DOHA ENGLISH SPEAKING SCHOOL
Learning Together • High Expectations • Celebrating Success

HEALTH AND SAFETY MANUAL for Parents

November 2019

To be reviewed November 2020

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SECURITY, HEALTH AND SAFETY POLICY

PURPOSE

To provide a safe environment for children, staff and all other persons who visit the school, and to ensure that roles and responsibilities in maintaining a healthy and safe environment are understood by the school community.

POLICY STATEMENT

DESS is committed to:-

1. Establishing and maintaining a safe and healthy environment throughout the school for children, staff and all other people who come onto the school premises, through thorough risk assessment processes.
2. Where appropriate, seeking expert advice regarding security risks and precautions. (eg British Embassy, OSAC)
3. Ensuring that sufficient information, instruction and supervision is provided to enable staff, children and visitors to the school to avoid hazards and contribute positively to their own health and safety, and to ensure that they have access to health and safety training as appropriate or as and when provided.
4. Formulating effective procedures for use in case of fire or other emergencies, and for evacuating the school premises, and for accident and medical related incidents, as well as security standards.
5. Educating children and staff on safety where appropriate.
6. Ensuring that all members of the school community understand their own responsibilities in maintaining a healthy safe and secure environment.
7. Employing a third party security company to manage site security, including CCTV cameras.
8. Ensuring that all physical security features are maintained, including CCTV cameras, alarm system, perimeter walls, gates and stand-off blocks.
9. Linking to and following all Civil Defense requirements and recommendations.
10. Conducting an annual Security, Health and Safety Management System review.
11. Ensuring that all local and international legislation and standards are adhered to.

PROCEDURE

In order to meet its commitment, DESS will establish and maintain, at a minimum, the following procedures and guidelines:

- Emergency Procedures
- Lockdown/Evacuation Procedures
- First Aid Procedures and Guidelines
- Roles and Responsibilities Guidelines

The Headteacher will appoint a Health and Safety Officer, who is appropriately qualified to carry out the role, or is working toward such qualification.

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The Headteacher will present to the Board of Governors each term a report detailing the health and safety measures at DESS and their effectiveness, suggestions for improvement and highlighted risks. The Headteacher will ensure that the procedures and guidelines are regularly reviewed and are made available to staff and, where appropriate, to the School Community.

Approval Date: October 2018
Review Date: October 2020
Signature (Chairman Board of Governors)

September 2019

HEALTH AND SAFETY ROLES AND RESPONSIBILITIES

These Guidelines should be read in conjunction with the:

- DESS Health and Safety Policy
- DESS Emergency Procedure
- DESS Lockdown/Evacuation Procedure
- DESS First Aid Procedures (various)
- DESS Pool Procedures

Responsibilities:

The Board of Governors will:

1. Approve and monitor the effectiveness of the Health and Safety Policy and shall revise and amend it, as necessary, on a regular basis.
2. Provide advice, guidance and assistance where necessary on the policy and guidelines.

The Headteacher will:

1. Prepare an emergency evacuation procedure and arrange for periodic practice evacuation drills (normally at least once a term) to take place and for the results of these to be recorded.
2. Make arrangements to draw attention of all staff employed at the school to the school safety policies and procedures.
3. Ensure staff are all aware of the accident reporting procedure.
4. Make arrangements for informing staff and pupils on safety procedures.
5. Make arrangements for outside users to be informed of safety procedures.
6. Ensure that regular safety inspections are undertaken.
7. Arrange for the withdrawal, repair or replacement of any item of furniture, fitting or equipment identified as being unsafe.
8. Identify a staff member to assist the Board of Governors and Headteacher in the management of health and safety at the school. Such delegated responsibility must be defined as the Health and Safety Officer.

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The Health and Safety Officer will:

1. Assist the Headteacher in the implementation, monitoring and development of the safety policy within the school.
2. Monitor general advice on safety matters arising from relevant bodies and advise on its application to the school.
3. Co-ordinate arrangements for the design and implementation of safe working practices within the school.
4. Investigate any specific health and safety problem identified within the school and take or recommend (as appropriate) remedial action.
5. Order that a method of working ceases on health and safety grounds on a temporary basis subject to further consideration by the Board of Governors or Headteacher.
6. Assist in carrying out regular safety inspections of the school and its activities and make recommendations on methods of resolving any problems identified.
7. Ensure that staff with control of resources give due regard to safety.
8. Co-ordinate arrangements for the dissemination of information and for the instruction of employees, pupils and visitors on safety matters and make recommendations on the extent to which staff are trained.

All staff members will:

1. Take reasonable care for the health and safety of themselves and of any person who might be affected by their acts or omissions at work.
2. Co-operate with the Health and Safety Officer, Board and Governors and Headteacher and not interfere with or misuse anything provided in the interest of health, safety and welfare.
3. Make themselves aware of all safety rules, procedures and safe working practices applicable to their posts; where in doubt seek immediate clarification from the Headteacher.
4. Ensure that tools and equipment are in good condition and report any defects through the correct channels.
5. Use protective clothing and safety equipment provided and ensure that these are kept in good condition.
6. Ensure that offices, classrooms, storerooms, workshops and public areas are kept tidy.
7. Ensure that any accidents, whether or not an injury occurs, and potential hazards are reported to the Health and Safety officer and/or the Headteacher.

WHENEVER AN EMPLOYEE IS AWARE OF ANY POSSIBLE DEFICIENCIES IN HEALTH AND SAFETY ARRANGEMENTS, HE/SHE MUST DRAW THESE TO THE ATTENTION OF THE HEADTEACHER and/or HEALTH AND SAFETY OFFICER

Please note the following:

1. It must be realised that newly appointed employees could be particularly vulnerable to any risk and it must be ensured that all relevant health and safety matters are drawn to their attention at an early stage.
2. Whilst it is a management responsibility to instruct all employees in safe working procedures in relation to their posts and work places, Line Managers are required to ensure that employees under their department are familiar with procedures.
3. All volunteer helpers will be expected, as far as reasonably possible, to meet the same standards required of employees.

Responsibilities of Teaching Staff Towards Pupils and others in their Care

All staff are responsible for the health and safety arrangements in relation to themselves, co-workers, pupils and any volunteer workers. They will monitor their own work activities and take all reasonable steps to:

1. Exercise effective supervision over all those for whom they are responsible, including pupils.
2. Be aware of and implement safe working practices and to set a good example personally.
3. Identify actual and potential hazards and introduce procedures to minimise the possibility of mishap.
4. Ensure that any equipment or tools used are appropriate to that use and meet accepted safety standards.
5. Provide appropriate protective clothing and safety equipment as necessary and ensure that these are used as required.
6. Evaluate promptly and, where appropriate, take action on criticism of health and safety arrangements.
7. Provide the opportunity for discussion of health and safety arrangements.
8. Investigate any accident (or incident where personal injury could have occurred) and take appropriate action.
9. Where private vehicles (cars or buses) are used to transport children to and from school functions, staff should ensure that child restraints are used.

NB: When any member of staff considers implementing corrective action, this should first be referred to the Headteacher or Health and Safety Officer for consideration.

Responsibilities of Pupils

All pupils are expected, within their expertise and ability, to:

1. Exercise personal responsibility for the safety of themselves and their fellow pupils.
2. Observe standards of dress consistent with safety and/or hygiene. (this would preclude unsuitable footwear and toys and items deemed dangerous).
3. Observe all safety rules of the school and in particular the instructions of the teaching staff in the event of an emergency.
4. Use and not wilfully misuse, neglect or interfere with things provided for safety purposes.

NB: The Board of Governors and Headteacher will make pupils (and where appropriate parents) aware of these responsibilities through direct instruction and/or notices.

Visitors

Regular visitors and other users of the premises (eg contractors and delivery men) are expiated, as far as is reasonably possible, to observe the safety rules of the school.

Lettings: (See Lettings Policy)

The Board of Governors and Headteacher must ensure that:

1. The means of access and egress are safe for the use of hirers, and that all equipment made available to and used by the hirers is safe.
2. Fire escape routes and exits are clearly marked for the benefit of unfamiliar users of the building, particularly during the hours of darkness.
3. Hirers of the building are briefed about the fire procedures, and receive relevant written instructions
4. Hirers conform with the security arrangements of the school.

Fire and Emergency Evacuation Procedures (See Fire Procedure Document)

1. All staff to be familiar with the Fire Procedure Document.
2. These procedures are updated as appropriate.
3. A log is available for recording and evaluating all practice and evacuation drills, including by video.
4. All staff members to attend fire training at the beginning of the academic year.

Fire Prevention Equipment

1. Arrangements are made to regularly monitor the condition of all fire prevention. equipment. This would include the regular visual inspection of fire extinguishers and the fire alarm system.
2. Weekly random checks of the emergency alarm to be monitored as appropriate.

First Aid and Accident Reporting Procedures (See Medical Procedures)

1. First Aid is available in the Nurse's Room, administered by the School Nurse.
2. An AED is available for use in a public area.
3. Accident reporting procedures as well as other medical related procedures to be kept updated, as appropriate.
4. Arrangements for first aid for sports, outdoor pursuits and field trips are the responsibility of the supervising staff, after consultation with the School Nurse.

To be read in conjunction with the Health and Safety manual.

FIRE DRILL PROCEDURE

(Updated September 2019)

(This document is periodically updated – please consult the most recent version)

MUSTER POINT **A**	Field
MUSTER POINT **B**	Quadrangle
MUSTER POINT **C**	Tennis Courts
MUSTER POINT **D**	Multi-Purpose Hall

IN CASE OF FIRE OR EMERGENCY DIAL 999 AND ASK FOR THE SERVICE REQUIRED.

REMEMBER TO WALK QUICKLY, BUT DO NOT RUN.
PLEASE FAMILIARISE YOURSELF WITH THE LOCATION OF ALARM BUTTONS AND FIRE EXTINGUISHERS IN YOUR TEACHING AREA.

If activated, the fire alarm will sound for a few seconds and then be silenced. There is no need to evacuate at this point. IF the fire alarm is reactivated, then evacuate as per procedure.

On hearing the alarm, teachers should, if there is time, turn off their ACs and shut as many doors and windows as possible. If vacating from the classroom, teachers are to wear the high visibility vest that is stored in the classroom cupboard. Teachers to take class list and green/red cards as they evacuate their rooms. Once the room is evacuated, the white 'class evacuated' card should be left in a visible area. High visibility vests are also located in all shared teaching areas. Teachers must accompany their classes, having made sure no children have remained in the garden, **by the shortest safe route to the area demarcated at the Muster Point**. Muster Point A is to be used unless otherwise stated. Classes should be lined up in silence as denoted by the signs on the walls. This should be done in an orderly fashion, quietly and quickly, but without running. **Special caution should be taken regarding Foundation Stage children. Younger children automatically have right of way.**

Class lists will be printed by the School Office and distributed on the field by Admin Staff **who will be wearing high visibility vests.** The Headteacher's Secretary will then be responsible for helping the General Secretary (also wearing high visibility vest) to check that non class based staff are all present.

On receiving the register sheet, class teachers should check that all pupils are accounted for, **first by a head count**, then by name if a child is missing. Teaching Assistants permanently attached to a teacher/class should remain with the class/year group and be accounted for in the class register. **Phase Leaders are responsible for their team** and should raise their hands to indicate that all are accounted for. The Headteacher will check with KS2 Year Group Leaders. The Deputy Headteacher will check FS and KS1.

Administrative, Specialist and Support Staff should quietly congregate in clearly distinguishable groups. Department Heads should check their staff are present and report to the register holder (General Secretary). Visitors, e.g. parent helpers, should also report to the

General Secretary, who will check their names in the Visitors' Book. Parents, dropping off or picking up children, should also be instructed to go to the muster point. The Headteacher's Secretary will inform the Headteacher when all are accounted for.

BLOCK A
Fire Warden to close all doors and check all toilets.

The Assistant Head will assist any FS class without an Assistant, if necessary.

BLOCK B
Fire Warden to close all doors and check all toilets.

BLOCK C
Fire Warden to close all doors and check all toilets and Presentation and Cookery Room.

PRESENTATION ROOM:
Teacher to accompany children to muster point.

BLOCK D
Fire Warden to close all doors and check all toilets.

BLOCK E
Fire Warden to close all doors and check all toilets.

MUSIC ROOM
The teacher should evacuate all children in this room by the safest route and accompany them to join their year group at the muster point. Children should be made aware of the location of the fire exit. Music staff should muster together with admin and non-teaching staff.

FOOD TECHNOLOGY, LS ROOM AND CLASSROOM
The assistants/teachers should evacuate all children to the muster point.

LIBRARY, SMALL GYM AND COMPUTING ROOM
Library Fire Warden to close all doors and check all toilets.

SWIMMING POOL
Library Fire Warden to check toilets.

Should fire alarm sound during a class changeover period, swimming Assistants to check and take charge of any children remaining in changing rooms, after the majority of the class has left.

MULTI-PURPOSE HALL COMPLEX
Fire Warden to close all doors and check.

Children discovered in toilets or other areas of the school should be escorted or sent to the muster point to join their class.

EXTRA-CURRICULAR ACTIVITY TIME
The rules above apply - except teachers should take with them a register of the children who are attending their activity at that time of day.

ADMINISTRATION AREA
Admin Fire Warden to close all doors and check all toilets.

Headteacher:
The Headteacher should turn off the electricity in the mains cupboard. On field, take charge of KS2.

Deputy Headteacher:
On field, take charge of FS and KS1 children.
The Deputy Headteacher should take control on the field should the Headteacher be elsewhere on the premises.

Assistant Headteacher:
The Assistant Headteacher is to assist any FS class that requires assistance.

It is the responsibility of the AHT to organise the register documents and the Office Staff to take them to the muster point and give them to each teacher.

Office Staff:
The **General Secretary**, wearing a high visibility vest, should account for all non-class based staff and visitors, and inform the Headteacher when all are accounted for.

All Administrative Staff to muster together with other non-teaching staff and Specialist Staff, - Head of Departments to account for their staff.

Nurse
The Nurse is to take charge of any children in the sickbay and take the individual emergency medication with her.

Finance Officer and Assistants:
The Finance Officer and Assistants should lock cash and current receipt books in fireproof safe and assist with distribution of registers as required at the Muster point.

IT Staff:
The IT Staff are to take back-up tape and muster together with other non-teaching staff.

SUPPORT STAFF UNDER DIRECTION OF THE SCHOOL CARETAKER
On alarm sounding, Support Staff should meet at the Gatehouse to note location of fire and get keys **to open** and man gates for emergency services and evacuation if necessary. At least one Support Staff member to go to the scene of the fire together with a member of the Security Staff. One staff member to remain at threat, while the Head Caretaker reports to Gatehouse, the Headteacher and Health and Safety Officer. All other Support Staff to report to the muster point.

SECURITY STAFF
On alarm sounding, Security Staff should cancel the alarm immediately, identify location of fire and send a staff member, who will be assisted by DESS Caretaking Staff, to the location. If an incident has occurred, then re-activate the alarm. This will automatically summons Civil Defence. If a false alarm, then cancel and re-set. Gate barriers to be manned and opened for emergency services and evacuation if necessary. One person to remain at threat, while Head Caretaker reports to Gatehouse, the Headteacher and Health and Safety Officer. Gatehouse to be manned as usual by two guards. If fire occurs after school hours, it is the responsibility of the Security Staff to follow the above guidelines.

RUMAILLAH
All Staff members on site to immediately muster together with Admin and Non-teaching staff where they will be accounted for in the register.

LIAISON WITH FIRE OFFICIALS
The Headteacher/Health and Safety Officer and Head Caretaker should be available to meet and direct Fire Officials.

Our details:
Doha English Speaking School
Zone 35
Al Maarri Street : St 940
Telephone: 44592750

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SITE INFORMATION GUIDELINES

The following guidelines are applicable to all persons using the DESS site.

1. DESS is situated at: Zone 35, Al Maari Street, Fereej Kulaib, Doha. The school main switchboard number is: 44592750. The Security Office can be reached on: 44592758
2. With the exception of the residential area, DESS is a non-smoking site.
3. Reverse parking is required in all demarcated bays.
4. Sufficient access for Civil Defence vehicles in the residential area must be kept open at all times.
5. There are four fire engine hard-standing bays and operational fire hose reels throughout the campus.
6. The fire alarm control panel is located at the Security Gate.
7. Any defective fire control equipment is to be reported immediately to a member of the DESS staff.
8. Visitors need to show Qatar identity if required and should cooperate with the Security Staff.
9. All fire evacuation procedures must be adhered to.
10. Pedestrian crossings are to be used at all times.
11. DESS has disabled parking within the school grounds and ramps to accommodate wheelchairs.

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CHILD PROTECTION POLICY

Purpose

At DESS, we fully recognise the responsibilities and duties placed on us to have arrangements to safeguard and promote welfare of all pupils. We recognise that all staff including volunteers, have a full and active part to play in protecting pupils from harm. We believe that our school should provide a caring, positive, safe and stimulating environment in which pupils can learn and which promotes the social, physical and emotional wellbeing of each individual pupil. The policy has been developed in line with the guidance set out in Every Child Matter's Framework, Working Together to Safeguard Children 2015 and Keeping Children Safe in Education 2015.

The school will raise child protection concerns with parents/carers at the earliest opportunity, and work in partnership with them and other agencies to improve outcomes.

The school will ensure that all the staff are provided with the appropriate training in child protection issues, as recommended in Appendix 4. In particular, the designated members of staff will be released to attend the necessary enhanced training courses to enable them to carry their role out effectively.

All staff are required to read this policy carefully and be aware of their roles in these processes. Staff are also required to read the 'Keeping Children Safe in Education' document (Appendix 4).

This policy, however, is rooted very much in the context of Qatar and subject to Qatari law, customs and support systems.

Aims

- To support children in line with our school mission statement and values.
- To raise the awareness of all teaching and non-teaching staff of the need to safeguard all pupils and of their responsibilities in identifying and reporting possible cases of abuse.
- To provide a systematic means of monitoring students known or thought to be at risk of harm, and ensure we, the school, contribute to assessments of need by providing the necessary support.
- To emphasise the need for good levels of communication between all members of staff in matters relating to child protection.
- To develop a structured procedure within the school which will be followed by all members of the school community in cases of suspected abuse. To ensure that all adults within our school who have substantial access to pupils, have been checked through references and Disclosure and Barring services (DBS).

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Procedures

At DESS we will ensure that:

- All members of staff and the governing body understand and fulfil their responsibilities.
- We will ensure that designated staff attend training every two years and all staff are provided with training every three years as a minimum.
- All staff are familiar with this school's Child Protection Policy as well as the staff code of conduct and these issues are included in the induction for each new staff member. [***CC comment: Query whether this wording needs to be changed. Assume that it is not only new staff members that have a code of conduct.***].
- All staff develop their understanding of signs and indicators of abuse and report any concerns to the designated child protection officer.
- We will ensure that all staff are aware that it is important to identify any concerns about children at as early a stage as possible so that their needs could be identified and monitored and appropriate support put in place.
- All parents/carers are made aware of the responsibilities of staff members with regard to child protection procedures through the publication of the schools' Child Protection Policy on our website.
- Community users organising activities for pupils are aware of the school's child protection guidelines and procedures.
- We will ensure that our selection and recruitment of staff meet the safer recruitment requirements as per our Recruitment and Selection Policy.
- We will ensure that members of the interview panel have completed the Safer Recruitment in Education online course.
- Any visiting professionals or guest speakers will be discussed at leadership level before they can present to a body of pupils. This is to ensure the suitability of the visitor and appropriateness for the age of pupils they will present to.

Our procedures will be regularly reviewed and updated.

Responsibilities

At DESS, the key Designated Child Protection Officer is the Headteacher who has had relevant training.

For any outside agencies using the school premise such as Brownies and private run ECAs, the direct liaison is the Health & Safety Officer who would be responsible for informing the Headteacher as Child Protection Officer. [***CC comment: This is not clear, is the Health & Safety Officer also a Designated Child Protection Officer? The document uses both singular and plural so for consistency it needs to be clear whether there is just one or in fact two.***

***Also the wording of this sentence is not clear (informing the Headteacher of what? What are the outside agencies doing?)*]**.

The Designated Child Protection Officers [***CC comment: query plural***] are responsible for:

- Keeping written records of concerns about a pupil.
- Ensuring that all such records are kept confidentially and securely and are separate from pupil records.
- Ensuring that an indication of further record keeping is marked on the pupil's records.
- Providing advice, guidance and support to staff in child protection matters.
- Organising child protection training for all school staff.
- Providing an annual report for the governing body, detailing any changes and reviews of relevant policy and procedures; training undertaken by the Designated Child Protection Officers [*CC comment: query plural*], and by all staff and governors; number and type of incidents/cases.
- The SENCO (Special Educational Needs Coordinator) [***CC comment: Assume this is a common acronym?***] & School Nurse will support the work of the Designated Child Protection Officers [***CC comment: Query singular/plural***] and attend regular safeguarding meetings.

Supporting Pupils

Our school will support all pupils by:

- Providing the best pastoral care for all pupils – ensuring that pupils know their rights, know the difference between right and wrong and the difference between a good and bad secret.
- Recognising that the needs of the pupils are paramount and underpin all our child protection work and pastoral care.
- Encouraging development of self-esteem and self-assertiveness, through the curriculum as well as our relationships through the school's core values and ethos, whilst not condoning aggression or bullying.
- Liaising and working together recognising that we all have a duty to safeguard and promote the welfare of pupils.
- Providing continuing support to a pupil about whom there have been concerns who leaves the school by ensuring that appropriate information is forwarded under confidential cover to the pupil's new school and ensuring the school medical records are forwarded as a matter of priority.

Confidentiality

- We recognise that all matters relating to child protection are confidential.
- The Designated Child Protection Officers will disclose any information about a

pupil to other members of staff on a need to know basis only.

- All staff must be aware that they have a professional responsibility to share information with the Designated Child Protection Officers in order to safeguard students.
- All staff must be aware that they cannot promise a pupil to keep secrets, which might compromise their safety or wellbeing.
- We will always aim to share our intention to contact the pupil's parents with the pupil before doing so.
- We will always aim to share our intention to contact the Police in suspected criminal cases with the pupil's parents unless to do so could put the pupil at greater risk of harm, or impede a criminal investigation.

Supporting Staff

- We recognise that staff working in the school, who have become involved with a pupil who has suffered harm, or appears to be likely to suffer harm, may find the situation upsetting.
- We will support such staff by providing an opportunity to talk through their anxieties with one of the Designated Child Protection Officers and to seek further support as appropriate.

Dealing with disclosure of abuse

If a pupil discloses abuse to a member of staff, the member of staff must do the following:

- Explain that if you are concerned about what they have disclosed then you have to report it (no secrets).
- Reassure them that you are doing this to help and support them and that you are taking what they are telling you seriously.
- Allow the pupil to speak and listen to what they are telling you without interrupting.
- Do not press for details or ask leading questions.
- Only ask the minimum number of clarifying questions necessary to establish understanding of the concerns.
- Do not ask to see any injuries.
- If you can, write brief notes of what they are telling you, while they are speaking. These may help later, if you have to remember exactly what was said. Keep your original notes, however rough they are. It is what you write at the time that may be important later, not a tidier and improved version you write up afterwards. If you do not have the means to write at the time, make notes of what was said as soon as possible afterwards.
- Do record date, time, place and exact words used.
- Record all subsequent meetings with the pupil.

- Report the concerns to the pupil's Head of Year or the Designated Child Protection Officers – do not attempt to investigate the concerns yourself.
- If reports of concern are passed to any member of staff within the school, the Year Group Leader should consult with the Designated Child Protection Officers for guidance to determine if the pupil is at risk of significant harm.
- If there is concern that the pupil is at risk of significant harm, the Designated Child Protection Officers should report to the Chair of the Board of Governors.
- In cases where criminal acts are involved or suspected the Headteacher will speak with the Chair of the Board of Governors in order to agree relevant action. The options available in Qatar are:
- **Phone hotline – 919 – to ensure this is solved amicably**
- **Contact capital police – formal investigation – 44521111**
- **Phone paediatric social worker – 66667725 (adult social worker)**
- **Investigation through the paediatric care centre on Al Saad – legally not required to get the parent's permission**
- **Social workers at Family Therapy First**

  Tel: 4456 5800

  Fax: 4466 6607

  Email to: h.alchegab@Qfpsr.qa

Allegations against staff

- All school staff should adopt safe working practices when working with pupils.
- Avoid one to one situations where possible.
- Be visible if you are in the situation where you are working alone with pupils (let someone know where you are, who you are with and why, and for how long).
- Avoid unnecessary physical contact.
- Ensure all contact during lessons is appropriate, visible and in context.
- Adopt discretion with distressed pupils.
- Maintain appropriate communication with pupils both in and out of school.
- Staff must not have pupils as 'friends' via any social media or social networking site.
- If an allegation against a member of staff is made [***CC comment: Not clear what "such an allegation is"***] directly by a pupil to a staff, the staff receiving the allegation will immediately inform the key Designated Child Protection Officer- the Headteacher.

The Designated Child Protection Officers will then investigate the allegations to establish:

Who made the allegation?

The nature of the allegation
Where and when the alleged incident took place
Who was involved?
Whether there were any witnesses

- All allegations made against members of staff will be reported to the Headteacher.
- The member of staff against whom the allegations have been made, may be suspended (with pay) pending investigation, in order to protect all parties involved.
- If the outcome of the investigation establishes that abuse has occurred, due to failure to meet applicable professional standards, the member of staff involved shall be dealt with through the school's Disciplinary policy [***CC comment: Assume this is the name of a document-yes)***.
- If the allegation made to a member of staff concerns the Headteacher, the person receiving the allegation will immediately inform the Chair of the Board of Governors who will then investigate the allegations.
- In the event of an allegation against the Headteacher, the decision to suspend will be made by the Chair of Governors and transferred to the Embassy.

Whistleblowing (confidential reporting)

- All staff should be aware of their duty to raise concerns, where they exist, about the management of child protection, which may include the attitude or actions of colleagues. If necessary, they should speak with the Headteacher or the Chair of the Board of Governors.

Anti-Bullying policy

- Our Anti-Bullying policy is set out in a separate document and acknowledges that to allow or condone bullying may lead to consideration under child protection procedures. This includes homophobic, gender related and racist bullying. The school delivers a zero tolerance approach to all forms of bullying including verbal, physical and cyber.

Prevention

- We recognise that the school plays a significant part in the prevention of harm to our pupils by providing pupils with good lines of communication with trusted adults, supportive friends and an ethos of protection.

The school community will therefore:

- Establish and maintain an ethos where pupils feel secure and are encouraged

to talk and are always listened to.

- Ensure that all pupils know there is an adult in the school whom they can approach if they are worried or in difficulty.
- Include opportunities, across the curriculum, including and particularly within PSHE education, which equip pupils with the skills they need to stay safe from harm and to know to whom they should turn for help.

Other Relevant policies

- Our **Recruitment and Selection policy**, set out in a separate document, reflects the consideration we give to the protection of our pupils during the recruitment and selection of staff to work at the school.
- Our **Standards of Conduct policy** for staff, set out in a separate document, reflects the consideration we give to the protection of our pupils by setting out the standards of conduct and behaviour expected of our staff both within school and in the wider community.
- Our **Health & Safety Policy**, set out in a separate document, reflects the consideration we give to the protection of our pupils physically within the school environment.
- Our **Trips and Visits** policy, set out in a separate document, reflects the consideration we give to the protection of our pupils when away from the school when undertaking school trips and visits.
- Our **IT Acceptable Use policy**, set out in a separate document, reflects the consideration we give to the protection of our pupils whilst accessing and using the school's ICT resources.

Record of revisions to Policy

Revision Date	Description	Sections Affected

Appendix 1 –Type of Abuse

Child abuse is taken to refer to any child of under 18 years who, through the actions of adults (with a caring role for that child) or their failure to act, has suffered or is at risk of suffering significant harm.

Abuse is broadly divided into four categories:

- Physical Abuse
- Sexual Abuse
- Emotional Abuse
- Neglect

A child can be at risk from any combination of the four categories.

Physical Abuse

This involves physical injury to a child, including deliberate poisoning, where there is definite knowledge or a reasonable suspicion, that the injury was inflicted or knowingly not prevented.

Typical signs of Physical Abuse:

- Bruises and abrasions - especially about the face, head, genitals or other parts of the body where they would not be expected to occur given the age of the child. Some types of bruising are particularly characteristic of non-accidental injury especially when the child's explanation does not match the nature of injury or when it appears frequently.
- Slap marks - these may be visible on cheeks or buttocks.
- Twin bruises on either side of the mouth or cheeks - can be caused by pinching or grabbing, sometimes to make a child eat or to stop a child from speaking.
- Bruising on both sides of the ear - this is often caused by grabbing a child that is attempting to run away. It is very painful to be held by the ear, as well as humiliating and this is a common injury.
- Gripping bruises on arm or trunk can be associated with shaking a child. Shaking can cause one of the most serious injuries to a child, i.e. a brain haemorrhage as the brain hits the inside of the skull. X-rays and other tests are required to fully diagnose the effects of shaking. Grip marks can also be indicative of sexual abuse.
- Black eyes - are most commonly caused by an object such as a fist coming into contact with the eye socket. N.B. A heavy bang on the nose however, can cause bruising to spread around the eye but a doctor will be able to tell if this has occurred.
- Damage to the mouth - e.g. bruised/cut lips or torn skin where the upper lip joins the mouth.
  Bite marks, poisoning and other misuse of drugs - e.g. overuse of sedatives.

Burns and/or scalds - a round red burn on tender, non-protruding parts like the mouth, inside arms and on the genitals will almost certainly have been deliberately inflicted. Any burns that appear to be cigarette burns should be cause for concern.

Some types of scalds known as 'dipping scalds' are always cause for concern. An experienced person will notice skin splashes caused when a child accidentally knocks over a hot cup of tea. In contrast a child who has been deliberately 'dipped' in a hot bath will not have splash marks.

Sexual Abuse

Involves forcing or enticing a child or a young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape) or non-penetrative acts. They may include non-contact activities or encouraging children to behave in sexually inappropriate ways.

Typical signs of Sexual Abuse are:

- A detailed sexual knowledge inappropriate for the age of the child.
- Behaviour that is excessively affectionate or sexual towards other children or adults.
- Attempts to inform by making a disclosure about the sexual abuse often begin by the initial sharing of limited information with an adult. It is also very characteristic of such children that they have an excessive pre -occupation with secrecy and try to bind the adults to secrecy or confidentiality.
- A fear of medical examinations.
- A fear of being alone - this applies to friends / family / neighbours / baby-sitters, etc.
- A sudden loss of appetite, compulsive eating, anorexia nervosa or bulimia nervosa.
- Excessive masturbation.
- Promiscuity.
- Unusually explicit or detailed sex play in young children.
- Sexual approaches or assaults - on other children or adults.
- Pregnancy, urinary tract infections (UTIs), sexually transmitted infections (STIs) are all cause for immediate concern in young children, or in adolescents if his / her partner cannot be identified.
- Bruising to the breasts, buttocks, lower abdomen, thighs and genital / rectal areas.
- Bruises may be confined to grip marks where a child has been held so that sexual abuse can take place.
- Discomfort or pain particularly in the genital or anal areas.
- The drawing of pornographic or sexually explicit images.

Emotional Abuse

The persistent ill treatment of a child, such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate or valued only insofar as they meet the needs of the other person. It may feature age or developmentally inappropriate expectations

being imposed on children. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill treatment of a child although it may occur alone.

It is important to recognise that many children will be living (or may have lived) in families where domestic abuse is a factor, and that these situations have a harmful impact on children emotionally, as well as placing them at risk of physical harm.

The following may be indicators of emotional abuse:

- Developmental delay
- Abnormal attachment between a child and parent/carer e.g. anxious, indiscriminate or no attachment
- Aggressive behaviours towards others
- Scape-goated within the family
- Frozen watchfulness, particularly in pre-school children
- Low self-esteem and lack of confidence
- Withdrawn or seen as a 'loner'-difficulty relating to others
- Over-reaction to mistakes
- Fear of new situations
- Inappropriate responses to painful situations
- Neurotic behaviours
- Self-harming
- Running away

Neglect

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. It may involve a parent or carer failing to provide adequate food, shelter or clothing, failing to protect a child from physical harm or danger or the failure to ensure access to appropriate medical care and treatment. It may also include neglect of, or unresponsiveness to a child's basic emotional needs.

Typical signs of Neglect are:

- Underweight: a child may be frequently hungry or pre-occupied with food or in the habit of stealing food or with the intention of procuring food. There is particular cause for concern where a persistently underweight child gains weight when away from home, for example, when in hospital or on a school trip. Some children also lose weight or fail to gain weight during school holidays when school lunches are not available and this is a cause for concern.
- Inadequately clothed [***CC comment: suggest reword***] where the lack of care is preventing the child from thriving.
- Neglect is a difficult category because it involves the making of a judgment about the seriousness of the degree of neglect. Much parenting falls short of the ideal but it may be appropriate to invoke Child Protection Procedures in the case of Neglect where the child's development is being adversely affected.

The Symptoms of Stress and Distress

When a child is suffering from any one or more of the previous four 'categories of abuse', or if that child is 'at risk', they will nearly always suffer from/display signs of stress and distress.

An abused child is likely to show signs of stress and distress as listed below:

- A lack of concentration and a fall-off in school performance.
- Aggressive or hostile behaviour.
- Moodiness, depression, irritability, listlessness, fearfulness, tiredness, temper tantrums, short concentration span, acting withdrawn or crying at minor occurrences.
- Difficulties in relationships with peers.
- Regression to more immature forms of behaviour, e.g. thumb sucking.
- Self-harming or suicidal behaviour.
- Low self-esteem.
- Wariness, insecurity, running away or truancy - children who persistently run away from home may be escaping from sexual/physical abuse.

Parental Signs of Child Abuse

Particular forms of parental behaviour that could raise or reinforce concerns are:

- Implausible explanations of injuries.
- Unwillingness to seek appropriate medical treatment for injuries.
- Injured child kept away from school until injuries have healed without adequate reason.
- A high level of expressed hostility to the child.
- Grossly unrealistic assumptions about child development.
- General dislike of child-like behaviour.
- Inappropriate labelling of child's behaviour as bad or naughty.
- Leaving children unsupervised when they are too young to be left unattended.

Appendix Two – Cause for Concern form

Cause for Concern

Name of child: Date:

Class:

Details of Concern
Reported to:
Actions:

Teacher/Staff member: _____

Appendix Four

Every Child Matters Framework

https://www.education.gov.uk/consultations/downloadableDocs/EveryChildMatters.pdf

Keeping Children Safe in Education

DfE Statutory guidance issued April 2015

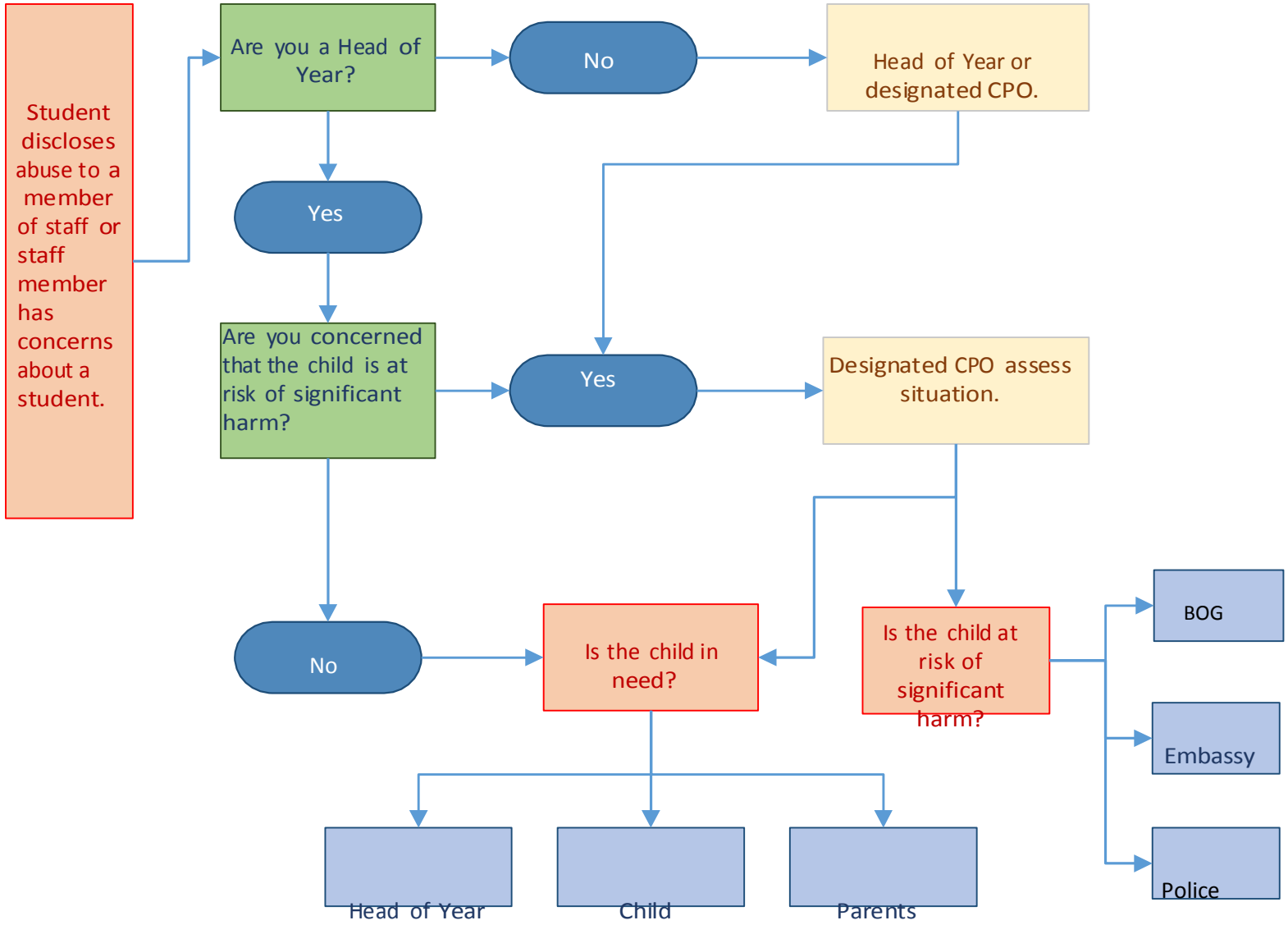
www.gov.uk/government/publications/keeping-children-safe-in-education--2

Working Together to Safeguard Children 2015

DfE Statutory Guidance on inter-agency working to safeguard and promote the welfare of children.

www.gov.uk/government/publications/working-together-to-safeguard-children--2

Appendix Three – Dealing with a disclosure – process flow (September 2016)



October 2019

HEALTH AND NURSING GUIDELINES

At DESS the health and safety of our pupils and staff are of upmost importance. These guidelines and the attachments have been developed to ensure that health needs are met with up-to-date evidence and research based guidelines, information and advice.

Statement of Intent

DESS is committed to:

- Ensuring pupils and staff have access to a health care professional (Registered Nurse) throughout the hours of the school day.
- Ensuring first aid guidelines and information sheets are up-to-date and evidence based.
- Providing basic care to injured and unwell children and staff.
- Offering health advice and health promotion information as appropriate
- Adhering to guidelines and policies of the Supreme Council of Health, Qatar.

The Nurse

The Nurse's room is located next to the Accounts office in the main reception. The Nurse can be found here from 7am until 2pm Sunday to Wednesday and 7am to 1pm on a Thursday. If the Nurse is not available, firstly a supply Registered Nurse should cover. In the rare event of one not being available a trained first aider will be assigned to cover the position. This decision will be made by a member of the Senior Management Team. A list of trained first aiders can be found in the Nurse's room and on the staff information board located in the staff room.

If the Nurse is not in the Nurse's room then the office should be informed and it will ring the Nurse's mobile.

If a child is to be left unattended when the Nurse is called away then a First Aider will be informed to keep watch over the child until the Nurse returns.

For access to the Nurse's room after hours, spare keys for the Nurse's room and medicine cupboards are kept in the General Office. Access can be gained through Security and the Caretaker.

The Nurse will adhere to the confidentiality guidelines of the school and follow the Nursing and Midwifery council (UK) code of conduct for nurses and midwives.

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Infection Control

Hand washing is the single most effective measure in preventing the spread of disease. Hand washing should be promoted throughout the school by both discussing the importance of hand washing and demonstrating the correct techniques.

Children and staff should ensure that hands are washed before and after eating and using the toilet. Younger children should be supervised and aided in washing their hands by staff at school. A hand sanitizer is available in the foyer.

Medical Waste and Sharps will be collected by United Medical Waste Management W.L.L. All waste should be stored and packaged in approved waste containers and labelled as per national guidelines by the MOPH.

Unwell or Injured child at school.

The Nurse will provide nursing care as appropriate to unwell students.

To limit unnecessary visits to the Nurse, children must have a pass showing that the teacher or TA has given permission to go. All teachers, including specialists will be provided with labelled passes. At break time 4 first aid bags are available for the teachers/ TAs on break duty within these, there are passes.

When a child is unwell or injured at school, the Nurse will be responsible for their care until a parent/guardian or trained health care professional arrives to take over the care.

The Nurse will not diagnose conditions or illnesses.

For a medical diagnosis, the student's parents or Staff members should consult a Doctor.

Reporting Procedure

All care provided by the Nurse will be documented in the Engage system school database under First Aid. If electronic recording is not possible for any reason a written copy will be completed in the Nurse's diary.

Any serious accident/ incident will be recorded on the system plus the Assistant Headteacher will be notified and an Accident form completed.

When a child is assessed by the Nurse as too unwell to remain at school, the parents will be contacted to collect their child. It may be advised to see a Doctor or healthcare practitioner.

In the event of an emergency, an ambulance and parents will be contacted immediately.

Head Injury

In the event of a pupil receiving a head injury the Nurse will:-

- Assess conscious level
- Control any bleeding/clean wound as appropriate
- Record heart rate, respiration and pupil reaction
- Observe for headache, sensitivity to light, memory loss, agitation, loss of concentration, lethargy, tiredness and dizziness

Following assessment, the Nurse will plan care appropriately.

Following the incident, the Nurse will contact the parent with written information.

Medications for children

Medications of any form will not be given to a child without parental/guardian consent. On admission to the School a pupil health record form is completed. This form includes parents' authorisation regarding certain “over the counter” medications

A basic stock of “over the counter” medications will be kept in the Nurse’s room. They are kept in locked cupboards labelled 1, and 2 or refrigerator as appropriate. The keys are with the Nurse and a spare set is kept in the General Office.

Individual student's medications are kept in locked cupboard 1. Asthma inhalers are kept in cupboard 3. These medications are reviewed termly by the Nurse.

Any medication brought into school should include the following information:-

- Student’s name
- Student’s class
- Condition for which the medication is administered
- Dose of the medication
- Route of the medication
- Time of the medication

Epipens for children and staff

Epipens and health care plans are to be kept in the First Aid unit. The First Aid unit is to remain unlocked until after School Run ECAs are completed. Sunday – Wednesday (15:30) and Thursdays (14:30)

Parents are responsible for providing an Epipen and procedures to outside school club providers. A spare Epipen is kept in the First Aid Unit.

All Staff are to be aware of children at risk, and should have completed Anaphylaxis training.

DESS will ensure that all staff are familiar with the use of Epipens.

In the event of an anaphylaxis episode, the following protocol is to be followed:

- Patient is not moved.
- Epipen is collected and administered.
- Ambulance is called.
- Parents are called.
- A second dosage may be given after 5 minutes.
- CPR is administered if necessary.

Patient must be accompanied by a DESS staff member to hospital.

Child's individual health care plans

A pupil health record assessment form should be completed by the child's parents upon application to the school. This will be assessed by the Nurse.

If appropriate the Nurse will liaise with the parents regarding the care of the child whilst at school.

A list of children's medical conditions, treatments, medication and allergies will be produced by the Nurse. This will be reviewed at the start of the school year and up dated as changes occur. This will be emailed to teaching staff at the start of the school year, a hard copy is kept in the Nurse's room (not on public display) and in the Medical file in the staff room (not on public display).

The Nurse will oversee the care of the child with complex medical needs, (e.g diabetic, severe allergy) with the collaboration of the parents and child. From this an Individual Care Plan will be agreed. These plans will be given to the individual class teacher and Year Group leader. They will also be placed with the list of medical conditions in the Nurse's room and staff room.

School Trips.

First aid bags will be provided by the Nurse for school trips. If a child with special medical needs, (eg Diabetes, severe allergy, asthma) is attending then the Nurse will liaise with both parents and Staff to discuss how the child's condition will be managed whilst off the school premises. A registered First Aider should be on every trip.

Calling an Ambulance

If an incident occurs when an ambulance is required the following should be undertaken:-

- Nurse informed of incident
- Patient assessed by Nurse and decision whether to call ambulance made
- Ambulance called by Nurse or designated person with all relevant information
- Head/Assistant Head informed that an ambulance has been called
- Parent/Guardian informed that an ambulance has been called and information given about the nature of the incident. The Nurse's mobile telephone number will also be given to the parent/guardian

- The Nurse will remain with the student until the ambulance arrives
- The Nurse will give a clear and concise medical handover to the EMS including treatment and medication given, times and doses
- If the ambulance arrives prior to the parent/guardian the Nurse will travel in the ambulance with the casualty and stay with them until the parent/guardian arrives
- Following the event the Nurse will complete all necessary paperwork and debrief staff as appropriate

Healthy Eating

At DESS we are very keen for the children to understand the importance of healthy eating. We encourage a healthy snack that includes 2 pieces of fruit or vegetables amongst other nutritional food. We are a **nut free zone** and children are not allowed any nut products in their snack at any time, as we have children with severe allergies to nuts. Chocolate bars, sweets as well as fizzy drinks are not allowed.

P.E and Swimming

Where possible we encourage all children to participate in PE and swimming as it is an important part of their curriculum.
If a parent does not wish their child to do PE or swimming then a medical (Doctor's) note must be provided to the Nurse. If a note is not produced then the parent and child will be directed to speak to the Nurse. A decision as to whether the child should swim will be made based on the information provided by the parent and the clinical assessment carried out by the Nurse.

Staff Health

The Nurse will provide nursing care as appropriate to unwell staff.

The Nurse may keep a private log of any visits/ health checks conducted on staff members. This is to ensure the safety and continuity of care the Nurse is providing.

The following medications are available for staff use:-

- Paracetamol tablets 500mg
- Brufen tablets 200mg
- Loratadine 10mg
- Loperamide 2mg
- Throat lozenges
- Antacids

Medical Equipment

The Nurse will ensure all medical equipment (Oxygen, thermometer, AED, BM machine) are in good working order and are maintained as per manufacturer's instructions.

DESS Guidelines

The following guideline can be found on the DESS website and in this manual:-

- A.E.D. (Automated external defibrillator)

Common Ailment Information and Advice Sheets

Advice sheets can be found on the DESS website and in this manual about the following:-

- Asthma
- Athletes foot
- Chicken Pox
- Croup
- Diarrhoea and Vomiting
- Hand, Foot and Mouth disease
- Head Lice
- Impetigo
- Infection Control
- Measles
- Moving and Handling
- Ringworm
- Scarlett fever
- Seasonal Flu
- Threadworms
- Warts and Verruca’s
- Pool Chemicals

September 2019

AED Guidelines

Introduction

We aim to ensure the safe keeping and use of the Automated External Defibrillator (AED). An AED is a device which delivers an electric shock to a person who has suffered a sudden cardiac arrest. Sudden Cardiac Arrest (SCA) is a condition that occurs when the electrical mechanism in the heart fails, causing the heart to malfunction and alter the heart's rhythm. An AED will analyse the heart rhythm through electrodes placed on the person's chest and will decide upon appropriate action.

Responsibilities

The School Nurse

- Ensures the safe keeping of AED whilst she is on site
- Maintains adequate system checks
- Reviews and approves guidelines for emergency procedures/CPR and AED.

Office Staff

- Be familiar with the location of the AED (Foyer)
- Deploy AED trained staff to the location of patient
- Assist and delegate roles in an emergency, i.e. making 999 calls
- Liaise with patient's next of kin
- Meet the Emergency team upon their arrival

Trained AED users

- Ensure that they fully understand the training given
- Can provide basic life support/assist Nurse
- Be familiar with the location of the AED
- Must be prepared to be called in event of an emergency

Equipment

- AED to be in a location that is easy to access and well known
- AED to be brought to all medical emergencies
- Oxygen cylinder and mask to be found in Nurse's Room

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AED Procedure

Approach the patient using:
ABC
Airway, Breathing, Circulation

If the patient is not breathing please check airway is open.
If still not breathing please attach oxygen mask on highest flow.
OXYGEN CYLINDER LOCATED IN NURSE'S ROOM WITH INSTRUCTIONS

CIRCULATION- If a pulse is not detected:
Please locate the AED
If Pulse found please lay patient in RECOVERY POSITION and call 999. Constantly assess patient.

Open the AED bag and leave AED in plastic cover
Plug in electrode pads
Children under 8 years use PAEDIATRIC
Adults and children over 8 years use ADULT

Please remove any clothing from the upper body
Males- please remove any chest hair with razor provided, take as little time as possible (in areas pads are applied)
Females- Please remove bra
Please dry patient if body is wet, as quick as possible
PLACE PADS AS SHOWN ON PACKAGING
Switch the device on (press button briefly!)

DOHA ENGLISH SPEAK

September 2019

Asthma Information Sheet

What is Asthma?

Asthma is a condition which involves narrowing of the airways, which we use to pass oxygen in and out of the body. Asthmatics can suffer intermittent attacks of wheezing and shortness of breath that can vary in severity. Asthma can develop at any age, but is more likely to develop in childhood and can progress into adulthood. Some of the main triggers and causes for asthma are listed below:

- Allergies usually to pets/dust/pollen.
- Colds and infections.
- Exercise.
- Laughing and excitement, especially in children.
- Emotional stress, crying for long periods of time.
- Family history of disease, especially parents and siblings.
- Eczema or allergies in siblings.
- Smokey environments, e.g. if a parent smokes in the house.
- Environmental factors.

Physiology of Asthma:

- Muscles around the airway walls tighten and become narrower.
- Lining of airways becomes inflamed and begins to swell.
- Sticky phlegm and mucous can build-up and can cause narrowing.

What happens in a mild attack of asthma?

- Wheezing
- Coughing
- Tight feeling in the chest
- Shortness of breath and gasping

What happens in a severe asthma attack?

- All of the above symptoms
- Difficulty in talking
- Blue/grey fingernails (not enough oxygen to the cells)
- Stomach seems to be moving erratically (this is known as using your accessory muscles as an attempt to draw in air)
- Very wide nostrils
- Racing pulse

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Diagnosis

Diagnosis should be made through a medical professional in order to gain the appropriate treatments. Diagnosis is usually based on the symptoms described and through peak flow measurements (blowing into a meter to test lung's capacity to exhale).

Treatments

The most effective treatment is using inhalers. Some people need to take inhalers when they are wheezy, others require a regular, preventative inhaler taken everyday, as well as one to relieve immediate symptoms of asthma. There are many types of inhalers available. Your doctor will be able to prescribe the one that is most suitable.

Prognosis

Asthma is a manageable condition and children can grow out of it into their teenage years, some have asthma into adulthood. Children should be able to participate in physical activity and sport as normal. It is important to understand that an asthma attack can be life-threatening and the child should be taken to hospital immediately if they do not respond to their inhalers. It is advised that you be cautious and try not to expose your child to any of their trigger factors, such as pollen and animal hair.

Further information can be found www.nhs.uk/conditions/asthma

September 2019

Athlete's Foot Information Sheet

What is Athlete's foot?

Athlete's foot is a fungal infection of the foot and the toes. The medical term for this is Tinea Pedis. It is quite infectious and can affect anybody, but typically occurs in teenagers and male adults. The fungi like to live in warm, dark and humid environments, often affecting those who participate in sporting activities, hence the common name Athlete's foot. The initial infection lasts 1-10 days, but if untreated the infection can become persistent and last for months.

What are the symptoms?

- Itchy, scaly, dry rash on sides/bottom and in between toes.
- Inflammation/blisters on soles of feet.
- Cracking and raw skin tissue on soles causing pain and swelling.
- Toenail infection can be present.

How is Athlete's foot transmitted?

- Bare feet come into contact with fungus.
- Warm and damp environments encourage fungal growth.
- Infection can be spread through contaminated clothing and bed sheets.

What are the treatments for Athlete's foot?

- Wash feet frequently and dry them thoroughly between the toes.
- Change socks daily.
- In severe cases, doctor may prescribe creams and lotions that kill fungi.
- Early treatment is necessary to prevent infection spreading to the toe nails. If this occurs then the infection becomes harder to deal with.

Prevention

- Wash feet daily and dry them carefully, especially between toes.
- Avoid tight footwear, especially in hot weather.
- Reduce foot perspiration by using talcum powder.
- Change socks frequently, cotton socks are best, especially if you tend to sweat heavily.

Further information can be found at www.nhs.uk/conditions/athletes-foot

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September 2019

Chickenpox (Varicella) Information Sheet

What is Chickenpox?

Chickenpox is a mild disease that most children will catch at some point. It is highly contagious and usually affects many children at the same time, especially in nurseries and schools. Chickenpox is most common between the ages of 2 and 8, although it can also infect adults who have never been exposed to the disease. The Chickenpox vaccine only generally ensures approximately 80% immunity rate in any child that takes the vaccine.

What are some of the common Symptoms?

- Small red spots at start, leading to:
- Many blisters, which burst and crust over into scabs
- New blisters may occur 3-6 days after the first blisters
- Usually very itchy
- Commonly starts on the face and trunk and later the limbs and scalp
- High temperatures
- Cold-like symptoms

How is it transmitted?

- Direct person to person contact
- Airborne droplets from coughing/sneezing
- Contact with infected articles e.g. bedding and clothing
- Infection occurs from airborne droplets before any rash appears

Diagnosis

There is no need for any laboratory testing. A doctor can diagnose chickenpox from clinical symptoms.

How is it treated?

- Treatment mostly consists of easing the symptoms
- Stop the infected person from scratching as this could cause infection
- Calamine lotion will help relieve itching
- No need for antibiotics as it is a viral infection
- Treat the fever with a Paracetamol or Brufen based medicine.

Please keep your children away from school until the last blister has formed a scab, approximately 5-10 days after the rash first appeared.
Further information can be found at www.nhs.uk/conditions/chickenpox

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September 2019

Common Childhood Minor Ailments

Headaches

Headaches are one of the most common medical complaints in the world. However, nearly all headaches are not serious and can easily be treated. Dehydration is a common cause of headaches for school aged children.

Further information can be found:

http://www.nhs.uk/conditions/Headache/Pages

Earache

Earache is a common complaint in young children and is often related to an ear infection, although can be related to other conditions such as, tonsillitis, dental abscess, teething and the common cold. Most earaches improve in a few days. However, it is advisable to see a GP if there is a fever, swelling, fluid coming from the ear or changes in hearing.

Further information can be found:

https://beta.nhs.uk/conditions/earache

Stomach Ache

Stomach ache in children are common and usually don't last long. Possible causes in children include constipation, urinary tract infections, gastroenteritis, trapped wind and heartburn. Encouraging a healthy diet with plenty of fresh fruit and vegetables can eliminate some of the causes of stomach ache.

Further information can be found:

http://www.nhs.uk/conditions/stomach-ache-abdominal-pain/Pages

Toothache

Toothache can be experienced in many ways. It may come and go or be constant. It may be worsened with cold or hot drinks. It may be felt as a sharp pain or dull ache. Toothache can also be related to other illnesses, for example, sinusitis. If the symptoms of toothache last more than a couple of days it is important to see a Dentist for a checkup.

Further information can be found:

http://www.nhs.uk/conditions/Toothache/Pages

Fever

A fever is a high temperature greater than 38C (100.4F). It is the body's response at fighting infections and the high body temperature makes it difficult for viruses and bacteria to survive. Fevers can be controlled with the use of cooling methods (wearing light, loose clothing) and Paracetamol.

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Common childhood conditions that can cause fevers are:

- Respiratory tract infections
- Urine infection
- Ear infection
- Chicken Pox
- Tonsillitis
- Common cold/Flu

Further information can be found:

http://www.nhs.uk/conditions/feverchildren/Pages

Dizziness and Fainting

Dizziness means different things to different people. Some use it to describe feeling off balance or that the room is spinning. Some use it to describe feeling light headed.

Fainting (syncope) is a sudden loss of consciousness resulting in a fall, lasting a few seconds to a couple of minutes. Some people experience warning signs prior to a fainting episode which include:

- Feeling clammy
- Feeling sick
- Feeling light headed
- Blurred vision or spots in front of the eyes
- Ringing in the ears

Most causes of dizziness and fainting are not a cause for concern but it is recommended to seek medical advice if episodes are recurrent.

Further information can be found:

http://www.nhs.uk/conditions/Fainting/Pages

Conjunctivitis

Conjunctivitis, also known as pink eye or red eye, can affect one or both eyes. It can make the eyes feel:

- Feel gritty and itchy
- Make the eyes feel like they are burning
- The eyes will become red and blood shot
- The eyes will produce pus that sticks to the eyelashes.

Conjunctivitis can be highly contagious so it's important to seek medical advice. Further information can be found:

https://beta.nhs.uk/conditions/conjunctivitis

Burns and Scalds

Burns and scalds are damage to the skin caused by heat.

A burn is caused by dry heat, for example, an iron or a fire and can be very painful causing blisters, peeling skin, swelling and charred skin.

A scald is caused by something wet, for example, hot water or a hot glue gun and can also be very painful.

First aid for burns and scalds are:

- Remove the burn from the heat
- Cool the burn under cool/lukewarm running water ***for 20 mins. DO NOT USE ICE, CREAMS OR BUTTER.***
- Remove any items of clothing or jewelry close to the burn but do not attempt to remove anything that is stuck to the burn.
- Keep the person warm taking care not to rub the burn
- Cover the burn with cling film or a plastic bag.
- Use painkillers such as Paracetamol or Ibuprofen for pain
- ***DO NOT BURST BLISTERS***
- ***Seek medical advice immediately for any serious burns.***

Further information can be found:

http://www.nhs.uk/conditions/Burns-and-scalds/Pages

Allergies

An allergy is where the body reacts to a particular substance or food. Substances that cause allergic reactions are called allergens. Allergies are very common in children and most children outgrow their allergies by adulthood.

Common allergens include:

- grass and tree pollen – an allergy to these is known as hay fever(allergic rhinitis)
- dust mites
- animal fur
- food – particularly nuts, fruit, shellfish, eggs and cow's milk
- insect bites and stings
- Medication – including ibuprofen, aspirin, and certain antibiotics.

Symptoms of an allergic reaction can include:

- a blocked nose
- sneezing
- itchy, watery eyes
- red itchy rash including hives or welts
- wheezing and coughing
- exacerbation of asthma and eczema symptoms

Most allergic reactions are mild and can be managed without treatment. However sometimes it is necessary to take an antihistamine to control minor allergy symptoms. Occasionally, some people develop a severe reaction to an allergen called

anaphylaxis which can result in an ***anaphylactic shock***. This is a ***medical emergency*** and needs urgent treatment.

Further information can be found:

http://www.nhs.uk/conditions/Allergies/Pages

September 2019

Common Childhood Skin Ailments

Insect Bites & Stings

Most insect bites and stings are not serious and symptoms will improve within a few hours or days.

Occasionally they can cause a serious allergic reaction (anaphylaxis), become infected or spread disease such as Lyme disease or Malaria.

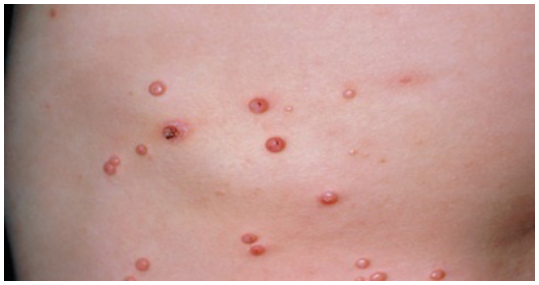
Further information on symptoms and treatment can be found: http://www.nhs.uk/conditions/Bites-insect/Pages

Molluscum Contagiosum

Molluscum contagiosum (MC) is a viral skin condition that mainly affects children but can occur at any age.

It is a harmless condition but can take up to 18months to clear. The small, firm raised spots normally develop in clusters.

Swimming may continue provided the child wears a rash vest or a suitable waterproof dressing.



Further information on MC can be found: http://www.nhs.uk/conditions/Molluscum-contagiosum/Pages

Skin Rashes in children

Skin rashes are common and often not a cause for concern. Most are harmless and disappear on their own. However, if your child seems unwell or has a temperature, then see your G.P for advice.

The most common rashes seen at school are:

Eczema
Chickenpox
Prickly Heat
Impetigo
Hand foot and mouth disease

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Ringworm
Scarlett Fever
Slapped Cheek
Hives (Urticaria)
Athlete's foot

Further information can be found:

http://www.nhs.uk/conditions/skin-rash-children/Pages

Cuts and Grazes

Most cuts and grazes are minor and can easily be treated. They should heal within a few days.

Minor cuts and grazes can be cleaned with clean running tap water. Avoid using antiseptics and cover with a dry dressing.

Further information can be found: http://www.nhs.uk/conditions/Cuts-and-grazes/Pages

September 2019

Croup Information Sheet

What is Croup?

Croup is a condition that develops quickly in children generally under the age of five. Croup is caused by a viral infection of the upper airways, throat and surrounding tissue. A barking cough is the obvious sign of Croup.

How do you get croup?

The virus that will cause croup can be transmitted from person to person through airborne droplets from sneezing and coughing.

Signs of Croup

- Rough/barking cough
- Hoarseness and noisy breathing

Symptoms seem to be worse at night when the child has been lying down for some time.

What should you be especially aware of?

- Your child becomes very tired
- Difficulty in breathing
- Blueness around mouth, nose and nails

What can you do?

- Calm the child as much as possible
- Keep calm yourself- show no anxiety to your child
- Sit your child upright to ensure maximum lung capacity
- Inhaling steam may help- simple to do if you run a hot bath in a closed bathroom
- Avoid heavy meals as coughing may lead to vomiting
- Encourage the child to drink plenty of fluids
- Treat a fever with paracetamol/brufen products and remove excess clothing

Treatment

Viral infections cannot be treated with antibiotics.

Serious cases may be admitted to hospital for further treatment.

Prognosis

Croup usually clears up in 3-4 days on its own. The coughing may last sometime longer though. Symptoms usually worsen when the child is in bed.

Children who have had croup in the past may develop it again when they have a cold.

Further information can be found at www.nhs.uk/conditions/croup

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September 2019

Diarrhoea and Vomiting Information Sheet

What Causes Diarrhoea and Vomiting?

Diarrhoea and vomiting is caused by a number of different organisms, including bacteria, viruses and parasites. One of the most common reasons for a child suffering from diarrhoea and vomiting is something called rotavirus gastroenteritis, which is very contagious. Diarrhoea and vomiting can also occur if a child has a cold or flu, ear infections, throat/chest infections or runs high fevers.

How are gastro-intestinal illnesses transmitted?

- Eating contaminated foods.
- Drinking contaminated water.
- Poor personal hygiene.
- Contact with infected items such as bed clothes and sheets.
- Infrequent hand washing.

How are Gastro-intestinal illnesses treated?

- Encourage your child to wash their hands thoroughly after going to the toilet and before eating
- Children to be cared for at home and isolated from school and nurseries.
- **Do not allow your child to return to school until 48 hours have passed since their last episode of diarrhoea and vomiting**.
- Most children will improve without medications or specific treatment.
- Rest is important.
- Children must drink plenty of fluids in order to not become **dehydrated.**
- Do not allow your child to go swimming for 2 weeks after their last episode of diarrhoea.

What are the signs to look out for if my child is dehydrated?

- Less frequency in passing urine
- Lethargy
- Cold to touch
- Irritable
- Faster/slower breathing
- Dry mouth/tongue and lips

Advice

- Drink little and often.
- If they cannot keep fluid down, let them rest and try again later.
- Water is easier for the stomach to handle if it is not ice cold.
- If it is an older child that is sick, try to refrain from giving them milk.
- You can by replacement electrolyte sachets, to re-hydrate the body and give it essential salts and energy.
- If diarrhoea and/or vomiting continue for several days, then please consult your doctor.
- Children are not permitted to swim for two weeks following a bout of diarrhoea.

Further information can be found at www.nhs.uk/conditions/rotavirus-gastroenteritis

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Hand Foot and Mouth Information Sheet

Here's yet another reason to encourage kids to wash their hands: it can help prevent the spread of hand, foot, and mouth (HFM) disease. HFM disease is a common contagious illness caused by viruses from the enterovirus family, most commonly the coxsackievirus.

These viruses live in the body's digestive tract and spread from person to person, usually on unwashed hands and surfaces contaminated by feces. Kids ages 1 to 4 are most prone to the disease; cases are often found in childcare centers, preschools, and other places where kids congregate. The illness typically lasts 3-5 days.

Outbreaks usually occur during the warm summer and early fall months, though they can happen year-round in tropical parts of the world.

Signs and Symptoms

HFM disease (not to be confused with hoof and mouth disease, a totally unrelated illness that affects barnyard animals and livestock) causes painful blisters in the throat, tongue, gums, hard palate, or inside the cheeks. Blisters are red with a small bubble of fluid on top and often turn into ulcers. The soles of the feet and the palms of the hands also may be affected with a rash that can look like flat red spots or red blisters.

Occasionally, a pink rash may be seen on other parts of the body, such as the buttocks and thighs. However, some children with HFM disease develop no symptoms, or if they do, may only have sores in the back of the throat.

It can be hard for a parent to tell if a child (especially a preverbal child) has HFM disease if sores are only inside the mouth or throat. Very young kids may not be able to complain of a sore throat, but if a child stops eating or drinking, or wants to eat or drink less often, it's a signal to parents that something is wrong.

A child also might:

- develop fever, muscle aches, or other flu-like symptoms
- become irritable or sleep more than usual
- begin drooling (due to painful swallowing)
- gravitate toward cold fluids

Treatment

If your child is continually irritable or refusing food or drink, it's time to see the doctor. While there is no medical cure for HFM disease (the illness needs to run its course), the doctor might recommend home health remedies to make your child more comfortable during recovery.

Acetaminophen or ibuprofen can be given to console a child who is achy or irritable or ease painful mouth sores or discomfort associated with fever. Do not give aspirin to children or teens as it may cause a rare but serious illness called Reye syndrome.

A child who has difficulty swallowing might be prescribed "magic mouthwash"— a mixture made by pharmacists that can be dabbed onto sores to alleviate pain. Cold foods like ice cream and

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popsicles ease pain by numbing the area, and will be a welcome treat for those who have difficulty swallowing (and even those who don't!).

Kids with blisters on their hands or feet should keep the areas clean (wash with lukewarm soap and water, pat dry) and uncovered. If a blister pops, dab on a bit of antibiotic ointment to help prevent infection and cover it with a small bandage.

It is very important to make sure your child drinks plenty of fluids to prevent dehydration. Call your doctor if your child remains very irritable; can't be consoled; is lethargic; or has signs of dehydration such as dry tongue, sunken eyes, or decreased urine output; or if symptoms worsen.

HFM disease usually resolves within several days to a week and kids recover completely. Very rarely it can lead to complications such as viral meningitis (infection of the fluid around the brain and spinal cord) or encephalitis (infections and inflammation of the brain)

Preventing the Spread

There is no vaccine to prevent HFM disease or any other similar infection. HFM is contagious and can spread through contact with feces, saliva, mucus from the nose, or fluid from the blisters. Even after recovery, kids can pass the virus in their stool for several weeks, so still can spread the infection to others even though they're no longer sick.

Hand washing is the best protection. Remind everyone in your family to wash their hands frequently, particularly after using the toilet, changing a diaper, before meals, and before preparing food. Shared toys in childcare centers should be cleaned often with a disinfectant because these viruses can live on objects for several days.

Keep children home from school and childcare while they have a fever or open blisters on the skin and mouth.

Further information can be found at www.nhs.uk/conditions/hand-foot-and-mouth-disease

September 2019

Head Lice Information Sheet

What are head lice and nits?

- **Head lice** are tiny grey/brown insects. They are about the size of a sesame seed (the seeds on burger buns). Head lice cling to hairs, but stay close to the scalp which they feed off. Head lice lay eggs which hatch after 7-10 days. It takes about 10 days for a newly hatched louse to grow to an adult and start to lay eggs.
- **Nits** are the empty white egg shells which are left when the lice hatch. Nits look like dandruff, but stick strongly to hair. Unlike dandruff, you cannot easily brush out nits.

Who gets head lice?

Head lice are common in children, but can affect anyone of any age. They are not a sign of dirty hair or poor hygiene. Close hair to hair contact is usually needed to pass lice on. Head lice cannot jump or fly, but walk from one head to another. They soon die when away from hair, and do not live in clothes, bedding, etc. Most head lice infections are caught from family or close friends who are not aware that they have head lice.

What are the problems with head lice?

Many people with head lice do not have any symptoms. An itchy scalp occurs in some cases. This is due to an allergy to the lice, not due to their biting. It often takes about three months for an itch to develop after you are infested with lice. Therefore, you may not notice that you have head lice for a while, and you may have passed them on to others for some time. Head lice and nits do not wash off with normal shampoo. Head lice do not cause any other medical problems. The number of lice that may be on one person can vary greatly. However, commonly, there are fewer than 15 lice present.

How can you tell if you have head lice?

Head lice are difficult to find just by looking in the hair. If you suspect that your child or you have head lice, it is best to do detection combing. Some people advise that you do this to children's hair regularly, about once a week.

Detection combing: wet hair method

This will take 5-15 minutes to check each head, depending on hair length and thickness. It is also used as a treatment for head lice - see later.

- Wash the hair in the normal way with ordinary shampoo.
- Rinse out the shampoo and put on lots of ordinary conditioner.
- Comb the hair with a normal comb to get rid of tangles.
- When the hair is untangled switch to a detection comb. This is a special fine-toothed comb. (The teeth of normal combs are too far apart and the teeth of 'nit combs' are too close together.) Some pharmacies stock detection combs. One type (Bug Buster® detection comb) is also available on prescription.
- Slot the teeth of the detection comb into the hair at the roots so it is touching the scalp.
- Draw the detection comb through to the tips of the hair.
- Make sure that all parts of the hair are combed by working around the head.
- Check the comb for lice after each stroke. A magnifying glass may help.
- If you see any lice, clean the comb by wiping it on a tissue or rinse it before the next stroke.

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- After the whole head has been combed, rinse out the conditioner.
- Repeat the combing procedure in the wet hair to check for any lice that might have been missed the first time.

What are the treatment options for head lice?

Treatment is needed only if you see one or more live lice. Nits (empty eggshells) do not always mean that you are infested with lice. Nits can stick to hair even when lice are gone (for example, after treatment that kills the lice).

Currently, there are five main recommended options for clearing head lice:

- Dimeticone 4% lotion (trade name: Hedrin®).
- Wet combing using the Bug Buster® comb and method.
- Isopropyl myristate and cyclomethicone solution (trade name: Full Marks Solution®).
- Coconut, anise, and ylang ylang spray (trade name: Lyclear SprayAway®).
- Malathion 0.5% aqueous liquid (has various trade names).

The treatment chosen may depend on your personal preference, and what you have tried before (if appropriate). Each treatment has a good chance of clearing head lice if applied or done correctly *and* if all affected people in the household are treated at the same time. Read the instructions that come with the packaging.

Do family and friends need treatment?

Only if they have head lice. All people in the same home, and other close head-to-head contacts of the previous 4-6 weeks should be contacted. Tell them to look for lice and treat if necessary. (It used to be advised to treat all close contacts even if they had no symptoms. This has changed to just treating people who have head lice.) All people with head lice in the same home should be treated at the same time. This stops lice being passed around again.

Checking for treatment success

The wet combing method of treatment discusses above how to check for success. For other methods of treatment (lotions, sprays, etc), check that treatment was successful by detection combing 2-3 days after completing a course of treatment, and again after a further seven days. Treatment has been successful if no lice are found at both sessions.

What about school?

It is recommended that children do not attend school whilst they have live lice. When the child has been treated they may then return to school.

Can head lice be prevented?

There is no good way of preventing head lice. Lice repellent sprays do not work very well. If you do detection combing of children's hair every week or so, you will detect head lice soon after they have affected the hair. You can then start treatment quickly and reduce the risk of passing them on to others.

Further information can be found at www.nhs.uk/conditions/head-lice

September 2019

Impetigo Information Sheet

What is Impetigo?

Impetigo is an infection of the skin caused by bacteria, usually Streptococcus or Staphylococcus. It is extremely contagious and commonly occurs in children, although adults can also be infected. Impetigo is caused when bacteria infect cuts/bites and wounds. The infection can then spread when the infected person scratches their sores and then touches other parts of their body.

What are the common signs and symptoms of Impetigo?

- Symptoms usually occur 4-10 days after being infected.
- Small/itchy blisters appear and expand.
- Blisters burst and discharge is produced.
- Blisters can typically scab into yellow/thick crusts over 4-6 days.
- Tends to affect the hands and face, although can spread to other parts of the body.

How is Impetigo transmitted?

Impetigo can appear suddenly. It is usually spread through direct contact with another infected person. Sharing items such as towels and face cloths can cause the spread of Impetigo.

What is the treatment for Impetigo?

Please consult a doctor for diagnosis. Most doctors like to treat Impetigo with antibiotic ointment, applied to the affected areas. In more severe cases a doctor may prescribe oral antibiotics. It is important that the scabs are dissolved using an ointment/cream as the bacteria live underneath the scabs.

Children should be isolated from school and nurseries until all the lesions have crusted and healed and treatment has commenced. Please consult your doctor for diagnosis and advice.

Further information can be found at www.nhs/conditions/impetigo

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September 2019

Measles Information Sheet

Measles is a highly infectious viral disease. Anybody can contract the Measles virus especially if you have not been immunised with the MMR vaccination.

The measles virus is contained in the millions of tiny droplets that come out of the nose and mouth when an infected person coughs or sneezes. The virus spreads very easily and measles is caused by breathing in these droplets or by touching a surface that has been contaminated with the droplets then placing your hands near your nose or mouth.

Symptoms

- cold-like symptoms, such as runny nose, watery eyes, swollen eyelids and sneezing
- red eyes and sensitivity to light
- a mild to severe temperature, which may peak at over 40.6C (105F) for several days, then fall, but go up again when the rash appears
- tiny greyish-white spots (called Koplik's spots) in the mouth and throat
- tiredness, irritability and general lack of energy
- aches and pains
- poor appetite
- dry cough
- red-brown spotty rash

Rash

The measles rash appears two to four days after initial symptoms and lasts for up to eight days. The spots usually start behind the ears, spread around the head and neck, then spread to the legs and the rest of the body.

The spots are initially small but quickly get bigger and often join together. Similar looking rashes may be mistaken for measles, but measles has a range of other symptoms too, not just a rash.

Although uncommon complications can occur from the Measles virus and your child may need hospitalisation and specialist care.

Treatments

Should there be no other complications from the virus, the body will fight the infection itself. Below is a list of treatments to make your child more comfortable.

- Liquid paracetamol or ibuprofen for a high temperature or pain
- Dim lighting/blocking sunlight when the child rests
- Plenty of fluids
- Encourage food to be eaten if possible

Generally the symptoms of Measles should disappear within 7-10 days. Please keep your child away from school for at least five days from the onset of the rash.

Further information can be found at www.nhs.uk/conditions/measles

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September 2019

Moving and Handling Guidelines

Manual Handling Operations are defined as 'any transporting or supporting of a 'load' including
• Lifting
• Putting down/lowering
• Pushing
• Pulling
• Carrying
• Moving by hand or by bodily force'
Load includes any person, animal or inanimate object.

The four factors to take into account when assessing a situation when manual handling is required are:
• The nature of the **task**
• The **load**
• The working **environment**
• The **individual capability**

Moving and Handling

The following is a list of checkpoints that will ensure safe moving and handling.

Feet
Correct positioning of the feet is the secret of safer handling. Feet should be positioned to form a wide, mobile base.
Knees
Bending knees past 90 degrees becomes less efficient. Furthermore, additional stress is placed on the knee joints, increasing the risk of injury.Bending then relaxing your knees helps maintain balance and mobility, whilst allowing the best use of the most powerful muscles in the body – the leg and buttock muscles.
Legs
Muscles in the leg and buttocks are strong. If you follow this advice you will use these muscles and maintain a healthy back.
Back
We all understand that we do not want a 'poker' straight back whist undertaking a moving task. Always maintain the backs natural 'S' shaped curvature throughout all handling activities. Maintain a comfortable, upright position.
Arms
Correct use of arms is essential when performing a handling technique. The arms dictate the distance the load is held away from the body. The closer to your body the safer the technique becomes. Never take the weight of an object until it is close to your body.
Hands

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Ensure you have a secure grip of the load by grasping it firmly, but comfortably with your whole hand. Test the weight prior to moving the object. This will help to assess whether it is within your personal capacity. Where possible when lifting place one hand under the load.

Head

Always think about the activity you are about to perform .Use the position of your head to help promote good posture during any technique. Raising the head at the start of any manoeuvre automatically realigns the spine. Keep your head up and look forwards during a handling manoeuvre. After you have executed the technique ensure you **evaluate**. Consider the success of the task you have just performed, so you can rectify any mistakes prior to the task being repeated.

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	
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) Shigella* (dysentery)	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 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

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 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,
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www.publichealth.hscni.net
Information produced with the assistance of the Royal College of Paediatrics and Child Health and Public Health England.

September 2019

Ringworm Information Sheet

What is Ringworm?

- Common fungus infection of the skin
- Not actually a worm
- Appears in a round/ring shaped patch
- Common among children; adults can be infected too.

Causes of Ringworm

- Fungi can enter the body through broken skin (scratches, cuts and eczema)
- Fungi can come from animals, soil and humans
- Transmission is from person to person contact/sharing clothing and towels
- Ringworm thrives in warm/damp areas
- Those working with animals and children who have pets are more susceptible to becoming infected.

What areas of the body can be affected?

- Scalp
- Body
- Groin
- Feet
- Nails

Symptoms

- Round/ring shaped patches on skin
- Red/silver scaly skin
- Area is usually itchy
- The ring can spread outwards and the middle may heal and return to normal.

Diagnosis

Early detection could save a trip to the Doctor as your pharmacist will be able to provide you with treatment. A scraping of skin can be taken and observed under a microscope, but usually your doctor can diagnose ringworm from observation.

Treatment

- Antifungal creams, to be used for up to 4 weeks and 1-2 weeks after skin has healed
- Powders/lotions and creams are available from the pharmacy or on prescription from your doctor
- Visit your doctor if you are unsure if it is ringworm or if the infection appears to be severe
- Visit a doctor if the infection is not responding to treatment after about four weeks

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- If the affected areas are inflamed/red/sore then the doctor may prescribe a topical cream called a corticosteroid to treat this.

Scalp Ringworm

- Antifungal medication, can be prescribed for up to 10 weeks
- Medicated shampoos can be used alongside tablet treatment.

Prevention

- Do not share bedding/clothing or towels with somebody who has ringworm
- Check the whole family for signs of infection
- Touch the infected area as little as possible
- Take your pet to the vet if you believe it has ringworm
- Please cover exposed areas for school.

Further information can be found at www.nhs.uk/conditions/ringworm

September 2019

Scarlet Fever Information Sheet

What is Scarlet Fever?

Scarlet Fever, also known as Scarletina is a bacterial infection. Scarlet Fever is highly contagious and is spread from secretions from the nose and throat when a person coughs or sneezes. Scarlet Fever can occur in a person who has recently had a Streptococcal infection of the skin or throat.

Scarlet Fever usually affects the pharynx (back of the throat) but can also affect the skin. Scarlet Fever is most common among 4-8 year olds but can affect any age group. Scarlet fever is not a dangerous disease but does require immediate treatment.

What are the symptoms of Scarlet Fever?

Symptoms can vary from person to person. Not all symptoms may occur together. Symptoms usually occur 2-4 days after infection occurs.
Below is a list of the most common signs and symptoms of the disease:

- Sore throat
- Swelling of glands in the neck
- Tonsils may be covered in a white discharge
- Mild or widely spread bright red rash
- Rash appears to be fine and will fade under pressure
- Rash may have sandpaper feel to it
- Rash mainly occurs on neck/chest and in folds of the body, such as the elbows and inner thighs
- Flushed cheeks
- Strawberry coloured tongue
- High fever
- Nausea and vomiting
- Headache.

How will I know if my child has Scarlet Fever?

Please be aware that there are still common viral illnesses such as colds and flu in the school community. If you are unsure of your child's diagnosis and he/she presents some of the common symptoms as above, then a visit to the doctor is advised.

Diagnosis will be made by a doctor from the presentation of symptoms or from the analysis of a swab taken from the back of the throat.

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What is the treatment for Scarlet Fever?

Scarlet Fever will very quickly become non-infectious with the treatment of oral antibiotics. It is highly important to take your child to a doctor if they present any of the above symptoms. If the illness is untreated it can remain infectious for a further 2-3 weeks.

Paracetamol and/or Brufen based medications can be used to treat symptoms such as headache and fever.

How long should my child be absent from school if they have been diagnosed with Scarlet Fever?

It is recommended that children with Scarlet Fever should stay off school for at least 24 hours after commencing antibiotic treatment, providing they no longer have fever. Please check with a doctor for confirmation of this.

More Information can be found at www.nhs.uk/conditions/scarletfever

September 2019

Seasonal Flu information sheet

Flu is a common infectious viral illness spread by coughs and sneezes. It can be very unpleasant, but you'll usually begin to feel better within about a week.

You can catch flu, short for influenza, all year round but it's especially common in winter, which is why it's also known as "seasonal flu".

It is not the same as the common cold. Flu is caused by a different group of viruses and the symptoms tend to start more suddenly and can be more severe and last longer.

Some of the main symptoms of flu include:

- a high temperature (fever) of 38C (100.4F) or above
- tiredness and weakness
- a headache
- general aches and pains
- a dry, chesty cough

Cold like symptoms such as a blocked or runny nose, sneezing, and a sore throat can also be caused by flu, but they tend to be less severe than the other symptoms you have.

Flu can make you feel so exhausted and unwell that you have to stay in bed and rest until you feel better.

What to do
If you are otherwise fit and healthy, there is usually no need to see a doctor if you have flu-like symptoms.
The best remedy is to rest at home, keep warm and drink plenty of water to avoid dehydration. You can take Paracetamol or Ibuprofen to lower a high temperature and relieve aches if necessary.

Stay off work or school until you are feeling better. For most people this can take up to a week.

When to see your doctor
Consider visiting your doctor if:

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- you are 65 years of age or over
- you are pregnant
- you have a long-term medical condition such as diabetes, heart disease, lung disease, kidney disease, neurological disease or have a weakened immune system for example, because you are having chemotherapy.
- you develop chest pain, shortness of breath or difficulty breathing, or start coughing up blood
- your symptoms are getting worse over time or haven't improved after a week

In these situations you may need medication to treat or prevent complications of flu. Your doctor may recommend taking antiviral medicine to reduce your symptoms and help you recover more quickly.

How long does flu last and is it serious?
If you have flu you generally start to feel ill within a few days of being infected.

You should begin to feel much better within a week or so, although you may feel tired for much longer.

You will usually be most infectious from the day your symptoms start and for a further three to seven days. Children and people with weaker immune systems may remain infectious for longer.

Most people will make a full recovery and won't experience any further problems, but elderly people and people with certain long-term medical conditions are more likely to have a bad case of flu or develop a serious complication, such as a chest infection.

How you catch flu
The flu virus is contained in the millions of tiny droplets that come out of the nose and mouth when someone who is infected coughs or sneezes.

These droplets typically spread about one meter. They hang suspended in the air for a while before landing on surfaces, where the virus can survive for up to 24 hours.

Anyone who breathes in the droplets can catch flu. You can also catch the virus by touching the surfaces that the droplets have landed on if you pick up the virus on your hands and then touch your nose or mouth.

Everyday items at home and in public places can easily become contaminated with the flu virus, including food, door handles, remote controls, handrails, telephone handsets and computer keyboards. Therefore, it is important to wash your hands frequently.

You can catch flu many times, because flu viruses change regularly and your body won't have natural resistance to the new versions.

Preventing the spread of flu
You can help stop yourself catching flu or spreading it to others with good hygiene measures.

Always wash your hands regularly with soap and warm water, as well as:

- regularly cleaning surfaces such as your computer keyboard, telephone and door handles to get rid of germs
- using tissues to cover your mouth and nose when you cough or sneeze
- putting used tissues in a bin as soon as possible

You can also help stop the spread of flu by avoiding unnecessary contact with other people whilst you are infectious. You should stay off work or school until you are feeling better.

In some people at risk of more serious flu, an annual flu vaccine (see below) or antiviral medication may be recommended to help reduce the risk of becoming infected.

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The flu vaccine

The flu vaccine is available in Doha for those who require it, at Hamad Primary Health Care centres and also at the private health clinics.

The flu vaccination is recommended for those

- adults over the age of 18 at risk of flu with an underlying medical condition
- those over 65 years
- children and adults with a weakened immune system.

Further information can be found www.nhs.uk/conditions/flu

September 2019

Threadworms Information Sheet

Threadworms are small intestinal parasites that infect the intestines of humans. Threadworm, also known as pinworm is the most common worm parasite infestation. It is common amongst small children, although any age group can be infested with the parasite. Transmission is only from human to human and animals can neither catch nor pass threadworms to humans.

Male worms tend to only stay in the intestine, however female worms lay their eggs around sensitive and private areas. Eggs are usually laid at night time when the female worm also secretes an irritant mucous. If a child scratches the very irritated/itchy areas then eggs can stick under fingernails and on fingertips and can be transferred to the mouth where re-infestation can occur. When eggs are swallowed they hatch in the intestine and worms can reproduce once they reach adult size.

Symptoms

- Itching around private areas, more intense at night
- Persistent infestation; loss of appetite/severe irritability/weight loss
- Constipation and/or diarrhoea.,

Threadworms do not always produce symptoms therefore all members of the household should be treated.

Diagnosis

Threadworms are difficult to see due to their colour and size. The worms resemble pieces of small white cotton thread, hence their name. Threadworms may be detected at night when they are most active and laying their eggs. Sometimes worms can be seen in faeces.

Usually threadworms only become apparent when a child is constantly itching private areas, especially at night.

Treatment

Treatments are aimed at preventing re-infestation and getting rid of the parasites themselves. Following strict hygiene procedures (**especially hand washing**) and taking medication to remove threadworms will treat the problem.

- **PLEASE VISIT A PHARMACIST OR DOCTOR IF YOU BELIEVE YOUR CHILD OR SOMEBODY IN YOUR FAMILY IS INFESTED WITH THREADWORM**
- **MEDICATION MUST BE TAKEN OTHERWISE INFESTATION WILL CONTINUE INDEFINITELY AND MAY SPREAD TO OTHER PARTS OF THE BODY**
- **REMEMBER ALL FAMILY MEMBERS MUST BE TREATED**

Your pharmacist or doctor can recommend over the counter medication for threadworm that are often taken twice initially and two weeks after first dose, to ensure any surviving worms that hatched later are killed.

More information can be found at www.nhs.uk/conditions/threadworms.

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September 2019

Warts and Verrucas Information Sheet

Warts are usually harmless, but may be unsightly. Warts on the feet are called verrucas and are sometimes painful. Warts and verrucas usually clear in time without treatment. If required, they can often be cleared more quickly with treatment. For example, by applying salicylic acid, or by freezing with liquid nitrogen or a cold spray, or by covering with tape.

What are warts and verrucas?

- **Warts** are small rough lumps on the skin. They are caused by a virus (human papillomavirus) which causes a reaction in the skin. Warts can occur anywhere on the body but occur most commonly on hands and feet. They range in size from 1 mm to over 1 cm. Sometimes only one or two warts develop. Sometimes several occur in the same area of skin. The shape and size of warts vary, and they are sometimes classed by how they look. For example: common warts, plane (flat) warts, filiform (finger-like) warts, mosaic warts, etc.
- **Verrucas** are warts that occur on the soles of the feet. They are the same as warts on any other part of the body. However, they may look flatter, as they tend to get trodden in.

Who gets warts and verrucas and are they harmful?

Most people develop one or more warts at some time in their life, usually before the age of 20. About 1 in 10 people in the UK has warts at any one time. They are not usually harmful. Sometimes verrucas are painful if they press on a sensitive part of the foot. Some people find their warts unsightly. Warts at the end of fingers may interfere with fine tasks.

Are warts contagious?

Yes, but the risk of passing them on to others is low. You need close skin-to-skin contact. You are more at risk of being infected if your skin is damaged, or if it is wet and macerated, and in contact with roughened surfaces. For example, in swimming pools and communal washing areas.

You can also spread the wart virus to other areas of your body. For example, warts may spread round the nails, lips and surrounding skin if you bite warts on your fingers, or nearby nails, or if you suck fingers with warts on. If you have a poor immune system you may develop lots of warts which are difficult to clear. (For example, if you have AIDS, if you are on chemotherapy, etc.)

- To reduce the chance of passing on warts to others:
  - Don't share towels.
  - When swimming, cover any wart or verruca with a waterproof plaster.
  - If you have a verruca, wear flip-flops in communal shower rooms and don't share shoes or socks.
- To reduce the chance of warts spreading to other areas of your body:
  - Don't scratch warts.
  - Don't bite nails or suck fingers that have warts.
  - If you have a verruca, change your socks daily.

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To treat or not to treat?

There is no need to treat warts if they are not causing you any problems. Without treatment, about 3 in 10 warts have gone within 10 weeks, and most warts will have gone within 1-2 years, and leave no scar. The chance that a wart will go is greatest in children and young people. Sometimes warts last longer. In particular, warts in older people are sometimes more persistent and may last for several years.

Treatment can often clear warts more quickly. However, treatments are time-consuming and some can be painful. Parents often want treatment for their children, but children are often not bothered by warts. In most cases, simply waiting for them to go is usually the best thing to do.

Treatment Options

The three most commonly used treatments are:

- Salicylic acid.
- Freezing treatment.
- Covering with duct tape.

What about swimming?

A child with warts or verrucas should go swimming as normal. Warts can be covered with waterproof plasters. A verruca can also be covered with a waterproof plaster but some people prefer to wear a special sock which you can buy from pharmacies. It is also a good idea to wear flip-flops when using communal showers, as this may reduce the chance of catching or passing on virus particles from verrucas.

Further information can be found at www.nhs.uk/conditions/warts-varrucas

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SAFETY DATA SHEET

Invoice #	: Nl/DOH/975110	Form "E" No: MY B-3129083	
Date	: July 05, 2010	Date: 05-07-2010	
Consignee	: DELUX E TRADING & SERVICES, P.O.BOX 16041 DOHA -QATA R Tel: 4324925 Fax: 4431052	Shipment: By Sea H.S CODE: 2806.1000 Advance Payment & CAD Batch#: 05	
Destination	: Doha, Qatar	Manufacturing Date: July 2010	
Terms:	CIF DOHA, QATAR	Expiry Date: July 2013	

Chemical Identification

Chemical Name	Hvdrochloric Acid
Concentration	35% +- 1%
CAS No.	7647-01-0

Properties / Specifications

Aooearance	Colorless
Soecific Gravity	1.166-1.171
Calcium	0.0002% Max
Magnesium	0.0001% Max
Iron	0.0005% Max
Arsenic	0.0001% Max
Sulphate	0.0010% Max
Free Chlorine	0.0002% Max
Non-Volatile Substances	0.0100% Max
Mercury	NIL
Fluoride	NIL

Principal Application

Acidizing (activation) of petroleum wells manufacture of dyes, Phenols and plastics food processing (com, syrup, sodium glutamate) Manufacture of chemicals intermediates, such as FeCl3, Zncl2, AICl3, etc. General cleaning in households and in commercial, industrial establishments etc.

Material Handline

Spilled hydrochloric acid should be removed immediately by flushing the contamination area with large quantities of water.

Employees should never undul.> expose their skin to hydrochloric acid. Prolog exposure can cause severe and painful burns.

Since the hydrochloric acid fumes settle rather rapidly towards the ground, it must be thoroughly sprayed with water to minimize its irritating effects.

First Aid Measures

Inhalation:

Remove to fresh air. If not breathing, give artificial respiration. If breathing is difficult, give oxygen. Get medical attention

immediately.

Ingestion:
DO NOT INDUCE VOMITING! Give large quantities of water or milk if available. Never give anything by mouth to an unconscious person. Get medical attention immediately.

Skin Contact:
In case of contact, immediately flush skin with plenty of water for at least 15 minutes while removing contaminated clothing and shoes. Wash clothing before reuse. Thoroughly clean shoes before reuse. Get medical attention immediately.

Eye Contact:
Immediately flush eyes with plenty of water for at least 15 minutes, lifting lower and upper eyelids occasionally. Get medical attention immediately.

SAFETY DATA SHEET

1. CHEMICAL PRODUCT IDENTIFICATION

Substance Name: FRD-90 Disinfecting Granules
SDS Number: 10101
Chemical Name/Synonyms: TCCA, Trichloroisocyanuric Acid, Trichloro-s-triazinetrione
Product Use and Properties: algaecide, bactericide, disinfectant, fungicide, microbiocide/microbiostat (Active ingredient in household dry bleaches; dishwashing compounds, scouring powders; detergent sanitizers, commercial laundry; bleaches, swimming pool disinfectant).

2. COMPOSITION, INFORMATION ON INGREDIENTS

Component/Ingredient: TCCA, Trichloroisocyanuric Acid (Symclosene)
Percentage: >98
CAS-Number: 87-90-1
Number in Annex: 613-031-00-5
EINECS Number: 201-782-8

3. HAZARDS IDENTIFICATION

Physical/Chemical Hazards: Strong Oxidizer
Human Health Hazards: Corrosive. Avoid contact with eyes, can cause irreversible eye damage. Avoid contact with skin; may cause burns to moist skin, if not promptly removed. Avoid breathing this material; may be fatal, if inhaled. Harmful if swallowed.

4. FIRST AID MEASURES

Inhalation: If inhaled**, r**emove to fresh air. If irregular or not breathing, give artificial respiration. If breathing is difficult, oxygen should be administered by qualified personnel. Call for medical attention immediately.
Eye Contact: Check for and remove any contact lenses. Immediately flush eyes with clean water for at least 15 minutes. Retract eyelids to ensure complete wash of all eye and lid tissues. In case of continued irritation, get medical attention immediately.
Skin Contact: In case of contact with skin, wash off immediately with plenty of water. Immediately remove all contaminated clothing including footwear. If irritation persists, get medical attention.
Ingestion: If victim is conscious and alert, allow to rinse mouth, and then drink two cups of water. Never give anything by mouth to an unconscious person. DO NOT induce vomiting unless directed to do so by medical personnel. If vomiting occurs spontaneously, keep airway clear. Drink more water when vomiting stops. Seek medical attention immediately.

5. FIRE FIGHTING MEASURES

Suitable Extinguishing Media: Flood with plenty of water. Do not use dry chemicals, carbon dioxide or halogenated extinguishing agents.
Fire and Explosion Hazards: Fire hazards from this compound are negligible. In case of combustion or heat by an outside source (temperatures > 240 ^{o}C), the product will release under a

self-sustaining decomposition dense noxious gases (e.g. hydrogen oxide, nitrous oxides) without visible flame. Wet material may generate nitrogen trichloride, an explosion hazard.
Fire Fighting: Do not inhale explosion or combustion gases. In case of combustion use an approved/certified respirator or equivalent. Wear protective clothing. Isolate hazard area and deny entry. Consider evacuation of personnel located downwind. Collect contaminated firefighting water separately. Do not discharge contaminated water into drains. Dispose contaminated drums and damaged or damp material in a proper manner. Contact company for further instructions.

6. ACCIDENTAL RELEASE MEASURES

Personal Precautions and Protection of staff: Isolate hazard area and keep unnecessary people away. Wear chemical safety goggles. Have suitable clothing and gloves, avoid exposing skin. A self-contained breathing apparatus should be used, if working in contaminated area. Remove clothing immediately after work. Wash hands thoroughly before eating, drinking, smoking or using the toilet.
Environmental Precautions and Clean up methods: Stop leak if without risk. Do not get water inside container. Avoid raising dust. Ensure ventilation and circulation of air. Prevent entry into sewers, water supplies and confined areas. Damp material/product should be neutralized to a non-oxidizing state. When material is being removed, follow the directions under HANDLING AND STORAGE. Call for further assistance on disposal.

7. HANDLING AND STORAGE

Handling: Do not get in eyes, on skin, and or on clothing. Avoid breathing dust and vapors when opening product containers. Ensure adequate ventilation. Wash thoroughly after handling. Never add water to this product; always add the product to large quantities of water. Use clean and dry utensils.
Storage: Follow all current regulations and standards. Keep properly labeled product container tightly closed and dry in a cool, well ventilated area. Keep away from heat and direct sunlight. Keep away from food, drink, animal feed. Keep away from potential sources of ignition and any incompatible substances.

8. EXPOSURE CONTROLS, PERSONAL PROTECTION

Protective Provisions/Engineering Measures: Use process enclosures, local exhaust ventilation or other engineering controls to keep airborne levels low. Use respirator in dust-laden atmosphere.
Hygiene Measures: Remove clothing immediately after work. Wash hands, forearms, and face thoroughly before eating, drinking, smoking, using the toilet and at the end of the day.
Occupational Exposure Limits: None.

Personal Protective Equipment
Respiratory System: Wear approved/certified respirator or equivalent when ventilation is inadequate.
Skin and Body: Depending of the amount of product handled, wear full protective clothing to minimize skin contact.
Hands: Wear suitable gloves.
Eyes: Wear protective chemical safety goggles.

9. PHYSICAL AND CHEMICAL PROPERTIES

Appearance: White granules
Odour: Chlorine

pH: 2.7-3.3 at 25^{o}C (1% aqueous solution)
Molecular Weight: 232.41
Formula: C3 CL3 N3 O3
Boiling & Melting Point: N/A
Decomposition Point: 225^{0}C
Flammability: N/A
Bulk Density: 2.07 g/cm^{3} at 25°C or 850 kg/m^{3}
Oxidizing Properties: Yes
Solubility: 12 g/l in water at 25^{o}C

10. STABILTY AND REACTIVITY

Stability: **The product is stable under normal temperatures and pressures. Keep product dry. Follow instructions under HANDLING AND STORAGE.**
Reactivity: **Wet material may generate nitrogen trichloride, a potential explosion hazard. Avoid contact with any oxidizable organic material.**
Incompatibility: **Incompatible products are acids, ammonia, bases, calcium hypochlorite, reducing agents and organic solvents.**
Decomposition: Hazardous decomposition and combustion products such as chlorine, cyanogens chloride, hydrogen oxide, nitrogen, nitrogen trichloride, nitrous oxides, phosgene can be generated when in contact with heat or water.

11. TOXICOLOGICAL INFORMATION

Eye and Skin irritation: Very hazardous in case of eye contact and contact with wet skin.
Acute Toxicity: Oral-rat LD50= 809 mg/kg; dermal-rat > 5,000 mg/kg.
Health Effects: **Direct contact on wet skin may cause severe irritation, pain and potential burns. Direct eye contact may cause severe irritation, pain, burns, and permanent damage including blindness. The product granules should not cause any respiratory problems. If ground or in powdery form, inhaling can cause mucous membrane irritation with coughing and shortness of breath. Ingestion may cause immediate pain and severe burns of the mucous membranes in the mouth, esophagus and gastrointestinal tract.**

12. ECOLOGICAL INFORMATION

Ecotoxicity: The product is highly toxic to fish (Bluegill Sunfish - Lepomis macrochirus LC50 = 0.3 ppm); invertebrates (Daphnia magna LC50 = 0.21 ppm), and Green Algae (LC50 < 0.50 ppm).
Fate and Transport: The product is subject to hydrolysis within minutes, forming cyanuric acid and halogen moieties, which is inherently biodegradable. The material degrades relatively fast and is not considered to bioaccumulate.
Persistence: The product is unstable in the environment because the available chlorine is rapidly reduced. Hydrolysis occurs within minutes. None of the hydrolysis products are persistent.

13. DISPOSAL CONSIDERATIONS

Methods of Disposal, Waste of Residues, Contaminated Packaging: Waste must be disposed in accordance with applicable federal, state and local environmental control regulations. Keep spilled product out of trash containers, drains, and sewers. Incompatible material can cause a reaction and combustion. Do not transport wet or damp material. Damp material should be neutralized. Contact Company for further disposal instructions.

14. TRANSPORT INFOPRMATION

Land Transport - ADR/RID
Proper Shipping Name: Trichloroisocyanuric Acid, dry
ID Number: UN 2468
Hazard Class: 5.1
Packaging Group: II
Hazard ID Number: 50
Label Requirements: 5.1
Marine Transport – IMDG/GGV
Proper Shipping Name: Trichloroisocyanuric Acid, dry
ID Number: UN 2468
Hazard Class: 5.1
Packaging Group: II
EmS F-A, S-Q
Air Transport – ICAO/IATA
Proper Shipping Name: Trichloroisocyanuric Acid, dry
ID Number: UN 2468
Hazard Class: 5.1
Packaging Group: II

15. REGULATORY INFORMATION

EEC Directive**: 91/155/EEC amended by 93/112/EEC; Dangerous Substances and Preparations, and in accordance with current product labeling:**

EINECS Number: 201-782-8

Hazard Symbols:

O: Oxidising
Xn: Harmful
N: Dangerous for the environment

Risk Phrases:

R8: Contact with combustible material may cause fire.
R22: Harmful if swallowed.
R31: Contact with acids liberates toxic gas.
R36/37: Irritating to eyes and respiratory system.
R50/53: Very toxic to aquatic organisms, may cause long-term adverse effects in the aquatic environment.

Safety Phrases:

S2: Keep out of reach of children.
S8: Keep container dry.
S26: In case of contact with eyes, rinse immediately with plenty of water and seek medical advice.
S41: In case of fire and/or explosion do not breathe fumes.
S46: If swallowed, seek medical advice immediately, and show this container or label.
S60: This material and/or its container must be disposed of as hazardous waste.
S61: Avoid Release to the environment. Refer to special instructions/Safety data sets.

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SAFETY DATA SHEET

1. CHEMICAL PRODUCT IDENTIFICATION

Substance Name: FRD-55 Disinfecting Granules
SDS Number: 10104
Product Use and Properties: algaecide, bactericide, disinfectant, fungicide, microbiocide/microbiostat (Active ingredient in household dry bleaches; dishwashing compounds, scouring powders; detergent sanitizers, commercial laundry; bleaches, swimming pool disinfectant).

2. COMPOSITION, INFORMATION ON INGREDIENTS

Chemical Name: Sodium Dichloro-s-triazinetrione Dihydrate
Synonyms of the Substance: Sodium Salt of Dichloroisocyanuric Acid Dihydrate, Sodium Dichloroisocyanurate (NaDCC) Dihydrate, Troclosene Sodium Dihydrate
Percentage: > 98
CAS Number: 51580-86-0
Number in Annex: 613-030-01-7
EINECS Number: 220-767-7 (Anhydrous product)

3. HAZARDS IDENTIFICATION

Physical/Chemical Hazards: Contact with combustible material may cause fire. Thermal decomposition may release toxic gases.
Human Health Hazards: Corrosive. Avoid contact with eyes, can cause irreversible eye damage. Avoid contact with skin; may cause burns to moist skin, if not promptly removed. Avoid breathing this material; may be fatal, if inhaled. Harmful if swallowed.

4. FIRST AID MEASURES

Inhalation: If inhaled**, r**emove to fresh air. If irregular or not breathing, give artificial respiration. If breathing is difficult, oxygen should be administered by qualified personnel. Call for medical attention immediately.
Eye Contact: Check for and remove any contact lenses. Immediately flush eyes with clean water for at least 15 minutes. Retract eyelids to ensure complete wash of all eye and lid tissues. In case of continued irritation, get medical attention immediately.
Skin Contact: In case of contact with skin, wash off immediately with plenty of water. Immediately remove all contaminated clothing including footwear. If irritation persists, get medical attention.
Ingestion: If victim is conscious and alert, allow to rinse mouth, and then drink two cups of water. Never give anything by mouth to an unconscious person. DO NOT induce vomiting unless directed to do so by medical personnel. If vomiting occurs spontaneously, keep airway clear. Drink more water when vomiting stops. Seek medical attention immediately.

5. FIRE FIGHTING MEASURES

Suitable Extinguishing Media: Flood with plenty of water. Do not use dry chemicals, carbon dioxide or halogenated extinguishing agents.

Fire and Explosion Hazards: Fire hazards from this compound are negligible. In case of combustion or heat by an outside source (temperatures > 240 ^{o}C), the product will release under a self-sustaining decomposition dense noxious gases (e.g. hydrogen oxide, nitrous oxides) without visible flame. Wet material may generate nitrogen trichloride, an explosion hazard.
Fire Fighting: Do not inhale explosion or combustion gases. In case of combustion use an approved/certified respirator or equivalent. Wear protective clothing. Isolate hazard area and deny entry. Consider evacuation of personnel located downwind. Collect contaminated firefighting water separately. Do not discharge contaminated water into drains. Dispose contaminated drums and damaged or damp material in a proper manner. Contact company for further instructions.

6. ACCIDENTAL RELEASE MEASURES

Personal Precautions and Protection of staff: Isolate hazard area and keep unnecessary people away. Wear chemical safety goggles. Have suitable clothing and gloves, avoid exposing skin. A self-contained breathing apparatus should be used, if working in contaminated area. Remove clothing immediately after work. Wash hands thoroughly before eating, drinking, smoking or using the toilet.
Environmental Precautions and Clean up methods: Stop leak if without risk. Do not get water inside container. Avoid raising dust. Ensure ventilation and circulation of air. Prevent entry into sewers, water supplies and confined areas. Damp material/product should be neutralized to a non-oxidizing state. When material is being removed, follow the directions under HANDLING AND STORAGE. Call for further assistance on disposal.

7. HANDLING AND STORAGE

Handling: Do not get in eyes, on skin, and or on clothing. Avoid breathing dust and vapors when opening product containers. Ensure adequate ventilation. Wash thoroughly after handling. Never add water to this product; always add the product to large quantities of water. Use clean and dry utensils.
Storage: Follow all current regulations and standards. Keep properly labeled product container tightly closed and dry in a cool, well ventilated area. Keep away from heat and direct sunlight. Keep away from food, drink, animal feed. Keep away from potential sources of ignition and any incompatible substances.

8. EXPOSURE CONTROLS, PERSONAL PROTECTION

Protective Provisions/Engineering Measures: Use process enclosures, local exhaust ventilation or other engineering controls to keep airborne levels low. Use respirator in dust-laden atmosphere.
Hygiene Measures: Remove clothing immediately after work. Wash hands, forearms, and face thoroughly before eating, drinking, smoking, using the toilet and at the end of the day.
Occupational Exposure Limits: None.

Personal Protective Equipment
Respiratory System: Wear approved/certified respirator or equivalent when ventilation is inadequate.
Skin and Body: Depending of the amount of product handled, wear full protective clothing to minimize skin contact.
Hands: Wear suitable gloves.
Eyes: Wear protective chemical safety goggles.

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9. PHYSICAL AND CHEMICAL PROPERTIES

Appearance: White granules
Odour: Chlorine
pH: 5.5-7.0 at 25°C (1% aqueous solution)
Molecular Weight: 256.02
Formula: $C_3N_3O_3CL_2Na{\cdot}2H_2O$
Boiling & Melting Point: N/A
Decomposition Point: 240-250^{0}C
Flammability: N/A
Bulk Density: 800 – 900 kg/m^3 at 20°C
Oxidizing Properties: Yes
Solubility: 285g/l in water at 25°C

10. STABILTY AND REACTIVITY

Stability: The product is stable under normal temperatures and pressures. Keep product dry. Follow instructions under HANDLING AND STORAGE.
Reactivity: Wet material may generate nitrogen trichloride, a potential explosion hazard. Avoid contact with any oxidizable organic material.
Incompatibility: Incompatible products are acids, ammonia, bases, calcium hypochlorite, reducing agents and organic solvents.
Decomposition: Hazardous decomposition and combustion products such as chlorine, cyanogens chloride, hydrogen oxide, nitrogen, nitrogen trichloride, nitrous oxides, phosgene can be generated when in contact with heat or water.

11. TOXICOLOGICAL INFORMATION

Eye and Skin irritation: Very hazardous in case of eye contact and contact with wet skin.
Acute Toxicity: Oral-rat LD50= 735 mg/kg; dermal-rabbit LD50 = 2,000 mg/kg.
Health Effects: Direct contact on wet skin may cause severe irritation, pain and potential burns. Direct eye contact may cause severe irritation, pain, burns, and permanent damage including blindness. The product granules should not cause any respiratory problems. If ground or in powdery form, inhaling can cause mucous membrane irritation with coughing and shortness of breath. Ingestion may cause immediate pain and severe burns of the mucous membranes in the mouth, esophagus and gastrointestinal tract.

12. ECOLOGICAL INFORMATION

Ecotoxicity: The product is highly toxic to fish (Bluegill Sunfish - Lepomis macrochirus LC50 = 0.40 ppm, and Rainbow Trout – LC50 = 0.24 ppm), and invertebrates (Daphnia magna: 0.05 ppm < EC50 < 0.1 ppm).
Fate and Transport: The product is subject to hydrolysis within minutes, forming cyanuric acid and halogen moieties, which is inherently biodegradable. The material degrades relatively fast and is not considered to bioaccumulate.
Persistence: The product is unstable in the environment because the available chlorine is rapidly reduced. Hydrolysis occurs within minutes. None of the hydrolysis products are persistent.

13. DISPOSAL CONSIDERATIONS

Methods of Disposal, Waste of Residues, Contaminated Packaging: Waste must be disposed in accordance with applicable federal, state and local environmental control regulations. Keep spilled product out of trash containers, drains, and sewers. Incompatible material can cause a reaction and combustion. Do not transport wet or damp material. Damp material should be neutralized. Contact Company for further disposal instructions.

14. TRANSPORT INFOPRMATION

Land Transport - ADR/RID
Proper Shipping Name: Sodium Dichloro-s-triazinetrione Dihydrate
ID Number: UN 3077
Hazard Class: 9
Packaging Group: III
Hazard ID Number: 90
Label Requirements: 9
Marine Transport – IMDG/GGV
Proper Shipping Name: Sodium Dichloro-s-triazinetrione Dihydrate
ID Number: UN 3077
Hazard Class: 9 + MP
Packaging Group: III
Air Transport – ICAO/IATA
Proper Shipping Name: Sodium Dichloro-s-triazinetrione Dihydrate
ID Number: UN 3077
Hazard Class: 9
Packaging Group: III

15. REGULATORY INFORMATION

EEC Directive: 91/155/EEC amended by 93/112/EEC; Dangerous Substances and Preparations, and in accordance with current product labeling:
EINECS Number: 220-767-7 (Anhydrous product)
Hazard Symbols:

Xn: Harmful
N: Dangerous for the environment

Risk Phrases:

R22: Harmful if swallowed.
R31: Contact with acids liberates toxic gas.
R36/37: Irritating to eyes and respiratory system.
R50/53: Very toxic to aquatic organisms, may cause long-term adverse effects in the aquatic environment.

Safety Phrases:

S2: Keep out of reach of children.
S8: Keep container dry.
S26: In case of contact with eyes, rinse immediately with plenty of water and seek medical advice.
S41: In case of fire and/or explosion do not breathe fumes.
S46: If swallowed, seek medical advice immediately, and show this container or label.

S60: This material and/or its container must be disposed of as hazardous waste.

S61: Avoid Release to the environment. Refer to special instructions/Safety data sets.

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MATERIAL SAFETY DATA SHEET

1. CHEMICAL PRODUCT IDENTIFICATION

Substance Name: FRD-90 Disinfecting Tablets
SDS Number: 10102
Product Use and Properties: algaecide, bactericide, disinfectant, fungicide, microbiocide/microbiostat, sanitizer

2. COMPOSITION, INFORMATION ON INGREDIENTS

Chemical Name: Trichloro-s-triazinetrione
Synonyms of the Substance: Trichloroisocyanuric Acid, TCCA, Symclosene
Percentage: >98
CAS-Number: 87-90-1
Number in Annex: 613-031-00-5
EINECS Number: 201-782-8

3. HAZARDS IDENTIFICATION

Physical/Chemical Hazards: Strong Oxidizer

Human Health Hazards: Corrosive. Avoid contact with eyes, can cause irreversible eye damage. Avoid contact with skin; may cause burns to moist skin, if not promptly removed. Avoid breathing this material; may be fatal, if inhaled. Harmful if swallowed.

4. FIRST AID MEASURES

Inhalation: If inhaled**, r**emove to fresh air. If irregular or not breathing, give artificial respiration. If breathing is difficult, oxygen should be administered by qualified personnel. Call for medical attention immediately.

Eye Contact: Check for and remove any contact lenses. Immediately flush eyes with clean water for at least 15 minutes. Retract eyelids to ensure complete wash of all eye and lid tissues. In case of continued irritation, get medical attention immediately.

Skin Contact: In case of contact with skin, wash off immediately with plenty of water. Immediately remove all contaminated clothing including footwear. If irritation persists, get medical attention.

Ingestion: If victim is conscious and alert, allow to rinse mouth, and then drink two cups of water. Never give anything by mouth to an unconscious person. DO NOT induce vomiting unless directed to do so by medical personnel. If vomiting occurs spontaneously, keep airway clear. Drink more water when vomiting stops. Seek medical attention immediately.

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5. FIRE FIGHTING MEASURES

Suitable Extinguishing Media: Flood with plenty of water. Do not use dry chemicals, carbon dioxide or halogenated extinguishing agents.

Fire and Explosion Hazards: Fire hazards from this compound are negligible. In case of combustion or heat by an outside source (temperatures > 240 ^{o}C), the product will release under a self-sustaining decomposition dense noxious gases (e.g. hydrogen oxide, nitrous oxides) without visible flame. Wet material may generate nitrogen trichloride, an explosion hazard.

Fire Fighting: Do not inhale explosion or combustion gases. In case of combustion use an approved/certified respirator or equivalent. Wear protective clothing. Isolate hazard area and deny entry. Consider evacuation of personnel located downwind. Collect contaminated fire fighting water separately. Do not discharge contaminated water into drains. Dispose contaminated drums and damaged or damp material in a proper manner. Contact company for further instructions.

6. ACCIDENTAL RELEASE MEASURES

Personal Precautions and Protection of staff: Isolate hazard area and keep unnecessary people away. Wear chemical safety goggles. Have suitable clothing and gloves, avoid exposing skin. A self-contained breathing apparatus should be used, if working in contaminated area. Remove clothing immediately after work. Wash hands thoroughly before eating, drinking, smoking or using the toilet.

Environmental Precautions and Clean up methods: Stop leak if without risk. Do not get water inside container. Avoid raising dust. Ensure ventilation and circulation of air. Prevent entry into sewers, water supplies and confined areas. Damp material/product should be neutralized to a non-oxidizing state. When material is being removed, follow the directions under HANDLING AND STORAGE. Call for further assistance on disposal.

7. HANDLING AND STORAGE

Handling: Do not get in eyes, on skin, and or on clothing. Avoid breathing dust and vapors when opening product containers. Ensure adequate ventilation. Wash thoroughly after handling. Never add water to this product; always add the product to large quantities of water. Use clean and dry utensils.

Storage: Follow all current regulations and standards. Keep properly labeled product container tightly closed and dry in a cool, well ventilated area. Keep away from heat and direct sunlight. Keep away from food, drink, animal feed. Keep away from potential sources of ignition and any incompatible substances.

8. EXPOSURE CONTROLS, PERSONAL PROTECTION

Protective Provisions/Engineering Measures: Use process enclosures, local exhaust ventilation or other engineering controls to keep airborne levels low. Use respirator in dust-laden atmosphere.

Hygiene Measures: Remove clothing immediately after work. Wash hands, forearms, and face thoroughly before eating, drinking, smoking, using the toilet and at the end of the day.

Occupational Exposure Limits: None.

Personal Protective Equipment

Respiratory System: Wear approved/certified respirator or equivalent when ventilation is inadequate.

Skin and Body: Depending of the amount of product handled, wear full protective clothing to minimize skin contact.

Hands: Wear suitable gloves.

Eyes: Wear protective chemical safety goggles.

9. PHYSICAL AND CHEMICAL PROPERTIES

Appearance: White tablets
Odour Chlorine
pH: 2.7-3.3 at 25°C (1% aqueous solution)
Molecular Weight: 232.41
Formula: C3 CL3 N3 O3
Boiling & Melting Point: N/A
Decomposition Point: 225°C
Flammability: N/A
Bulk Density: 2.07 g/cm³ at 25°C or 850 kg/m³
Oxidizing Properties: Yes
Solubility: 12 g/l in water at 25°C

10. STABILTY AND REACTIVITY

Stability: **The product is stable under normal temperatures and pressures. Keep product dry. Follow instructions under HANDLING AND STORAGE.**

Reactivity: **Wet material may generate nitrogen trichloride, a potential explosion hazard. Avoid contact with any oxidizable organic material.**

Incompatibility: **Incompatible products are acids, ammonia, bases, calcium hypochlorite, reducing agents and organic solvents.**

Decomposition: Hazardous decomposition and combustion products such as chlorine, cyanogens chloride, hydrogen oxide, nitrogen, nitrogen trichloride, nitrous oxides, phosgene can be generated when in contact with heat or water.

11. TOXICOLOGICAL INFORMATION

Eye and Skin irritation: Very hazardous in case of eye contact and contact with wet skin.

Acute Toxicity: Oral-rat LD50= 809 mg/kg; dermal-rat > 5,000 mg/kg.

Health Effects: **Direct contact on wet skin may cause severe irritation, pain and potential burns. Direct eye contact may cause severe irritation, pain, burns, and permanent damage including blindness. The product granules should not cause any respiratory problems. If ground or in powdery form, inhaling can cause mucous membrane irritation with coughing and shortness of breath. Ingestion may cause immediate pain and severe burns of the mucous membranes in the mouth, esophagus and gastrointestinal tract.**

12. ECOLOGICAL INFORMATION

Ecotoxicity: The product is highly toxic to fish (Bluegill Sunfish - Lepomis macrochirus LC50 = 0.3 ppm); invertebrates (Daphnia magna LC50 = 0.21 ppm), and Green Algae (LC50 < 0.50 ppm).

Fate and Transport: The product is subject to hydrolysis within minutes, forming cyanuric acid and halogen moieties, which is inherently biodegradable. The material degrades relatively fast and is not considered to bioaccumulate.

Persistence: The product is unstable in the environment because the available chlorine is rapidly reduced. Hydrolysis occurs within minutes. None of the hydrolysis products are persistent.

13. DISPOSAL CONSIDERATIONS

Methods of Disposal, Waste of Residues, Contaminated Packaging: Waste must be disposed in accordance with applicable federal, state and local environmental control regulations. Keep spilled product out of trash containers, drains, and sewers. Incompatible material can cause a reaction and combustion. Do not transport wet or damp material. Damp material should be neutralized. Contact Company for further disposal instructions.

14. TRANSPORT INFOPRMATION

Land Transport - ADR/RID
Proper Shipping Name: Trichloroisocyanuric Acid, dry
ID Number: UN 2468
Hazard Class: 5.1
Packaging Group: II
Hazard ID Number: 50
Label Requirements: 5.1

Marine Transport – IMDG/GGV
Proper Shipping Name: Trichloroisocyanuric Acid, dry
ID Number: UN 2468
Hazard Class: 5.1
Packaging Group: II
EmS F-A, S-Q

Air Transport – ICAO/IATA
Proper Shipping Name: Trichloroisocyanuric Acid, dry
ID Number: UN 2468
Hazard Class: 5.1
Packaging Group: II

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15. REGULATORY INFORMATION

EEC Directive**: 91/155/EEC amended by 93/112/EEC; Dangerous Substances and Preparations, and in accordance with current product labelling:**

EINECS Number: 201-782-8

Hazard Symbols:

O: Oxidising
Xn: Harmful
N: Dangerous for the environment

Risk Phrases:

R8: Contact with combustible material may cause fire.
R22: Harmful if swallowed.
R31: Contact with acids liberates toxic gas.
R36/37: Irritating to eyes and respiratory system.
R50/53: Very toxic to aquatic organisms, may cause long-term adverse effects in the aquatic environment.

Safety Phrases:

S2: Keep out of reach of children.
S8: Keep container dry.
S26: In case of contact with eyes, rinse immediately with plenty of water and seek medical advice.
S41: In case of fire and/or explosion do not breathe fumes.
S46: If swallowed, seek medical advice immediately, and show this container or label.
S60: This material and/or its container must be disposed of as hazardous waste.
S61: Avoid Release to the environment. Refer to special instructions/Safety data sets.

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December 2019

TRAINED FIRST AIDERS

First Aiders:

Charlotte Molloy – DHT[4]
Neil Macfarlane – Business Manager[4]
Julie Chapman – Music[4]
Nicola Murray – H&S[3]
Pamela Ferguson – Nurse[2]

Femi Patel – LS[4]

Neal Gough – PE[3]
Charlotte Horton – PE[3]
Ann Kind – PE (private)
Natalya Christie – PE (private)

Adelle Pheby – FS1[3]
Tara Asbury – FS1[3]
Liz Holloway – FS1[2]
Tracey Frame – FS1[2]
Amy Edmunds – FS2[2]
Agata Thompson – FS2[2]
Amber Pollard – FS2[2]
Alix Kimber – FS2[2]

Ubah Farah – Year 1[3]
Cole Forrest - Year 1[2]
Dawn Urry – Year 2[3]
Suzanne Potter - Year 2[2]
Sarah Harper - Year 2[2]

Zhila Moradi-Sani – Year 3[4]
Kathy Rangeley – Year 3[2]
Sandra Murray - Year 3[2]
Hina Khan – Year 4[3]
Victoria Henry – Year 4[3]
Kate MacGillicuddy – Year 4[2]

Catherine Francis – Year 5[3]
Nadia Eneser – Year 5[2]
Beata Sulzycka – Year 5[2]

Hugh Molloy – Year 6[4]
Sarah Robson – Year 6[2]
Ian Urry – Year 6[2]

Raul Agapay – Support[4]
Loreto Alfon – Support[4]
Rommel Bustamante – Support[4]
Peter Cabudol – Support[4]
Anthony Chavenia – Support[4]
Subash Pokhrel – Support[4]
Afsal Thazha – Support[4]

2 – Renew September 2021

3 – Renew November 2021

4 – Renew May 2020

Sean Sibley
Headteacher

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Facsimile: + 974 4459 2761

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September 2019

Weather Guidelines

The Headteacher or his delegate is responsible for any decisions made regarding the weather, using the following points as a guideline. A weather station with data available on the school website is used as guidance.

- Rain: should the open areas be deemed unfit for use, then inside play will be instituted. In the case of outside PE sessions, these will be held indoors as appropriate. As a result of heavy rainfall, the pitch and swimming pool may be deemed unsafe for use.
- Thunder and lightning: All outside activities and swimming activities will cease immediately.
- Wind: Activities can continue in strong winds, if there is no danger of equipment becoming airborne, or debris becoming dangerous.
- Dust: If levels can be measured and monitored, then the maximum acceptable level is 10 mg/m^3 for an 8 hour period. Air-conditioner filters are to be serviced regularly (maintenance plan every 2 or 3 months). Decision to be made by H and S and a member of the Management team taking into account the readings on the handheld apparatus.
- Heat: Should the apparent temperature exceed 42ºC, exposure should be kept to a maximum of 10 minutes at any one time. Water must be available and hats are to be worn. An inside area will be made available for those who do not wish to be outside. Management will advise if deemed too hot.
- Earthquake: Sound alarm, and children and adults to evacuate to the field, following fire drill procedures.

Sean Sibley
Headteacher

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