CAMPUS HEALTH GUIDELINES

International SOS
Foundation

337 Education
Medical

AGENDA

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01. INTRODUCTION

A school is more than a physical building where students receive an education. It is an ecosystem which provides students with a safe environment to gain knowledge, build physical fitness, inculcate healthy lifestyle habits and integrate into society and the world at large as good citizens. In addition, a school is also a workplace where staff (academic and administrative) are employed to work. To keep them healthy and safe, workplace rules should be followed. The school has a huge responsibility for the health and well-being of its students and staff.

This booklet aims to provide school administrators and medical staff with basic guidelines on healthcare for students and staff. It is intended as a management guide to support schools in developing the appropriate policies that meet their needs. Hence, it may not cover all the details of school healthcare requirements.

Areas of consideration for campus healthcare include setting up medical facilities, administering first aid and medications as well as safeguarding the welfare and mental health of students.

School management systems should also adopt the health and welfare policies set by the Ministry of Health, Ministry of Education and Ministry of Labour in their countries.

02. SCHOOL HEALTH FACILITY

Definition

The School Health Facility (SHF) provides medical care to staff and students in the school's premises. It also renders first aid and emergency medical care to the school's visitors.

The medical capability of a SHF varies from simple first aid to basic and advanced life support. The SHF's function may range from dispensing over-the-counter (OTC) medications to acting as a primary health care provider. As such, the staffing needs of each SHF differs and can be manned by first aiders, nurses or doctors.

The SHF is also expected to provide health education and first level psychological first aid to students and staff.

First Aid Post

First Aid Post Requirements:

Premise

There should be a separate room set aside for first aid.

If it is not possible to secure a stand-alone space, schools can use an isolated part of an office as a first aid corner. It is important to ensure that the area is blocked off with a screen to provide privacy during treatments.

Personnel

The first aid post should be manned by trained first aiders.

Equipment (Non-Medical)

- Furniture (table, chairs)
- Single bed with curtains for privacy but not closed off for child safeguarding purposes
- Locked cabinets for medical records
- Locked cabinet for medication storage
- Adequate ventilation
- Signage which states "First Aid Room" displayed at the entrance of the room

Equipment (Medical)

- First Aid Kit
- Blood pressure set, stethoscope, otoscope, pulse oximeter
- Splints for immobilization
- Stretcher (adequate operator maintenance weekly, preventive maintenance annually and staff training in casualty transfer, especially for spinal and cervical injuries)
- Dressing sets
- Bin for biological waste

School Clinic (Nurse)

School Clinic (Nurse[1]) Requirements:

Premise

The minimum requirement is a separate room to be used for:

- Consultation and counselling
- Treatment
- Medical equipment and medications storage
- Reception / Waiting area
- Record-keeping (medical records of the students should be kept until the age of 25 years)
- Health education and promotion

Equipment (Non-Medical)

- Furniture (table, chairs)
- Examination light
- Patient examination bed with privacy screen/ ceiling-mounted curtain
- Lockable small refrigerator only for storage of medications
- Lockable cabinets (medications)
- Lockable cabinets (document and records)
- Computer / laptop (ideally for each nurse on the floor but if shared, to be logged in under different account)
- Telephones for both internal and external lines
- CCTV for common areas, especially where medication is stored and administered (not the consultation and treatment areas)
- Signage which states “Clinic” displayed at the entrance of the room

Equipment (Medical)

- First aid kit (within school premises but outside school clinic) managed by designated personnel with monthly check
- First aid kit (within clinic) managed by clinic nurses with weekly check
- Medical kit (especially for AED, daily check)
- Blood pressure set, stethoscope, otoscope, pulse oximeter
- Diagnostic: glucometer and glucose strips
- Diagnostic: urine dipsticks
- Salbutamol nebulizer kit (Schools should provide spacers but Salbutamol should be provided by parents)
- Splints for immobilization
- Stretcher (adequate operator maintenance weekly, preventive maintenance annually and staff training in casualty transfer, especially for spinal and cervical injuries)
- Dressing sets (sterile and non-sterile consumables, personal protective equipment e.g. gloves, masks, aprons etc.)
- Bin for biological waste
- AED (Automatic External Defibrillator)
- EpiPen kit provided by parents
- Diabetic kit prescribed by student’s doctor

Personnel

The school clinic (nurse) should be manned by staff nurses who are registered/ licensed in the country where the school is located.

[1] If not being registered / licensed in the country where the school is located, staff may not be referred to as a ‘nurse’ e.g. assistant nurse, technical advisor etc.

School Clinic (Doctor)

School Clinic (Doctor) Requirements:

Premise

The space should consist of a:

- Room for consultation and for counselling
- Room for treatment
- Room for lockable storage of medical records and medications
- Reception and waiting area
- Health education corner

Equipment (Non-Medical)

- Furniture (tables, chairs, sofa, TV screen for health education)
- Examination light
- Patient examination couch
- Lockable small refrigerator only for storage of medications
- Lockable cabinets (medications)
- Lockable cabinets (document and records)
- Computers
- Signage which states "Clinic" displayed at the entrance of the room

Equipment (Medical)

- First aid kit
- Medical kit
- Blood pressure set, stethoscope
- Diagnostic set (otoscope, opthalmoscope)
- Diagnostic: glucometer and glucose strips
- Diagnostic: urine dipstick
- 12-lead ECG machine
- AED
- Oxygen tanks and respiratory masks
- Splints for immobilization
- Stretcher (2-fold or 4-fold stretcher)
- Dressing sets
- Medications for common childhood ailments (separate assessment)
- Bin for biological waste
- Anaphylaxis kit
- Asthmatic kit
- Diabetic kit

Personnel

The school clinic (doctor) should be manned by doctors and supported by nurses. Both doctors and nurses should be registered / licensed in specific country where the school is located.

Training

Medical training requirements for the school clinic are:

- CPR and AED
- School first aid
- BCLS (minimum requirement for nurses, preferably ACLS)
- ACLS and ITLS (for doctors)

School medical staff should conduct internal drills for evacuation regularly and mass casualty incident management annually.

Medical/ nursing staff should also receive non-medical training such as Safeguarding of Children.

Health Education and Promotion

Schools without medical staff may consider engaging medical companies or part-time medical professionals such as nurses or doctors to deliver health education and promotion programmes. An alternative is to work with public hospitals or the Health Ministry for community medical support.

Regardless of whether the health education and promotion programmes are outsourced, it should be planned and not be ad-hoc. Health Education should be integral to the education curriculum. Rather than holding one-off sessions, the school medical team should work with a wider school team (e.g. counsellors, Educational Psychologist and pastoral Heads etc.) and with external resources such as medical company or community hospital to assess the school's needs and deliver a strategic year-long programme consisting of a series of topics.

The following topics are suggested to be covered:

- Talks on current health issues in the country
- Talks on students' common health issues
- Talks on mental health such as stress management
- Health screening for students and non-students
- Vaccinations
- Training in first aid to staff and older students
- Health and hygiene inspection

This also extends to education sessions with parents about keeping physical health, mental health issues etc.

Sporting Event Medical Support

The management team in school should have a Medical Emergency Response Plan (MERP) that provides further details on how to activate medical resources and evacuation assets such as advice on the most appropriate hospital near the school and the provision of ambulance.

Prior to any sporting event, training instructors or sports teachers should perform a risk assessment. Based on this recorded risk assessment, the sports teacher should discuss with the medical team in school about the provision of further medical support if necessary.

Level 1 (Low risk): Safety brief, MERP and first aid kit at sporting site

Level 2 (Low-Medium risk): Safety brief, MERP, first aider on site and first aid kit on site

Level 3 (Medium- High risk): Safety brief, MERP, nurse or paramedic on site with medical responder bag, stretcher, AED and oxygen resuscitator

Level 4 (High risk): Schools need to cancel any activities that are considered as high risk. Risk mitigation needs to be done if schools want to continue to facilitate high risk activities.

03. SCHOOL FIRST AID

Background

Education programmes in schools today consist of some activities that could potentially put students at some risk, however minimal. Examples of these activities are sports and physical exercise, laboratory class and play time in the open court or school field. In addition, some students may come to school sick or injured. As such, the school must be prepared to render emergency first aid to students in need of medical attention before the ambulance arrives or parents pick the students up.

Every school is managed by a team of academic, administrative and support staff. These adults may come to work with acute or chronic illnesses or injuries sustained outside. Heart disease is one of the top causes of mortality in many countries especially developed countries. The staff of the school may have heart disease and it is important that first aid is available for them.

First aid requirements and training for managing children (students) is different from that of managing adults. The first aid training for students should include common ailments seen in children within that age group. In the USA, such first aid is known as Pediatric First Aid and in the United Kingdom, it is known as Student First Aid[2].

Legislation for School First Aid[3]

Schools must adhere to the legislation on health support for education providers of the country where they are located. In addition, schools should also adhere to their school group's guidelines or policies on provision of school first aid.

WHO's definition of pediatric age group is from 1 year old to 18-years old. In many countries such as Singapore, a child is defined as someone between 1-year-old and puberty. Student first aid should also be provided in pre-schools such as childcare centres, nurseries, kindergartens and lower and upper grade schools.

Number of First Aiders

Aside from providing education, schools also operate as a business or workplace The Health, Safety and Environment (HSE) Executive / Ministry of Labour recommends that schools provide one first aider for every 50 personnel. It is important to note that this recommendation is based on the minimum requirement.

The school management should conduct a school risk assessment to determine how many first aiders are needed. Factors to consider include:

- Size of the school and the number of floors / levels
- Location of the school – whether it is located in remote location and separated from medical facilities by obstacles such as rivers or mountains where evacuation routes through a single bridge or tunnel could potentially be hampered by heavy traffic
- Places of specific hazards in the school which pose short-term risks (construction and maintenance works) or long-term risks (laboratory, sports hall, swimming pool and kitchen)
- Staff or students with special health requirements
- Age range and population size of students
- Off-site activities such as domestic and international field trips
- Presence of external contractors working in the school such as caterers, cleaners, school bookshop or food outlet workers. The school's management should work with its external contractors to agree on the responsibility and provision of first aid kits and first aiders

[2] Pediatric First Aid (US) covers infants and children up to 12 years of age and Student First Aid (UK) covers young people between the ages of 7 and 18 in primary and secondary schools.

[3] 'School First Aid' is used to cover a range from preschool to the ages of 18 as Asia does not have such unified term that define age covered, unlike US and UK.

The number of first aiders schools need must take into consideration the school's off-site first aid requirements as well as the possible absence of first aiders due to illness and holidays.

First Aid Kits

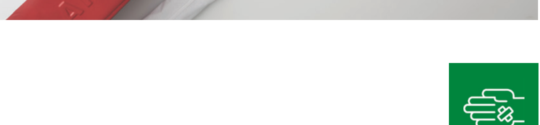
Quantity

- There should be a first aid kit allocated for each site identified to pose a risk for students and staff through the risk assessment
- Additional first aid kits would be required for different levels in the school, distant fields, near sporting facilities and off-site activities

Contents

- All first aid kits should be clearly marked with either a "white cross marking on a green background" or "white cross marking on a red background". The words "First Aid Kit" should be printed on the box.
- First aid kits should be checked for expiry date of items by a designated staff member
- A list of recommended content for the first aid kit is listed in the ANNEX A.
- A separate list for Anaphylaxis kit and Asthma kit is listed in ANNEX A2

School First Aid Training



First aiders should be trained in the following:

- CPR (children CPR is required) and AED
- School first aid

School First Aid Syllabus

Children Emergency

- Bronchial asthma
- Seizure
- Diabetes mellitus
- Anaphylaxis
- Choking (foreign body in airway)
- Approach to unconscious child

Injuries

- Head injury
- Back injury
- Burns (dry and wet)
- Sprain and strains
- Dislocation and fracture
- Eye and ear injury

Heat Disorders

Poisoning

Basic First Aid

- Arrest of haemorrhage
- Immobilization
- Dressing
- Use of first aid dressing

First aid recertification should be done every 2 years but in order to keep first aiders competent, refresher training is required annually.

04. ADMINISTRATION OF MEDICATIONS IN SCHOOL

Introduction

Students may need to take medications when they are in school regardless of their pre-existing medical conditions. In order to prevent and respond to those unforeseen illness of students, schools have a great responsibility to set their medication requirements as one of their medical management systems.

There are 3 main categories of medication requirement for schools:

Short Term Medications

Such medication requirement would not last more than one to two weeks.

e.g. Continuation of antibiotics started by doctor due to a recent episode of some minor illness

Long Term Medications

There are students who require long term medications to help them stay well.

e.g. Anti-epileptic medication to control seizures or immune-suppression medication for autoimmune diseases

Emergency Medications

Students with certain illnesses may require emergency medications to manage their medical conditions

e.g. Severe allergic reaction and bronchial asthma requiring adrenaline injections and Salbutamol inhalers

Responsibility

Schools are responsible for ensuring that all staff involved in the administration of medications is acquainted with the school medication policy and procedures. In addition, these staff must receive appropriate training which includes Children First Aid Training.

Staff administering medications should also have access to occupational health advice / doctor support in case of medicine overdose and needle stick injury or if they have questions about the students' medical conditions.

Schools which administer medications during school hours must obtain written approval form from students' parent / caregiver that contains all the relevant information. Verbal instructions are not allowed.

Parents have a primary responsibility for their

children's health and should update the schools with accurate information about their children's medical conditions. The parents should obtain the details (reports) from the doctors who are treating their children specifying diagnosis, treatment and fitness to participate with school curriculum and activities. Also, they have the responsibility of providing the school with correct, in date medication and replacing it when expired.

Policy

Schools must draft a policy regarding the administration of medications to students and share it with staff, parents and students. The policy should include:

- Procedures for managing prescription medications within the school compound and during school trips / outings (both domestic and international trips). This should include the policy that student should carry and take their own medications.
- Roles and responsibilities of the staff administering the medications as well as that of parents/ caregivers.
- Requirement for parents to provide prior written consent for any prescription medicines given to their children when in school
- Requirement for parents to provide prior written agreement for any non-prescription medicines given to their children when in school
- Staff training in administration of medications in school
- Documentation regarding the process of receiving, storing, distributing, recording and disposing medications
- Risk assessment of students with regard to the administration of medications

Prescription Medications

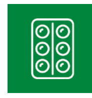
Schools should only accept medications prescribed by a registered professional such as a doctor or dentist. Medications must always be stored in the original container / pill bag dispensed by the pharmacist or doctor.

The following information has to be specified:

- Name of the student (Patient)
- Name of the medication (generic +/- brand name)
- Strength of the medication (strength per tablet or strength per 5 ml)
- Dosage and administration
- Frequency of administration (state date and time)
- Length of treatment / stop date (where appropriate)
- Any other instruction
- Expiry date of the medication
- Name of the doctor and contact

Schools should only accept medications prescribed by a registered professional such as a doctor or dentist. Medications must always be stored in the original container / pill bag dispensed by the pharmacist or doctor.

Non-prescription Medications



Schools can decide if they want to administer non-prescription medications to students. Some schools may choose to administer non-prescription medications only during school trips. Non-prescription medications should not be given to students without written consent / signature from parents / caregivers. Either paper form or online consent from parents / caregivers are acceptable.

It is recommended that the list of non-prescription medications should be limited such as the following, except when there is a doctor prescribing OTC:

- Paracetamol
- Antihistamine (example Benadryl)
- Activated Charcoal
- Antacids
- Oral Rehydration Salts
- Lozenges

Prior to dispensing any non-prescription medications, all staff has to follow the protocol which clearly states the indication of when to start

and when to stop taking it or when to start to seek medical attention.

Staff must follow the protocol when dispensing non-prescription medications. The reason for administering the non-prescription medication as well as when to stop the medicine and seek medical attention should be clearly stated.

Storage of Medications

The majority of medications should be kept in non-portable, locked cabinet located in a cool area. Staff who is managing the medications must always have access to them.

- Stored emergency medications should be readily accessible and not locked up. Examples of emergency medications are adrenaline injection for anaphylaxis delivered via autoinjector (e.g. Epipen) and Salbutamol inhaler provided by parents/ caregivers.
- If possible, students should be responsible for their own medications and keep their inhalers and EpiPen with them.
- Medications that require refrigeration must be kept in a closed plastic container with lid which is clearly marked as “Medication”. It would be ideal to have a separate small medication fridge.

Administration of Medications

Staff administering medications should receive appropriate training.

The facility where medications are administered should:

- Have a basin for hand washing before and after administering the medications and for cleaning the medical equipment after use to prevent diseases transmission
- Be in the same room where the medications are stored to minimize wastage/loss during the transfer
- Have a place to store the paper work and approval forms so that they can be easily accessed and referred to
- Have drinking water available

Staff should administer medications to only one student at a time.

Before administering medications, the staff should ensure that:

- The student's identity is verified
- There is written consent from the parent/caregiver
- The medication name(s) and dosage indicated on the containers / pill bags matches those in the parent/caregiver consent form
- The medication for the intended dose had been given. Immediately after administering the medications, the staff should complete and sign the written records.

If there is concern about administering the medications, the staff should contact the parent/caregiver as soon as possible and document the actions taken.

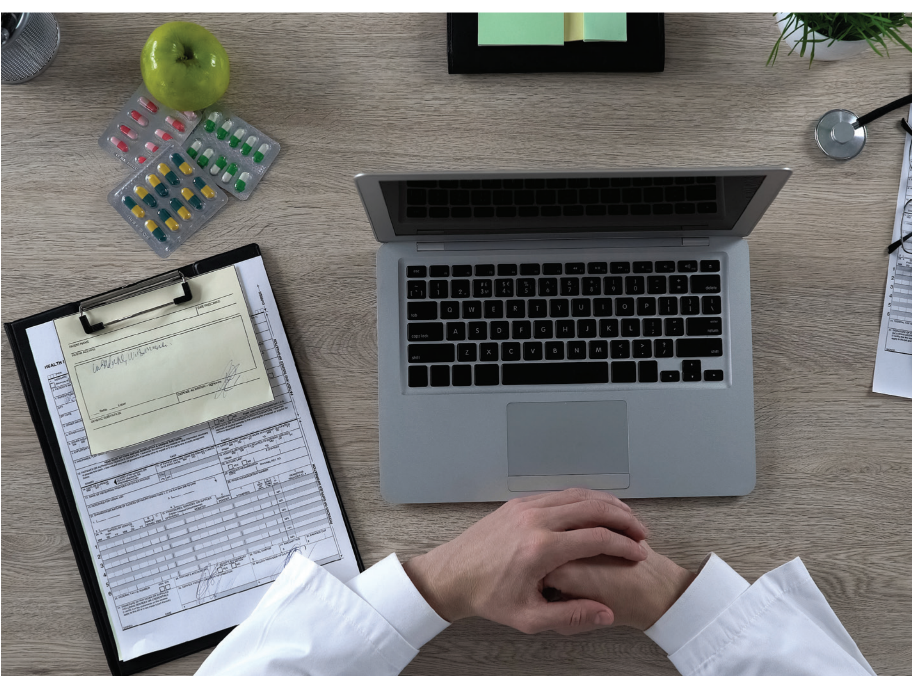
Parent/caregiver must be informed as soon as possible within the same day if the student refuses to consume the medications.

Record Keeping

The following records should be kept in the school:

- Consent forms from parents for administration of prescription medications
- Consent forms from parents for administration of non-prescription medications
- Record of medications given to the students

Schools should keep these records for as long as the student studies in the school.



Disposal / Return of Medication

Schools should have a written procedure for disposal of medications. Unused medications should be returned to the parent/caregiver who is responsible for the disposal of the medication.

If the parent/caregiver is not contactable, the medication should be disposed with the biomedical waste disposal company. Also, sharp boxes must be disposed by the biomedical waste disposal company.

05. SCHOOL MENTAL HEALTH

Introduction

Mental Health issues in children and young people are on the increase globally. Schools are in a prime position to be able to identify, and signpost students and their families to internal or external professionals who would be able to support, guide and treat students with a variety of mental health illnesses.

Health Centres or clinics are often the first point of contact for a student when they are not coping with daily activities. Whether they understand they are not feeling well with anxiety, low mood or depression, or whether their symptoms manifest through stomach aches, headaches or fainting, it is often the School Nurse who identifies a student who needs more support.

Mental Health Illnesses do start to manifest in school age children and can be due to a variety of reasons, some which may never be uncovered and therefore there is often no quick fix. Identifying issues early can help children and young people to access counsellors, psychologists and psychiatrists who can give them strategies to deal with anxiety or put care plans in place to treat eating disorders, depression, self-harm, conduct disorders and other mental illnesses.

It is therefore very important the School Nurse is part of the whole school's approach to Mental Health and Wellbeing of its students. Weekly meetings with key pastoral staff in a school are imperative. These work best when a team such as key teachers, Head of School, Safeguarding Officer, Nurses, Counsellors, Learning Support and Education Psychologist meet to discuss students of concern. The team should be able to highlight students of concern during a meeting and discuss how to provide support for a child or young person, liaising with parents, providing internal support or referrals to external professionals such as psychologists and psychiatrists. For vulnerable students, having an advocate in school they can liaise with, who is also responsible for communicating with the family and being a point of contact for external professionals is helpful. What is best for the child or young person should always be at the centre of the discussions. All discussions should be documented, and information kept securely.

Staff training is essential to enable teachers and other key school personnel such as Nurses, Counsellors and Educational Psychologists to provide support required for children and young

people who are not coping well or have been diagnosed with a mental health illness. Such courses such as the Mental Health First Aid Course and General Suicide Intervention Skill courses, should be more accessible to all schools and universities.

Communication with the school community by providing education and information sessions around Mental Health and Wellbeing is helpful to break down the stigma and stereotypes surrounding this, but also to help parents know what signs to look out for.

Mental Health and Wellbeing is an essential element of care, which sits alongside caring for students with physical ailments. Working in partnership with parents, as well as internal and external professionals, will enable schools to provide quality and holistic care for children and young people.

Note: For those who want more in-depth details on **School Mental Health**, please continue to read the rest of this section.

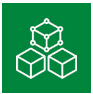
Background

Students can have mental health issues potentially caused by a variety of reasons behind both internal and external factors whilst they are of school age.

Students spend the majority of their time in school and may suffer from stress-related mental health issues arising from constant exposure to environmental stress within the campus. This type of stress is an 'internal' pressure most likely caused by students' desire to do better than their peers. This 'peer pressure' compels students to act in certain ways to perform well academically. Peer pressure is the most detrimental form of pressure which happens "when people of your own age encourage you to do something or to keep you from doing something else, regardless of whether you personally want to or not". Students who are under peer pressure portray themselves in a socially acceptable light, or act in certain ways to be accepted by the group.

External factors refer to influences beyond the campus environment and control of the students. An example is the family environment e.g. parental divorce, genetics, notion of belonging (third culture kid), financial pressures/ opulent neglect, unrealistic parental expectations etc. Students from broken or incomplete families may carry a mental burden or scars from what they had gone through. Another external factor is the expectation of parents on students. This issue is increasing as many parents expect their children to do well academically and graduate with a university degree.

Models for School Mental Health Care



School mental health care has to be with a holistic perspective. In order to encompass all related stakeholders involved in mental health care of students, there are several models of mental health programme for schools and the guidelines recommend the following two models:

- Three Tier Model by Positive Behaviour Support (PSB)
- Five Tier Model by the Singapore Ministry of Education

Stakeholders

School counsellors should not be the only ones responsible for the students' mental health. It should be taken care of through a multi-tiered approach by various stakeholders such as:

- Students
- Parents
- Teachers
- School counsellors
- Mental health professionals (child psychiatrist or child psychologist) from the school or community
- School medical team (doctors and nurses)

School Teachers

Teachers should be considered level 1 support as they interact with students closely and are trusted by them. They are usually the first to detect any changes in the student behaviour and may also be the ones students approach for help.

It is important to note that teachers are not expected to be experts in counselling. However, they should be trained to pick up early signs and symptoms of mental issues in students and refer them as soon as possible to the school counsellors. (See Annex C)

Teachers should attend a full-day training programme by the school counsellor annually.

School Counsellors

School counsellors are trained professionals attached to the school or hired directly by the school. Every school should have a full-time counsellor on site or a counsellor who visits the school regularly. For bigger schools, more counsellors may be needed to support the work load.

They work with staff, students, parents and external professionals such as psychiatrists or psychologists to provide quality school counselling support for the mental health and social-emotional development of students.

School counsellors should minimally possess a graduate degree in counselling. The qualification requirements vary with country and school standards.

Role of School Counsellors

Reactive Service:

- Provide direct individual and group counselling to students
- Meet with parents and teachers of students who are being counselled in strict confidentiality
- In consultation with parents, liaise with external mental health professionals if students require mental health support beyond the expertise of the school counsellors
- In critical incidents, work with external medical agencies to provide first level critical incident intervention
- Update school management on statistics of students undergoing counselling while observing medical confidentiality

Preventive Service:

- Provide health education programmes on mental health for the student and the non-student population which includes regular talks and materials on mental health and wellness
- Conduct group sessions on how to cope with stress for the school's general population or identified high-risk individuals

Administrative and Training

- Assist to develop school counselling programme to include early identification referral procedure for students with mental health, social, behavioural and emotional issues.
- Provide level 1 mental health support training to teaching staff and as well as mental health education to student and parents
- Establish links between the school and external mental health professionals early
- Compile, analysis and prepare reports on mental health

External Panel Psychologist / Psychiatrist

Mental health specialists handle more complex behavioural issues. Such resources are usually not employed by individual schools but are part of a panel supporting a group of schools assigned by the government or contracted by the schools.

Other Specialists

Schools especially the lower grade classes should have access to learning experts who can spot uncommon learning disabilities such as:

- Dyscalculia
- Dysgraphia
- Dyslexia
- Language processing disorder
- Attention deficit hyperactivity disorder
- Non-verbal learning disorder

(see Annex C2 for definitions)

Hearing and Vision Issues

It is crucial that hearing loss and vision acuity issues in students are resolved as they affect learning and indirectly contribute to the mental stress of the students. It is important that the school staff is aware of such health issues and runs existing screening programme for any visual and auditory problems so that school staff can refer to the specialists when such problems are suspected of detected. Otherwise, it would be handed over to the parents for further management.

Training

Mental Health First Aid

It is important that teachers are trained in simple Mental Health First Aid.

Mental health first aid provides:

- Basic knowledge on the common mental health issues faced by students
- Basic understanding and knowledge in physical, cognitive, behavioural and emotional changes in response to stress
- Simple conversations with students to help reduce stress
- Crisis assessment and intervention
- Referral to experts such as counsellors and psychologists

Such courses could be outsourced or conducted in-house if there are qualified counsellors.

06. HEAT DISORDER OF STUDENTS

Background

Physical activities such as sports and physical exercises are part of the school curriculum. As such, school staff (teachers and sports instructors) and students need to be aware of risks such as heat disorder, often arising from physical exercises, and the relevant precautionary measures.

In the worst case scenario, heat disorder, which is supposed to be an avoidable complication, could potentially lead to organ failures, permanent disability and death.

Definition

Heat Disorder can be viewed as the tilting of balance from increased heat gain to decreased heat loss. This leads to physiological changes causing pathological organ damages resulting in increased body core temperature, reduced amount of sweating and ultimately damaged organs such as brain, kidney and cardiac system.

Heat disorder could be classified into the following 3 categories; Heat cramps, Heat exhaustion, and Heat stroke. It is important to note that in some cases, the medical problems may be a continuum and not strictly divided in 3 categories.

Heat Cramps

Heat cramps is a mild form of heat disorder and may occur in healthy students who exercise in hot weather without paying attention to the external heat load and without taking sufficient hydration.

Signs and Symptoms include profuse sweating and muscular cramps; usually painful cramps in the lower limbs (calf muscles) and abdominal wall muscles.

Treatment:

- Stop activity and move to a shaded area
- Loosen clothes
- Cool off by fanning
- Drink iced cold water
- Do mild muscle stretching and massage

Heat Exhaustion

Heat exhaustion is a more serious form of heat disorder.

Signs and Symptoms include:

- Fainting, fatigue, headache
- Nausea, vomiting
- Muscular cramps
- Pale skin
- Profuse sweating
- Muscular cramps
- Increased heart rate, blood pressure

Treatment:

7 “R” Protocol

Patient should be evacuated to the hospital for further treatment and observation.

Heat Stroke

This is a medical emergency situation where there is a high risk of fatality.

Signs and Symptoms include:

- Mental status: confused, agitated and disoriented
- Drop in conscious state (GCS), seizure and loss of consciousness
- Hot and dry skin
- Core temperature rising > 40 degrees Celsius
- Risk of multi-organ failure; renal, cardiac and brain damage

Treatment:

7 "R" Protocol

Manage in hospital Intensive Care Unit (ICU)

Risk Factors

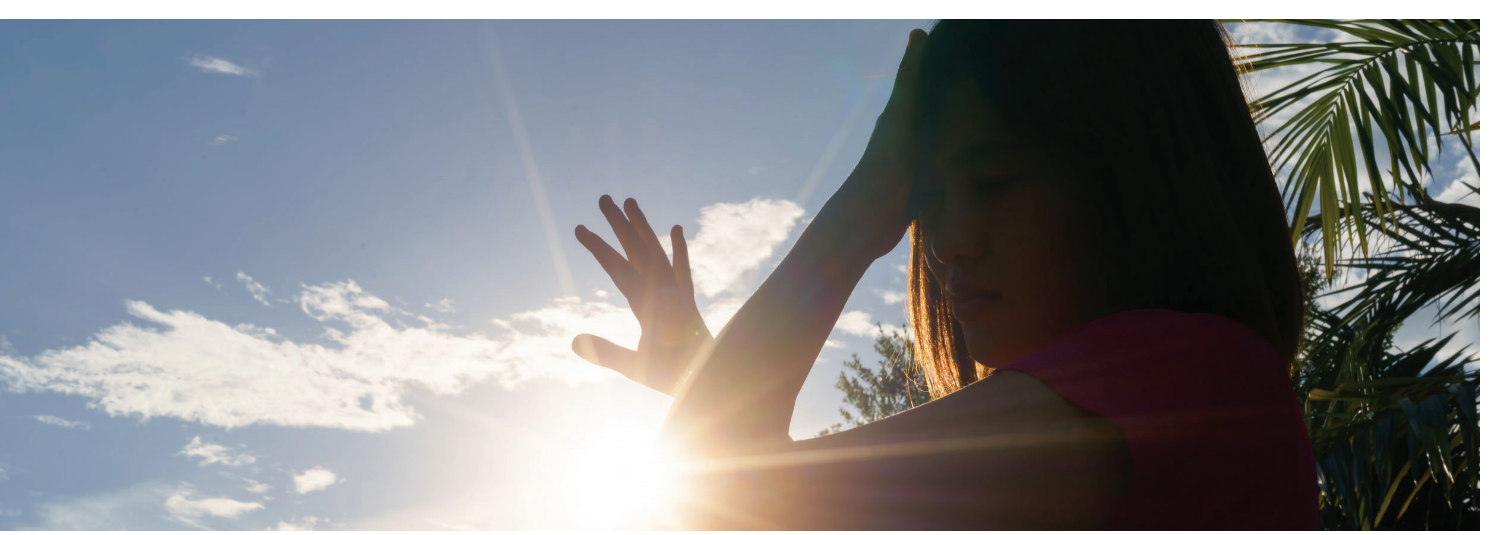
Risk factors for heat disorders could be classified as:

Human Factors

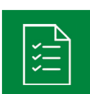
- Obesity
- Lack of physical fitness
- Illness or return from illness
- Lack of acclimatization (new students)
- Intense physical activity
- Medications
- "Sports mentality" and "peer pressure" persisting on with the game despite signs of heat disorder

Environmental Factors

- High ambient temperature
- High relative humidity
- Lack of wind



Management of Heat Disorder using 7 "R"



By following 7"R" protocol, heat disorder can be successfully managed and it is easy to remember:

- Recognize symptoms
- Rest casualty
- Remove (to shade, remove clothes)
- Rehydrate
- Reduce temperature (body temperature)
- Resuscitate
- Rush to the hospital

Prevention

Risk assessment prior to sporting activity and the school's safe sporting policy

- Avoid / No outdoor exercises between 1100 to 1500 hour (tropical climate)
- Hydration and supervision
- Monitor weather, especially using WBGT and provide appropriate warning if WBGT is high
- Prior to each training, sporting activity and exercises, conduct a formal check among all participating students if there is anyone not well and needs to be excluded from the sports and training
- Taking a rest regularly during training and providing cold plain water for student's hydration

07. HYDRATION LEVEL OF STUDENTS

Background

Water is essential to life and constitutes around 60 percent of the human body. Water is a crucial component of body fluids such as blood, mucus, saliva, joint fluid, cerebral spinal fluid and digestive juices; moreover, human body needs water to maintain blood pressure, cell turgor and to remove body waste such as urine and feces. In order to deliver all the necessary nutrients and minerals to the body cells, water components from digestion, absorption and plasma (the fluid carrying blood components) are required.

Nowadays, students have easy access to sports / energy drinks everywhere as a substitute of water; however, drinking an appropriate amount of pure and clean water is enough to maintain their good health condition.

How Much Water to Drink?

The amount of water required by individuals depends on the age, duration, intensity of activities and environment e.g. ambient temperature and humidity. It also depend if the student is sick, which means he / she would require more fluid intake.

The guidelines from USA (IOM) and Europe (EFSA) are both acceptable. The IOM guidelines would be recommended to schools in tropical countries or during the summer period as higher water intake is required. Meanwhile, schools located in cold countries or during the winter period may adopt the EFSA guidelines, requiring less water intakes.

Age (years old)	USA (IOM 2004)*		Europe (EFSA 2010)**	
1 - 2	1.3 Litres per day		1.1 - 1.2 Litres per day	
2 - 3	1.3 Litres per day		1.3 Litres per day	
4 - 8	1.7 Litres per day		1.6 Litres per day	
9 - 13	Females 2.1 Litres per day	Males 2.4 Litres per day	Females 1.9 Litres per day	Males 2.1 Litres per day
14 - 18	Females 2.3 Litres per day	Males 3.3 Litres per day	Females 2.0 Litres per day	Males 2.5 Litres per day
Adults > 18	Females 2.7 Litres per day	Males 3.7 Litres per day	Females 2.0 Litres per day	Males 2.5 Litres per day

* IOM: US Institute of Medicine of the National Academy of Sciences
** EFSA: European Food Safety Authority

The abovementioned guidelines would be further supported by the following three (3) indicators at an individual level.

- Urine Colour
- Body Weight Loss (not to lose beyond 2% due to water loss)
- Drinking beyond the point of thirst

Urine Colour Chart

Students would be able to check their urine colour with the chart below. The following chart should be printed, laminated and placed in the toilet where students can easily see it.

Colour	Status	Indication
	Good	Sufficient hydration
	Good	
	Fair	
	Dehydrated	Indication of dehydration; should drink 1 to 2 large glass of water as soon as possible
	Dehydrated	
	Very dehydrated	Indication of severe dehydration; should drink a large bottle of water as soon as possible
	Severe dehydrated	

School Drinking Water Policy

A good policy should provide the following:

- Health education regarding the importance of drinking water and maintaining adequate hydration level while exercising, during normal days and warm days
- Recommendation to bring along their water bottles to school, to take sufficient amount of water throughout the day, and to drink water prior to, during and after physical activity
- Provision of functional water coolers in the school; at least 2 water coolers in the school cafeteria. A survey should be conducted in order to assess the number of water coolers needed and the locations where to put them.
- Establishment of a subcommittee to review and analyse the food consumption within the school premises. A review should include drinks and food menu provided by the school caterers and cafeteria and drinks vending machine. Also, the policy regarding supply of sports drinks and energy drinks needs to be issued.

Sports Drinks

Consuming sports drinks would need to be limited to the following scenarios as drinking pure water is most likely sufficient to maintain students' hydration level:

- Physical exercise beyond one hour
- Intense physical activities
- Physical exercise or playing games in an extreme environment e.g. hot temperature and extreme humidity

As sports drinks contain glucose and electrolytes e.g. sodium and potassium apart from water content, it would help students quickly replace fluids lost during exercise and rebuild energy.

It is not recommended to mix sports drinks with energy drinks; moreover, sports drinks should not be regularly consumed, except in the cases mentioned above because of high energy and mineral content.

Energy Drinks

It is important to note that energy drinks may contain high sugar content, caffeine, taurine, vitamins especially vitamin B, guarana, ginseng extracts and others.

An excessive consumption of energy drinks may have an impact an individual's health.

Caffeine, a stimulant, keeps students awake for academic work. The recommended for daily intake limit of caffeine for adults would be 400 mg. However, for children, caffeine consumption should be avoided. Also, the following potential side effects of caffeine overconsumption needs to be aware of:

- Palpitations and increase in heart rate
- Tremor / hand shaking
- Agitation / anxiety
- Dizziness / headache
- Insomnia
- Increased urination and dehydration
- Addiction

HEALTH SUPPORT FOR NON-STUDENT POPULATION

Background

While there are many health programmes in place to support the well-being of the students, there are few that address the needs of the non-student population which are the school staff.

Research has shown that a prevalent health condition among teachers is stress. Between 5 to 20 percent of U.S. teachers feel burnt out. Compared to other professions, teachers exhibit high levels of exhaustion and cynicism which are the main symptoms of burnout. This leads to serious negative impact on their mental well-being (*Hakanen, Bakker and Schaufeli, 2006*).

There is clear correlation between the wellbeing of academic staff and the well-being of students. When staff miss fewer days of school and are healthier, they tend to have more energy to meet the day-to-day demands and challenges of teaching. This leads to less disruption, greater academic success for students and lower costs for school districts.

Assessment of Needs

Schools should not implement cafeteria-style health and wellness programmes where school staff can pick and choose activities to participate in. Such programmes usually attracts the wrong groups - the "worried well" and those "already practising healthy lifestyles". Instead, schools should conduct a health risk assessment on their non-student population and implement health and wellness programmes that are targeted at both the general population and those at risk.

A General Guide on Non-Student Health and Wellness Programme

Wellness programmes which are proven to be highly effective often tackle reversible risk factors such as smoking, alcohol, lack of physical exercise and unhealthy diet causing obesity. Another important component is mental wellness.

1) Administrative Support, Leadership and Resources

For the programme to be successful and sustainable, it should have the support of the school management and leadership. The organisers should share the potential benefits of the programme backed up with data (such as research showing financial benefits) with the management who should also be encouraged to take part in the programme.

2) Appoint a Subcommittee

Appoint a subcommittee to plan and implement the health and wellness programme. The members should be identified based on their capabilities to contribute to the programme and should come from both health and non-health professions. For example, the committee can consist of a physical education instructor, school nurse, school nutritionist, senior teaching staff and school administrator.

3) Surveys & Analysis

- Review and analyse existing data such as demographic information, staff compensation, medical claims and sick leave to understand workforce issues and areas of need.
- Conduct health screenings to assess factors such as blood pressure, cholesterol levels, Body Mass Index (BMI) and health behaviours. Health screenings can raise awareness among staff about their potential health risks and connect them to programmes and initiatives to improve their health.
- Conduct an assessment of the campus environment, systems and practices to identify factors that promote or hinder healthy living. The goal is to create an environment and work culture that fosters healthy choices and promotes wellness.

4) Develop and Implement the Programme

- The programme should be well-planned with enough resources for implementation.
- The programme should also have goals and measurable objectives.
- The subcommittee should only introduce one to two activities at a time so that the staff members are not overwhelmed.
- Promote the programme to create awareness and encourage participation. Creative ways to promote programmes include social media, challenges and games alongside conventional means such as emails, newsletters and posters.
- Schools can consider creating their own health and wellness app with in-built rewards. Some suggestions for apps include exercise programmes, calories counters, activities tracking or a combination of these.

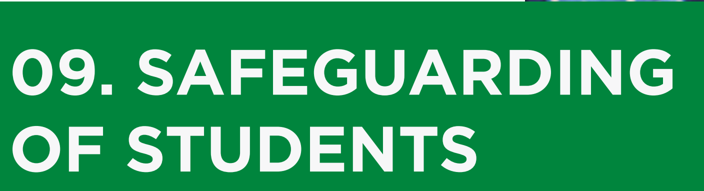
5) Review the Programme

Programme review should be done at regular intervals (every three months) to check if the objectives are met and provide a basis for the programme to be improved. Meaningful evaluation should assess the following:

- Staff participation rate
- Staff satisfaction rate
- Increase in health and wellness knowledge among staff
- Changes in staff behaviour, habits and health risks
- Perception among staff of support and healthy work environment availability

6) Sustain the Programme

- Evaluate programmes regularly and keep school management updated
- Revised policies if necessary
- Involve the community or the Education Ministry for support



09. SAFEGUARDING OF STUDENTS

Definition

The policy is for staff or volunteers working directly with children, young people and adults at risk. Support staff or trustees of organisations who are involved in child protection should also adhere to this policy. Children, adolescents, adults at risk and their parents / caregivers should be informed of the policy.

A child is defined as any individual who has not reached the age of 18-years -old. Even if a child is able to live and work independently, he or she is still considered a child by age definition and will be accorded the protection given to the group. Students in pre-schools, lower and upper grade schools are considered "children" and the safeguarding policy should apply to them.

Responsibility

The responsibility of safeguarding students does not only belong to the teaching staff

- Safeguarding of students is the responsibility of everyone involved in the education of students. The group should include the caregivers (parents or guardians), transportation providers, school administrative and academic staff, field trip organizers and leaders and medical staff.

Types of Abuse

The abuse to students can be categorized into several types:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect abuse

Physical Abuse

Physical abuse may involve physical violence such as hitting, shaking, throwing, burning, scalding, canning, suffocating, drowning, poisoning and other forms of physical harm to the child.

Physical abuse may leave behind signs such as bruises, burn marks and limps. However, it can also be done subtly such that it leaves little external physical signs.

Sexual Abuse

Sexual abuse involves coercing, enticing or tricking the child into sexual activities.

Sexual abuse includes both physical contact with penetrative acts such as rape (vaginal, anal or oral) as well as non-penetrative acts.

Non-penetrative acts include looking at or producing indecent material, watching sexual acts or encouraging the child to behave in sexually inappropriate ways.

Sexual abuse is not only perpetrated by adult males. Women and other children can also commit acts of sexual abuse.

Emotional Abuse

Emotional abuse takes place through persistent emotional maltreatment with messages that communicate that the child is worthless, unloved, inadequate, of no value or valued only if he or she meets the needs of another person. This causes hurt to the child emotionally.

Calling the child names that are degrading or insulting is a form of emotional abuse. It also happens when someone deliberately silences the child and makes fun of what the child says, does or wears. The culprit may not give the child an opportunity to express his or her views or hurts.

A subtle form of emotional abuse is expectations imposed on a child that are inappropriate for his or her age or level of development. An example is a child witnessing the ill-treatment or bullying of someone else that causes the child to feel frightened and endangered.

Emotional abuse can adversely impact the child's social and mental development.

Neglect Abuse

Neglect abuse is defined as the persistent failure to provide for a child's basic physical and psychological needs. This includes failure to provide adequate food, clothing and shelter as well as exclusion from home and abandonment.

It is important to point out that neglect must be persistent to be considered abuse. One cannot label a rare occasion where a caregiver genuinely forgot to prepare dinner or left the child without enough clothes as neglect.

Examples of neglect include failure to:

- Protect the child from physical and emotional harm and danger
- Ensure adequate supervision including providing a temporary caregiver
- Provide access to appropriate medical care
- Meet the child's basic emotional needs

Neglect abuse can result in the impairment of the child's physical and mental health development as well as negatively influence the outcome of the child's social and emotional development.

Potential Risks

Social Media

It is easy to access social media these days and most students own a mobile device which allows them to do so easily. "Predators" on social media hunting for potential victims pose a serious risk to these students as they unwittingly make "friends" with these "predators" and fall prey to their traps. Students must be educated on the dangers and risk of using the internet and social media.

Physical Affection

Staff or volunteers should avoid coming into physical contact with students regardless of the age of the student. Even with younger children, one should not initiate physical affection. However, you may choose to respond if younger children initiate the contact such as when they ask for a hug.

Meeting Outside Education Premises

Staff (administrator and academic) and school volunteers should avoid meeting up with students outside school. Helping students with homework in their homes with or without their parents' consent should be avoided as this can potentially lead to temptation, misunderstanding and accusation of abuse.

Photo, Video and Voice Recordings

Photos, videos and voice recordings of student activities in school should only be made using the school's designated cameras or recorders. The recording sessions must be approved by the school authority before they are conducted.

Reduced Visibility

Staff or volunteers should avoid being alone with students especially in places where they cannot be easily seen by others. Staff conducting student interviews should do so in a room with windows or a glass door so that they remain visible to others. In situations where a medical staff is examining or treating a student, it is good practice to have a chaperone present during the session. Where clothes are being removed, a chaperone is imperative e.g. assisting a small child to have a shower after a toilet accident.

Approach to Student Safeguarding

We recommend the 4 R approach for safeguarding students:

- Recognise
- Respond
- Report
- Record

Recognise

It is important to recognise the types of abuses that students can encounter. In addition, staff and volunteers should avoid getting into situations which put students at risk of abuse. Photos and videos of students should also be properly managed to prevent these from becoming instruments of abuse.

Respond

Listening to student feedback on possible abuse: Protect the child from physical and emotional harm and danger

- Practise supportive listening without questioning the child directly
- Allow the child to freely recall significant events
- Do not push the child to tell you more than what they are willing

Communicating to students

- Reassure the student that he or she is doing the right thing by informing you
- Reassure the student that he or she will not be blamed for what happened
- Show that you take the disclosure seriously
- Speak to someone who can do something about what is happening to protect the student

Important "dos" during the session:

- Be receptive and accessible
- Listen carefully
- Take it seriously
- Reassure the child that he is doing the right thing by telling you
- Explain what will happen next
- Escalate the situation to the authority figure in the organization immediately
- Make records carefully

Important "don'ts" during the session:

- Interrupt or stop the student who is sharing voluntarily. They need to be heard and you may be the first person they are speaking to about this
- Ask leading questions
- Ask a lot of questions or for more details unless you are the designated expert to do that
- Be judgmental or cast doubts about their disclosure or imply they should not make this disclosure
- Jump to conclusions, speculate or make accusations
- Promise to keep the information a secret. (You can reassure the student you will only inform people who need to know and are in a position to stop the abuse and prevent it from recurring.)
- Make promises you cannot keep
- Make further investigations on your own or follow up with alleged perpetrators

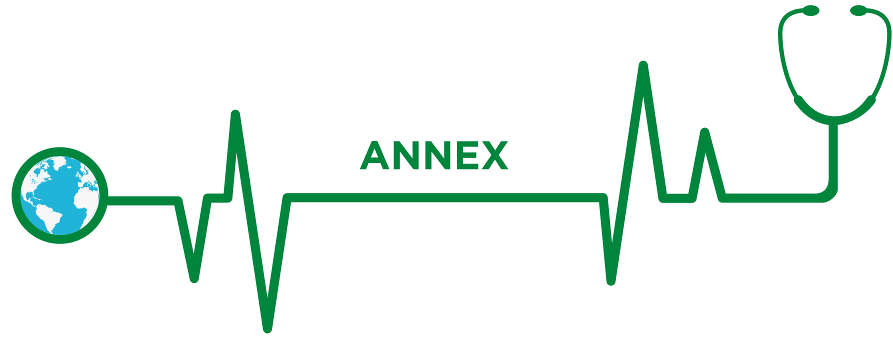
Report

Report alleged incidents, even if in doubt, to the school's designated safeguarding personnel or principal.

Record

Write down what you are told as soon as possible. Stick closely to the student's words and be careful not to include your own interpretations or rephrase his or her words. The information should be handwritten and not entered into any recording devices or photocopied.

If a colleague is present at the disclosure session, ask him or her to countersign your record of the conversation or make his or her own written record.


ANNEX

First Aid Kit

Content

Current First Aid Manual

Wound Cleaning

- Gauze (sterile) 2 packs of 5 gauze each
- Saline water (sterile) 10 ml x 4
- Chlorhexidine sachets / ampoules x 2
- Dressing Set Disposable x 1
- Non adhesive dressing pads x 2
- Gloves non sterile x 3 pairs (different sizes)
- Disposable bag (waste)

Wound Bandage

- Triangle Bandage x 6
- Crepe Bandage x 2
- First Aid Dressing x 2
- Roller Bandage x 2
- Eye patch (sterile) x 2 (individual packed)
- Wound Plaster x various sizes (1 box)
- Plaster Tape x 2 rolls

Instruments

- Scissors 1 pair (prefer Paramedic Type)
- Tweezers (x 2 disposable)
- Safety pins x 10
- Forceps (metal) for foreign body x 1
- Face Shield / Pocket Mask (CPR)

First Aid Kit Bag / Box

Anaphylaxis Kit

Content

- Adrenaline Autoinjector x 2 or alternatives for medical staff (nurse / paramedic / doctor)
  IV Adrenaline 1:1000 in 1 ml x 1 vial
  1 ml Syringe with 0.1 markings
  Vial Cutter
- Alcohol Swabs (Packets) x 5
- Anti-Histamine Oral (e.g. Benadryl)
- Salbutamol Inhaler x 1
- Inhaler Spacer x 1

Asthma Kit

Content

- Salbutamol Inhaler x 1
- Inhaler Spacer x 1

School Medication Administration Consent Form

Name of Student

Date of Birth

Class

Any Known Allergies

Name of Parent / Caregiver

Mobile Contact of Parent / Caregiver

Name and Strength and type of Medication

Dose to be given

Frequency (time to be given)

Route (e.g. oral, topical, inhalation etc.)

Other Instructions (e.g. on empty stomach, after food etc.)

Number of Tablets/Inhalers/Tubes etc./Quantity given to the School

Name of Doctor who Prescribed Medication

Doctor's Clinic Number

Parent / Caregiver Print Name

Parent / Caregiver Signature

Date

Note

**SEPARATE FORM IS REQUIRED FOR EACH SEPARATE MEDICATIONS

Record of Medication Administered

Name of Student

Date of Birth

Class

Name and Strength of Medication (1)

Dose and Frequency of Medication (1)

Date					
Time Given					
Dose Given					
Staff Signature					
Name of Staff					
Note if Parent/ Caregiver was Contacted					

Note

**SEPARATE SHEET FOR DIFFERENT MEDICATION GIVEN/ REASON FOR GIVING

Signs and Symptoms of Stress In Students

Physical Symptoms
- Change in bowel habits
- Headaches and muscle aches
- Nausea
- Easy fatigue
- Muscle aches and involuntary muscle twitching
- Insomnia
- Chest pain
- Getting sick more often than normal
- Heartburn or indigestion
- Changes in weight

Emotional Symptoms
- Impatience
- Restlessness and irritability
- Feelings of being overwhelm
- Low mood
- Loss of interest in activities used to enjoy
- Feelings of isolation and loneliness
- Trouble coping with study and relationship
- Pessimistic thoughts (anxiety, panic attacks, school avoiding/refusal etc.)

Cognitive Symptoms
- Unable to focus / concentrate
- Forget about homework assignments or deadlines
- Chronic worrying
- Reduced or impaired judgment
- Mumbling speech
- Repetitive or unwanted thoughts

Behavioral Symptoms
- Changes in eating and sleeping habits
- Drug, alcohol and solvent abuse/misuse
- Biting nails
- Abnormal failure or delay to complete daily roles or tasks
- Significant change in class work or school performance
- Unusual desire for social isolation
- Telling lies
- Bed wetting in younger students
- Truancy
- Trouble in getting along with classmates

Learning Disabilities

Dyscalculia

Dyscalculia is a learning disability that affects a person's ability to understand numbers and learn math. People who struggle with this disability may have difficulty understanding mathematical symbols, telling time, counting as well as memorising and organising numbers.

Dysgraphia

Dysgraphia is a learning disability that affects a person's fine motor skills and handwriting. People with this disability may have illegible handwriting, inconsistent handwriting spacing and poor spatial planning on paper. They may also find it challenging to spell, compose sentences as well as think and write at the same time.

Dyslexia

Dyslexia is a learning disability affecting a person's reading and language processing skills. The severity of this disability differs in individuals and may affect reading fluency, decoding and comprehension as well as text recall, writing, spelling and speech. Often referred to as a language-based learning disability, it can co-exist with other related disorders.

Language Processing Disorder

Language processing disorder is a type of auditory processing disorder (APD) where affected people find it difficult in gaining meaning from spoken words.

While APD affects the interpretation of sounds received by the brain, Language Processing Disorder (LPD) is related only to the processing of language. LPD makes it challenging for individuals to understand what they hear and express what they want to say.

Non-Verbal Learning Disabilities (NVLD)

NVLD is a disorder characterised by a significant discrepancy between a person's higher ability verbal skills and his/her weaker, visual-spatial and social skills. An individual with NVLD typically struggles with interpreting nonverbal cues like facial expressions or body language and may have poor physical coordination.

Visual Perceptual / Visual Motor Deficit

Visual perceptual / visual motor deficit is a disorder that affects a person's understanding of information he or she sees. It also affects the person's ability to draw or copy.

People with learning disabilities such as dysgraphia or NVLD may exhibit characteristics of visual perceptual / visual motor deficit disorder such as the inability to decipher subtle differences in shapes or printed letters and stay with the text on a page when reading. They may also have difficulty with cutting, an overly-tight pencil grasp and poor hand-eye coordination.

Attention Deficit Heperactivity Disorder (ADHD)

ADHD is a disorder characterised by difficulty in staying focused, paying attention and controlling behaviour as well as hyperactivity. Although ADHD is not considered a learning disability, research indicates that 30 to 35 percent of children with ADHD also have a learning disability. The combination of these two conditions make learning extremely challenging for these children.

Dyspraxia

Dyspraxia is a disorder characterized by difficulty in muscle control leading to problems with movement and coordination as well as language and speech. Although dyspraxia is not a learning disability, it can potentially affect a person's ability to learn and often exists alongside dyslexia, dyscalculia or ADHD.

Memory

The three types of memory affecting an individual's learning are: Headaches and muscle aches

- Working memory is the ability to hold different pieces of information until they blend into a complete thought or concept. An example is reading each word until the end of a sentence or paragraph and then understanding the context of the content.
- Short-term memory refers to the active process of storing and retaining information for a limited period of time. The information is temporarily available but not stored for long-term retention yet.
- Long-term memory refers to stored informaton available over a long period of time. Some individuals may have difficulty with auditory or visual memory.

First Aid Report Form

Date:

To be retained by the management team / school leaders in the workplace

First aid provided for: ☐ Injury ☐ Illness ☐ Staff ☐ Student ☐ Visitor

School name:

School code:

Location: ☐ Outside ☐ Campus

Phone number:

Address:

Name of person/s injured/involved

Sex ☐ Male ☐ Female

Date of birth

Phone Number (Home):

Address:

Phone Number (Mobile):

Phone Number (Business):

Parent/Guardian Advised (Student Only): ☐ Yes ☐ No

Date injury or incident occurred:

Time of occurrence: ☐ AM ☐ PM

Part of the body injured (e.g. right hand, left eye).

What happened? (e.g. Slipped on wet concrete whilst walking across yard).

Where did it happen? (e.g. classroom, gymnasium, sports oval, off site-school excursion; outdoor activity).

Medical Treatment: ☐ Nil ☐ First Aid ☐ Doctor ☐ Hospital

Action taken or details of first aid given:

Staff member attending and/or providing first aid: (Name)

Employee number

Witness

Hospital, if applicable

Name

Contact phone number

Statement ☐ Yes ☐ No

Name

Contact phone number

Statement ☐ Yes ☐ No

ABOUT INTERNATIONAL SOS

International SOS Foundation

Launched in March 2012, the International SOS Foundation has the goal of improving the safety, security, and health and welfare of people travelling, working, studying or doing research abroad or on remote assignments through the study, understanding and mitigation of potential risks.

The escalation of globalistion has enabled more individuals to work across borders and in unfamiliar environments; exposure to risks which can impact personal health, security and safety increase along with travel. The Foundation is a registered charity and was started with a grant from International SOS. It is a fully independent, not-for-profit organisation.

International SOS

International SOS enables organisations to manage the health and safety risks facing their international travellers, expatriates, and global workforce. As the world's leading provider of medical assistance, security services, international health care and outsourced customer care, we serve over 7,300 clients (educational institutions, NGOs, governments and corporate companies) including more than 500 educational institutions, 83% of the Global Fortune 100 and 64% of the Fortune Global 500 companies. Our strength stems from the expertise of our people, our worldwide reach and a commitment to deliver customer-focused solutions.

Authored by

Dr David Teo Kwang Joo

Dr David Teo Kwang Joo

Regional Medical Director,

Asia, International SOS

Dr. Teo oversees the assistance services provided by International SOS Assistance Centres. He also heads expert teams of Coordinating Doctors and Nurses in these Assistance Centres, ensuring a high level of service across the region. Dr. Teo joined International SOS Singapore in 2007. Prior to that, he was the Chief Army Medical Officer of the Singapore Armed Forces (SAF), holding the military of a Colonel.

During his 22-year career with SAF, he undertook several peacekeeping missions and was seconded to the Department of Peacekeeping Operations of United Nations in New York. He has lectured post-graduates at the National University of Singapore on occupational medicine and served as a Senior Medical Advisor in the Department of Industrial Health, Ministry of Manpower.

Dr. Teo supports various education institution in Asia and the Ministry of Education Singapore as a medical advisor for students and school staff by providing medical advice, especially for their school trips, conducting webinars related to health, providing pre-trip talks and organising the workshops for School Travel Health. In addition, he is the author of Managing Medical & Travel Security Risks in the Education Sector: a Framework, published by International SOS Foundation.

Dr. Teo holds MBBS and Master of Medicine (OM) from the National University of Singapore.

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