Ormiston Academies Trust

Allergy safety policy

Policy version control

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Review	August 2027 This policy will be reviewed annually in line with OAT's internal policy schedule, and after any serious allergy-related incident or near miss and updated when new legislation comes into force. It is published on the academy website and available in hard copy on request.
Description of changes	New policy, produced to meet the duty under section 34 of the Children's Wellbeing and Schools Act 2026.

	Updated September 2026 with minor changes to align with Supporting Children with Medical Conditions policy, as well as ensuring student's prescriptions are managed as per the Trust's guidance.

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1. Introduction

1.1. Ormiston Academies Trust (OAT) is committed to ensuring that every child can learn and thrive safely, whatever their medical needs. Allergies — to food, insect venom, medicines and latex — are common: around two children in every classroom have a food allergy, and many severe reactions occur in children with no previously known allergy.

1.2. This policy sets a consistent, trust-wide standard across all OAT academies. As now required in law, it is a dedicated, published allergy safety policy rather than part of the general medical conditions policy. The legislation and statutory guidance underpinning this policy, and the linked OAT policies, are set out in Appendix 4

1.3. The **Children's Wellbeing and Schools Act 2026, s.34 ("Benedict's Law")** exists (in memory of Benedict Blythe, a five-year-old who died after an allergic reaction at school in 2021) so that no family suffers a preventable loss of this kind again — a purpose at the heart of this policy.

2. Allergy Safety Policy at a Glance

2.1. How the policy works in practice — the key actions at each stage and the considerations that sit alongside them.

1. IDENTIFY — Know who has allergies: gather information for children, staff and visitors at admission and whenever new information arises. A formal diagnosis is not needed before support is put in place. (Section 6)

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2. PLAN — Agree an Individual Healthcare Plan (IHP) with the child and their parents/carers; share it with staff on a need-to-know basis. (Section 7)

▼

3. REDUCE RISK — Manage allergens in food provision, lessons, trips and events; apply Natasha's Law and control cross-contamination. (Section 9)

▼

4. PREPARE — Train all staff to recognise and respond to allergic reactions; ensure rapid access to medication, including the academy's spare adrenaline (AAIs). (Sections 10–11)

▼

5. RESPOND — In an emergency, use the adrenaline auto-injector without delay, call 999 and stay with the child. (Appendix 1)

▼

6. REPORT & LEARN — Record and report the incident, inform parents/carers, review the IHP and share the learning. (Section 13)

At every stage consider: wellbeing and inclusion (Section 12) • communication with families (Section 14) • safeguarding (Section 15) • data protection (Section 8) • adaptations for special schools, AP and EYFS (Sections 16–17)

It could happen here

A serious allergic reaction can occur in any of our academies, at any age, on any day — including in a child with no diagnosed allergy.

Up to one in five anaphylaxis emergencies in schools is a first-time reaction.

Safeguarding is everyone's responsibility

Keeping children safe — including from an allergic reaction not recognised or treated quickly — is the responsibility of every adult: trustees, governors, leaders, teachers, support and catering staff, site staff, agency and supply staff, contractors and visitors.

Allergy safety is treated as a whole-school safeguarding and health-and-safety matter, not a niche medical issue delegated to a first aider.

3. Policy Aims and Scope

3.1. This policy sets out how the trust will:

3.1.1. identify children and young people with allergies and minimise the risks of exposure to known allergens, including managing the risk of food allergy.

3.1.2. share how staff will be trained in allergy awareness and emergency response

3.1.3. how individuals at risk of anaphylaxis will have access to their prescribed adrenaline devices, alongside “spare” adrenaline devices.

3.1.4. how children and young people with allergy will be able to participate in visits and trips

3.1.5. how Individual Healthcare Plans will capture specific arrangements (including any Allergy Action Plan and/or Asthma Plan); and

3.1.6. how the wellbeing and inclusion of children and young people with allergy will be promoted.

3.2. This policy applies to:

3.2.1. All OAT academies registered early years and nursery provision, primary, secondary and sixth form, special schools and alternative provision (AP) schools

3.2.2. All employees, and to agency and supply staff, contractors, volunteers and visitors while on academy sites or on academy-led activities off site.

3.2.3. All academy premises, off-site visits, residential trips, sports fixtures, and before- and after-school provision including breakfast and holiday clubs.

3.3. This policy should be read in conjunction with:

3.3.1. Statutory legislation and guidance as outlined (but not definitive) in Appendix 4

3.3.2. OAT policies as outlined in Appendix 4

3.3.3. The term 'parents' in this policy covers parents, carers and guardians

4. Roles and Responsibilities

4.1. Allergy safety is a shared responsibility. This policy is to be shared with all staff and sets out how Ormiston Academies Trust meets its statutory duty to have allergy safety measures in place at our academy.

4.2. The trust is responsible for the overarching policy and for holding academies to account for allergy safety, but it is the responsibility of each principal and academy governing body to ensure the policy is followed and implemented within their own academy.

4.3. Each academy must designate a named Allergy Safety Lead, who is a member of the senior leadership team (SLT) as they will have overall responsibility and accountability, in line with statutory guidance.

4.4. The Allergy Safety Lead can delegate responsibility to a member of their team; however, they remain accountable. This person is likely to also be the academy's medical lead, given the overlap between allergy safety and wider medical conditions support.

4.5. Detailed responsibilities for each role and check list can be found in are set out in Appendix 2

5. Allergic Conditions and Reactions

5.1. An **allergy** is a reaction of the body's immune system to a substance — known as an allergen — that is normally harmless, such as a food, pollen, insect venom, latex or a medicine. In someone with an allergy the immune system mistakenly treats the allergen as a threat and releases chemicals to defend against it, producing symptoms that can range from mild, such as an itchy rash or a runny nose, to a severe and potentially life-threatening reaction known as anaphylaxis.

5.2. **Common allergic conditions** include:

- Hay fever
- Skin allergies (eczema, contact dermatitis, hives)

- Food allergy — the 14 allergens regulated in UK food law are lupin, fish, soya, sesame, peanuts, molluscs, egg, sulphites, cereals containing gluten, celery, crustaceans, milk, tree nuts and mustard
- Allergic asthma
- Less common conditions, including insect sting and medicine allergy, and other medically recognised sensitivities (e.g. mast cell disorders) that can also cause serious reactions and must be managed in the same way

5.3. Coeliac disease and food intolerances are not allergies and sit outside this policy but are supported through the trust's Supporting Children with medical conditions policy.

5.4. **Anaphylaxis** reactions range from mild to whole-body reactions to anaphylaxis. The most common triggers of anaphylaxis are:

- Food
- Insect stings
- Medication
- Latex

5.5. For how to recognise and respond to an allergic emergency — including when and how to administer adrenaline — staff must follow the emergency response procedure set out in Appendix 1.

6. Identifying Children, Staff and Visitors with Allergies

6.1. The policy sets out the arrangements for identifying individuals with allergy and gathering information about their allergy.

6.2. Identifying Children with Allergies

6.2.1. When a child starts with a new school, arrangements should be in place in time for the start of the relevant school term (or as soon as is practicable)- by gathering known allergies, medication carried, and any existing IHP or Allergy/Asthma Action Plan, from the child and/or parent or previous setting.

6.2.2. All allergy-related data for children is to be stored on Arbor and/or another secure location approved by the trust. Access to allergy information should be made accessible to all staff, and those volunteers that are working with children.

6.2.3. Where required, an IHP is completed (see section 7) as soon as possible — normally within two weeks of their start date.

6.2.4. Trip organisers must check the allergy register before finalising arrangements (section 11) which can be found within the registers list within the Evolve system.

6.2.5. A list of known allergies (with photos of the individual child) should be kept where food or other known allergens are handled such as canteen, food technology, craft and art) for staff access only.

6.3. Identifying Staff and visitors with a known allergy

6.3.1. Where a staff member has a known allergy, they will be supported by the academy in accordance with their individual wishes.

6.3.2. There should be a process in place for any visitors to the academy (particularly where they may be eating food) to be asked if they have any allergies to be shared with the catering team

7. Individual Healthcare Plans (IHP)

7.1. An **Individual Healthcare Plan (IHP)** is a written plan, agreed with the child (in a way appropriate to their age and understanding) and their parents, that sets out the additional or different arrangements needed to keep that child safe and included at the academy because of their medical condition (including allergies).

7.2. Children, particularly vulnerable children, may be subject to a variety of plans. A child will have an individual healthcare plan (IHP) covering all of their medical conditions, including any allergy, rather than separate plans for different conditions. Where the plan includes allergy arrangements, it is drawn up with the Allergy Safety Lead and complies with this policy.

7.3. **Please use** OAT standard's **Medical Conditions and Allergy IHP Template** which will cover all conditions and can be found here Medical and Allergy IHP template

7.4. A child does not need a formal diagnosis to have an IHP

7.5. A child must have an IHP if all three of the following apply:

- their allergy has a functional impact on them at the academy;
- they are at risk of harm as a result of their allergy
- and they need arrangements that are additional to, or different from, those provided generally.

7.6. Not every child with an allergy needs an IHP — for example, well-controlled hay fever may not — and this is a decision for the principal, made with the child and their parent and where relevant, healthcare professionals.

7.7. The IHP is to be completed by the academy (Allergy Safety Lead, with the child and/or parent) with the following information using the trust's standard template which can be found as detailed in 7.2 and here Medical and Allergy IHP template.

- the child's details and photo
- known allergens and triggers
- how the allergy is managed day to day (including at mealtimes, PE and trips)
- the impact on their education and wellbeing
- the emergency response, including where medication is kept and who is trained to give it.
- Arrangements in place for children and/or parents to take the individual prescribed AAIs home (where appliable)

- An Allergy Action Plan or Asthma Action Plan issued by a GP or allergy clinic (where applicable) which is attached to the IHP

7.8. The child is involved in decisions about their own allergy care in a way appropriate to their age and understanding, so that the plan is developed with them and not simply about them. Where a child is judged to have sufficient maturity and understanding to make a particular decision for themselves — known as Gillick competence — their wishes are given appropriate weight, for example in how and when they carry and self-administer their own medication.

7.9. IHPs for children stored on Arbor (or other secure medical system) with a printed copy kept in the main office/reception, first aid room and relevant classroom/kitchen so they are accessible in an emergency to staff who need them, while remaining confidential from those who do not.

7.10. Each IHP is reviewed at least annually, whenever new clinical advice is received, at key transitions (such as a change of year group or key stage), and after any allergic reaction or near miss involving the child. Any change is shared promptly with all staff who need to know, including catering staff and trip leaders.

8. Data Protection

8.1 Allergy and health information is "special category data" under UK GDPR and the Data Protection Act 2018. The academy processes it because doing so is necessary to protect a child's vital interests and to meet the academy's safeguarding and health and safety duties.

8.2 Children's allergy data is held on Arbor and/or another secure location, staff data on Every, generic risk assessments and incident recording are completed on iAM Compliant, and training and spare adrenaline auto-injector kit records are held on Kitt Medical. Access to all of these is limited to staff who need the information to keep the individual safe.

8.3 Data is kept only for as long as necessary, in line with the trust's data retention schedule, and disposed of securely once it is no longer needed.

8.4 Parents can ask to see, correct, or ask the academy to stop holding their child's allergy data by contacting the academy or the trust's Data Protection Officer; further detail is in the trust's Data protection and freedom of information policy (section 1).

8.5 Information is shared outside the academy only where necessary to protect the child — for example with emergency services, healthcare professionals, or a new school on transfer — or where the law requires it.

9. Managing the Risk of Allergens (including food)

9.1 Where children have known allergies, risk is minimised through the child's Individual Healthcare Plan (IHP), not a generic risk assessment, referring to "an individual" rather than naming the child in any shared or published document.

9.2 Food allergens through academy food provision

9.2.1 All food made or served in the academy must have the 14 known allergens recorded on an allergen matrix and kept on file and available for the end user to request to see, if required, in line with the Food Information Regulations 2014(FIR) . All food made or served in the Academy that is 'Pre- packed" for direct sale, must be labelled with the full ingredient list with allergens shown in bold font, in line with the Food Information (Amendment) (England) Regulations 2019 (known as "Natasha's Law").

9.2.2 Where a child has an allergy that is not included in the 14-allergen list, under the FIR legislation, the same procedure, as above, to record the allergen of a pupil, must apply.

9.2.3 Catering staff must be made aware of children who have a food allergy through the appropriate academy system and method (for example the allergy registers on Arbor, or a staff briefing), and ensure the meal prepared does not contain the allergens and that procedures are in place to control cross-contact (separate prep areas/utensils, handwashing, allergen-free meals prepared, covered and labelled, before other food preparation commences.

9.2.4 Where a child's allergy can be triggered by airborne particles, all reasonable additional measures (seating, ventilation, food location) are agreed through their IHP and shared with relevant staff.

9.2.5 Food provided by the academy also complies with the Requirements for School Food Regulations 2014 (the School Food Standards); where a child's food allergy needs a reasonable adjustment to a Free School Meal, this is agreed with catering and recorded through the child's IHP.

9.2.6 The academy takes an "allergy-aware" approach rather than a "nut-free" policy — nuts are only one of many allergens, and a nut-free policy implies the absence of nuts across the whole school and can create a false sense of security. The focus is on managing known allergens actively and maintaining robust emergency arrangements, rather than banning a single food group.

9.2.7 Where catering is provided by an external contractor, the contract sets out the same allergen safety expectations as for in-house catering, and the Allergy Safety Lead (with the Health and Safety central team) periodically checks the contractor's allergen management, staff training records and incident history as part of routine oversight.

9.2.8 At mealtimes, the academy uses at least two methods to identify children with a known food allergy — for example a member of catering staff checking against the allergy register, alongside a visual method such as photographs or coloured lanyards in the kitchen or serving area — chosen to suit the size of the academy and the age of the children, without segregating them from their peers.

10. Staff Training and Awareness

10.1 All academy staff present while children are on site — including temporary, supply, peripatetic, agency and regular volunteer staff — must complete allergy awareness training; this does not extend to contractors with no child-facing role. Completion is mandatory: no one may be left in sole charge of children until the training below is complete.

10.2 Anaphylaxis and allergy awareness training for all staff is embedded in Kitt Medical and forms part of the trust's general Health and Safety awareness training — it is not delivered via iAM Compliant. It is mandatory,

completed on joining and refreshed annually, and covers recognising allergic reactions and anaphylaxis, the difference between allergy, coeliac disease and intolerance, this policy, the allergy register and Action Plans, staff responsibilities in reducing exposure, and how to respond in an emergency, including locating and using AAIs and a reliever inhaler.

10.3 Kitt Medical is also used to store and track the academy's spare adrenaline auto-injector kits, including expiry dates and stock checks (section 11).

10.4 New staff complete this training during induction, before taking sole responsibility for children. Supply and cover staff are briefed on relevant allergy information before covering a class.

10.5 The Allergy Safety Lead monitors completion for every member of staff and reports compliance to the principal at least termly, following up individually with anyone who falls behind.

11. Access to Medication

11.1 Prescribed adrenaline

11.1.1 Children at risk of anaphylaxis are usually prescribed adrenaline auto-injectors (AAIs). Under Section 34 of the Children's Wellbeing and Schools Act 2026 ("Benedict's Law"), children should carry their AAI on their person at all times, not only outdoors, since most anaphylactic reactions are triggered by food and can happen anywhere on site.

11.1.2 Where a child cannot safely carry their own AAI, devices are stored unlocked in an agreed, always-accessible location, at room temperature.

11.1.3 All prescribed AAIs that are held at the academy must be checked at least termly to ensure that these are in date and recorded on Appendix-3---Academy-Allergy-Audit-Record.docx

11.2 Spare adrenaline

11.2.1 In line with the Human Medicines (Amendment) Regulations 2017, the academy also stocks unprescribed "spare" AAIs in pairs, clearly labelled, unlocked, and positioned so any part of the site can be reached within five minutes.

11.2.2 Each academy has received a minimum of 1 kit with (1 pair of 150mcg and 1 pair of 300mcg spare AAIs) in a kit provided by Kitt Medical. Where an academy is larger such as a secondary school and/or where there are multiple buildings, they will have received between 2-4 kits as detailed.

11.2.3 Storage location is for each academy to determine based on its own site; however, it is recommended that there is at least 1 AAI near to reception and canteen as a minimum. These spare devices are recorded and tracked on Kitt Medical and checked at least termly for expiry. These are tracked on KITT medical, before the AAI are due to expire new AAI are dispatched automatically to the academy.

11.3 Access to other prescribed medication for allergies (such as Ventolin Inhaler)

11.3.1 Where a child has severe asthma that is triggered from an allergic reaction, and always requires access to their Ventolin, a spare Ventolin inhaler must be kept in an accessible location (as well as with the child where appropriate) at all times and recorded as per section 10.4

11.3.2 The academy may also hold an emergency salbutamol (reliever) inhaler and spacer for use in an asthma emergency, in line with the Human Medicines Regulations 2012 (as amended) and the Department of Health and Social Care guidance on the use of emergency inhalers in schools. An emergency inhaler may be used only for a child who has been diagnosed with asthma, or prescribed a reliever inhaler, and whose parents/carers have given written consent. Emergency inhalers are stored with the spare adrenaline devices, checked at least termly for expiry, and any use is recorded and reported in line with section 13.

11.4 Records and consent

11.4.1 The academy must record the following information for all children that have allergies in conjunction with their IHP, using Appendix 3, Academy Allergy Audit Record:

11.4.2 This must be completed every term as minimum

- Name of child, form name
- Allergy Trigger
- IHP stored location
- Who has been notified (i.e. relevant staff)
- Have catering been made aware (where applicable)
- Location of emergency medication (always accessible)
- Check medication is in date

Please note that consent is not required to use a spare device to save a life in an emergency.

11.5 Disposal of devices

11.5.1 Used or expired devices are disposed of per manufacturer for guidance (sharps bin or via paramedics/pharmacy).

11.6 Educational visits and trips

11.6.1 For any trip, the trust's Evolve system is used to record and approve the trip risk assessment; for a trip involving a child at risk of anaphylaxis, this confirms a trained staff member will attend, medication (including spares) will travel with the group and stay within five minutes' reach, and the IHP is taken. No child is excluded from a trip because of their allergies.

12. Wellbeing and Inclusion

12.1 Allergy can cause anxiety for children and families. The academy provides reassurance that exposure risk is being minimised and that robust emergency arrangements are in place.

12.2 Good practice includes regular communication on allergy awareness; proactively engaging new joiners with a known allergy and their families; introducing them to catering staff and the dining environment; and using "allergy champion" roles among staff and pupils.

12.3 The academy does not: restrict access to prescribed medication; ignore the views of the child or their parents/carers, or the advice of healthcare professionals; assume all children need the same support, or that older children no longer need support; assume a child does not have an allergy simply because they do not yet have a diagnosis; send an unwell child to a room unsupervised (help comes to the child); penalise attendance for allergy-related absence; require parents/carers to attend the academy to administer medication or provide medical support, or otherwise let their child's allergy impact their work or other responsibilities; or exclude children with allergy from trips, activities or lunchtime with peers.

13. Incident Reporting

13.1 What counts, and how it's recorded

13.1.1 A serious incident includes any anaphylactic reaction or use of emergency adrenaline; a near miss is any exposure, or near-exposure, to a known allergen that was avoided or less severe than it might have been.

13.1.2 Any staff member aware of a suspected reaction, incident or near miss records it on iAM Compliant as soon as possible (what happened, when, medication given, outcome). Any use of an adrenaline device is also recorded on Kitt Medical.

13.2 Reporting and learning lessons

13.2.1 Incidents and near misses are reported to parents/carers the same day where possible, and to the Allergy Safety Lead, who notifies the principal, the trust and the academy's governing body. Any incident resulting in death or serious injury is reported to the Health and Safety Executive (HSE) under RIDDOR, and food-related allergen incidents may also require reporting to environmental health and the Food Standards Agency under food safety law. Every serious incident or near miss is investigated and the child's IHP and this policy reviewed; periodic allergy safety drills are good practice.

13.2.2 The academy uses Kitt Medical and iAM Compliant as its digital tools: Kitt Medical hosts staff training records and the record of emergency and spare adrenaline auto-injector kits; iAM Compliant holds risk assessment templates (section 9) and is used to record all accidents and incidents, including those involving adrenaline auto-injectors, which are also logged on Kitt Medical.

13.2.3 Staff should log incidents on the relevant system within 24 hours and notify the Allergy Safety Lead directly for anything serious.

14. Communication

14.1 This policy is shared with all staff, published on the academy website, and available in hard copy on request. Parents/carers are told about it when their child joins and reminded at least annually. The policy is also

brought to the attention of all pupils at least once a year in an age- and stage-appropriate way, for example through assemblies or tutor time, so that all pupils, parents/carers and staff are reached annually.

14.2 Where a shared classroom environment needs collective cooperation (e.g. an allergen-aware classroom), families are told what's being asked without identifying the child. Supply, cover and regular visiting staff are briefed on relevant allergy information before taking responsibility for a class or group.

14.3 Any change to this policy or an individual child's arrangements is communicated promptly to relevant staff. This policy is reviewed at least annually, in line with section 1.

15. Allergy Safety and Safeguarding

15.1 Under Keeping Children Safe in Education (KCSIE) 2026, the fact that a child has a medical condition or allergy is not an indicator that the child is at greater risk of harm. However, allergy safety connects directly to safeguarding, and it is treated as a whole-school safeguarding matter and not a niche medical issue.

15.2 A failure to recognise, plan for or respond to a child's allergy can cause serious harm or death, and may indicate wider weaknesses in the academy's culture of care.

15.3 Designated Safeguarding Leads (DSLs) must consider whether a medical incident, near miss or repeated failure to follow a child's plan triggers a safeguarding duty — for example, if it suggests neglect or that a child is being placed at risk — and whether further action or referral is needed.

15.4 Deliberately exposing a child to a known allergen, or using food or allergens to bully, coerce or harm a child, is a safeguarding matter and must be reported to the DSL.

15.5 Ofsted gathers evidence about allergy arrangements as part of its safeguarding evaluation. Allergy safety is not a separate, standalone judgement, but inspectors will expect to see that this policy, training records, Individual Healthcare Plans and incident learning are effective in practice, not merely present on paper.

15.6 Children with special educational needs or disabilities (SEND), medical conditions or allergies can face extra safeguarding risks, both online and offline. Abuse, neglect or exploitation may be harder to recognise in these children because: signs such as changes in behaviour, mood or injury may be wrongly put down to their condition; they are more likely to be isolated or bullied (including prejudice-based bullying) without showing obvious signs; communication difficulties can make it harder for them to report abuse; and they may need intimate care, depend more on adults, and find it harder to judge what is real online.

15.7 All adults must therefore be aware of and extra vigilant to the possible indicators of abuse and/or neglect for disabled children. The designated safeguarding lead should liaise regularly with the special educational needs co-ordinator, the behaviour lead, the mental health lead and the attendance lead, maintaining a culture of vigilance and being alert to any relevant new information or concerns.

16. Special Schools and Alternative Provision

16.1 OAT's special schools and alternative provision (AP) settings apply everything in this policy, with additional attention to the areas below.

16.2 Communication needs: some children cannot reliably report symptoms, so staff vigilance, close supervision and clear Individual Healthcare Plans are especially important.

16.3 Complex needs: allergies may coexist with other medical conditions, EHC plans, feeding or PEG needs, or delegated healthcare tasks; plans are joined up with the SENCO and health professionals.

16.4 Behaviour and food: where children may take or share food impulsively, environmental controls and supervision are strengthened and risk assessed.

16.5 Transport and off-site AP: AAIs, plans and trained staff travel with children, and commissioned or AP settings are expected to meet the same standard.

17. Early Years Foundation Stage (EYFS)

17.1 This section applies to academies with early years provision (nursery and Reception). Early years settings apply everything in this policy alongside the safeguarding and welfare requirements of the Statutory Framework for the Early Years Foundation Stage (EYFS).

17.2 Before a child starts, the academy gathers full information about any allergy, intolerance or special dietary requirement from parents/carers, and records it in the child's Individual Healthcare Plan and on the allergy register.

17.3 At meal and snack times, staff supervise children closely, know which children have allergies, and follow each child's plan. Food is not shared between children, and tables and surfaces are cleaned between sittings to reduce the risk of cross-contamination.

17.4 Allergen information for food provided is obtained from the caterer, or prepared in line with the Food Information Regulations, and is available to staff serving young children.

17.5 Staff working in early years complete the same anaphylaxis and allergy awareness training as other staff, and at least one trained member of staff is present wherever food is served to young children.

18. Insurance

18.1 Staff members who undertake responsibilities within this policy are covered by the academy's public liability section of the policy. This cover extends to any member of staff who administers a spare adrenaline device or the academy's emergency salbutamol inhaler in an emergency, whether or not they have volunteered to administer medication under this policy. This is defined as incidental treatment which includes the administration or supervision of medication orally, topically, by injection or by tube, and the application of appliances or dressings.

18.2 Full written insurance policy documents are available to be viewed by members of staff who are providing support to children with medical conditions. Those who wish to see the documents should contact the principal.

Appendices and Templates

Medical and Allergy IHP Template.docx

Appendix 1: Emergency Response Quick Reference

Appendix 2 Roles and Responsibilities 2026.docx

Appendix-3---Academy-Allergy-Audit-Record.docx

Appendix-4---Legislation--Guidance-and-Linked-OAT-Policies.docx