and will agree this with the Executive Head Teacher or Head Teacher. Training will be kept up to date.

Training will:

- Be sufficient to ensure that staff are competent and have confidence in their ability to support the pupils
- Fulfill the requirements in the IHPs
- Help staff to have an understanding of the specific medical conditions they are being asked to deal with, their implications and preventative measures

Healthcare professionals will provide confirmation of the proficiency of staff in a medical procedure, or in providing medication.

All staff will receive training so that they are aware of this policy and understand their role in implementing it, for example, with preventative and emergency measures so they can recognise and act quickly when a problem occurs. This will be provided for new staff during their induction.

## 10. Record keeping

The governing board will ensure that written records are kept of all medicine administered to pupils. Parents will be informed if their pupil has been unwell at school.

IHPs are kept in a readily accessible place which all staff are aware of.

A copy of an Administration of Medication Form is attached in Appendix 1.

## 11. Liability and indemnity

The governing board will ensure that the appropriate level of insurance is in place and appropriately reflects the school's level of risk.

The school's Employers Liability Insurance Policy is facilitated by LBTH and is currently with Zurich Municipal Insurance, policy number QLA-O1E229-0313.

## 12. Complaints

Parents with a complaint about their child's medical condition should discuss these directly with the Head Teacher or SENCO in the first instance. If the matter remains unresolved, they will direct parents to the school's complaints procedure.

## 13. Monitoring arrangements

This policy will be reviewed and approved by the governing board every three years.

## 14. Links to other policies

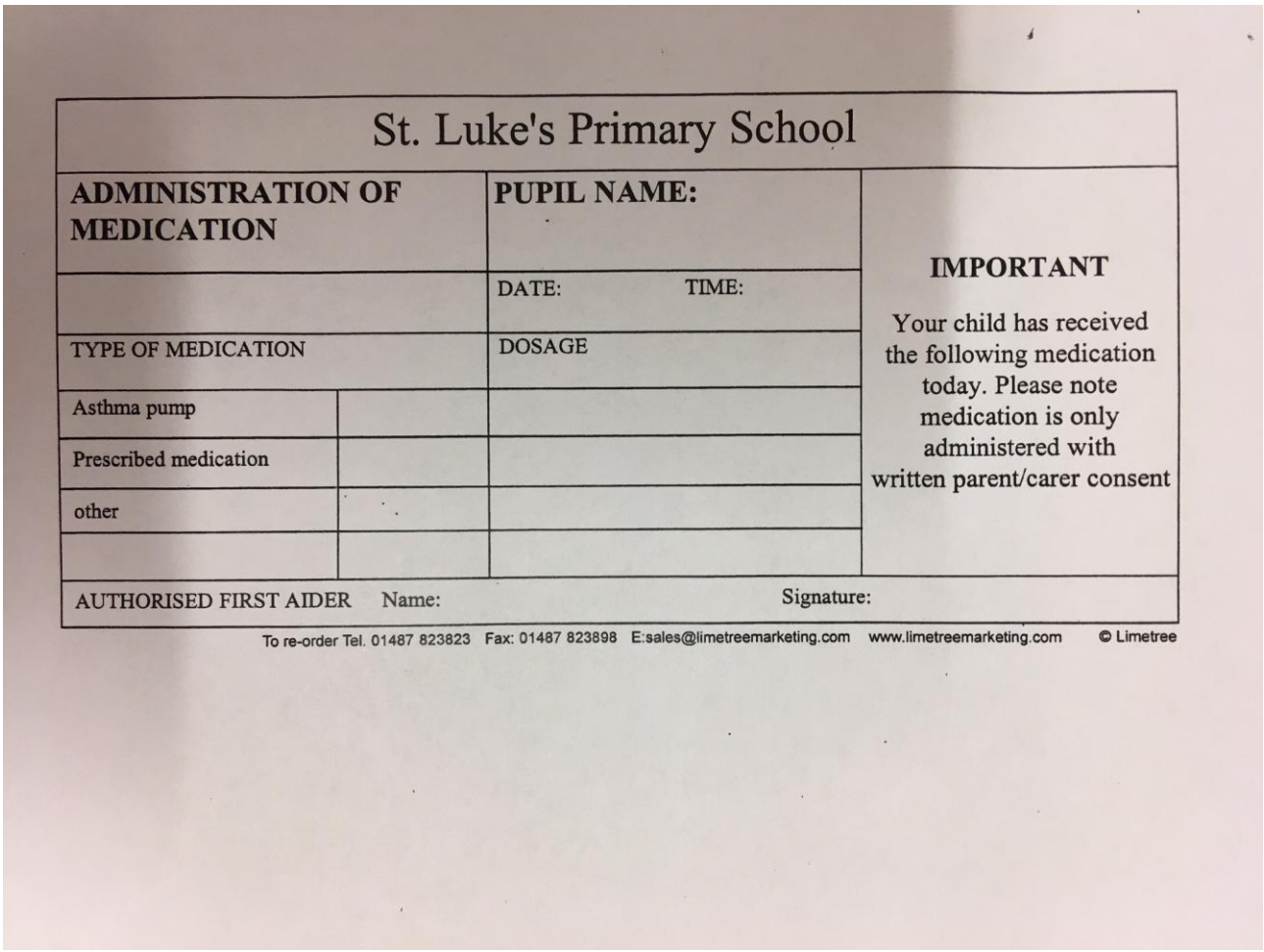
This policy links to the following policies:

- Accessibility Policy
- Complaints Procedure
- Equality information and objectives
- First Aid
- Health and Safety Policy
- Intimate Care Policy
- Risk Assessment Policy
- Safeguarding
- SEN and Inclusion Policy

**15. Guidance on Infection Control**

Posters produced by the Health Protection Agency on Guidance on Infection Control in Schools & Childcare Settings are sited throughout the school. A copy is attached in Appendix 2.

## Appendix 1: Administration of Medication Form

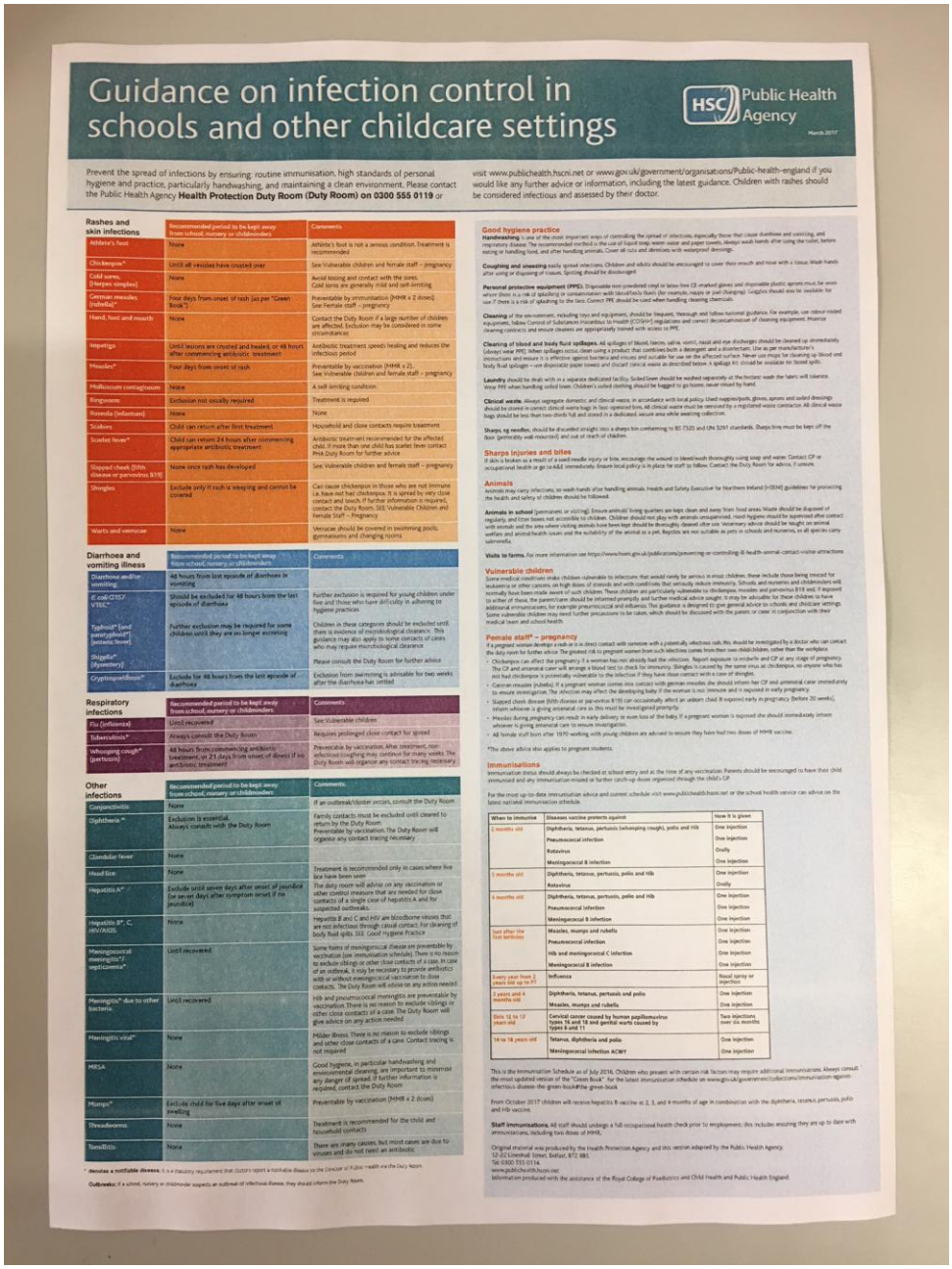


St. Luke's Primary School

| ADMINISTRATION OF MEDICATION | | PUPIL NAME: | IMPORTANT |
|---|---|---|---|
| | | DATE: TIME: | Your child has received the following medication today. Please note medication is only administered with written parent/carer consent |
| TYPE OF MEDICATION | | DOSAGE | |
| Asthma pump | | | |
| Prescribed medication | | | |
| other | | | |
| | | | |
| AUTHORISED FIRST AIDER Name: | | Signature: | |

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## Appendix 2: Guidance on infection control in schools and other childcare settings



# 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 |
| Slapped cheek (fifth disease 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 | Further exclusion is required for young children under five and those who have difficulty in adhering to hygiene practices<br><br>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<br><br>Please consult the Duty Room for further advice |
| E.coli O157 VTEC* | Should be excluded for 48 hours from the last episode of diarrhoea | |
| Typhoid* [and paratyphoid*] [enteric fever] | Further exclusion may be required for some children until they are no longer excreting | |
| Shigella* (dysentery) | | |
| 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 |

| Other infections | 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 skin sores 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.

**Clearing 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 1st 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.
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Tel: 0300 555 0114.
www.publichealth.hscni.net
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