POSITION PAPER

The management of the allergic child at school: EAACI/GA^{2}LEN Task Force on the allergic child at school

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Abstract

Allergy affects at least one-quarter of European schoolchildren, it reduces quality of life and may impair school performance; there is a risk of severe reactions and, in rare cases, death. Allergy is a multi-system disorder, and children often have several co-existing diseases, i.e. allergic rhinitis, asthma, eczema and food allergy. Severe food allergy reactions may occur for the first time at school, and overall 20% of food allergy reactions occur in schools. Up to two-thirds of schools have at least one child at risk of anaphylaxis but many are poorly prepared. A cooperative partnership between doctors, community and school nurses, school staff, parents and the child is necessary to ensure allergic children are protected. Schools and doctors should adopt a comprehensive approach to allergy training, ensuring that all staff can prevent, recognize and initiate treatment of allergic reactions.

Aim

The aim of this Task Force document is to describe an ideal model of care centred on the allergic children at school (Box 1), which is appropriate for use by all stakeholders. Despite a substantial body of literature on allergy management, the evidence available on how to best care for such children at school is inadequate. Furthermore, legislation, education, facilities and health care practices vary between countries. We have presented the information in such a way that individuals will be able to adopt the advice within the context of their local or national facilities to improve care for all children with allergy at school. Where local facilities are not able to support such an approach, this document may be used as a reference to inform national policy.

How to use the recommendations

Our key recommendations are presented as 'action points' for schools. Some of these are generic and apply to all allergic children at school (Box 2), and others are presented as disease-specific action points. To facilitate the implementation of these recommendations, specific responsibilities for each stakeholder have been identified (Box 3). A comprehensive protective package for children with allergy at school can therefore be provided within this framework. These recommendations are based upon the available evidence and expert opinion.

Allergy at school manifests in multiple ways: eczema, bronchial asthma (hereafter asthma), rhinitis and/or conjunctivitis, food allergy and less commonly venom allergy and

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Box 1: Rights of the allergic child

1. To be educated in a safe and healthy environment, with as few provoking allergens and irritants as possible and to breathe clean air in schools.
2. Not to be stigmatized as a result of their condition.
3. To be able to participate in all educational and recreational school activities to the same extent as their peers.
4. To have access to medication and other measures to relieve symptoms.
5. To have access to trained personnel who are able to treat acute reactions.
6. To have their education adapted to their condition if necessary (e.g. physical education).

urticaria. Children may present with various symptoms such as wheezing and dyspnoea related to asthma, which may be triggered by allergen contact, airway infection or physical exercise. Children with allergic rhinitis (or rhinoconjunctivitis) might have a runny nose, sneeze frequently, mouth-breath persistently and have itchy eyes in spring and/or summer, or they may have all-year-round symptoms. Indoor pollutants can be particularly harmful for students already affected by allergies or asthma. Exacerbation of asthma and allergic illnesses is often linked to exposure to allergens, such as house-dust mite, cat, dog, cockroach, fungi and mould, and to irritants such as tobacco smoke (1–3). Exposure to chemicals (e.g. volatile organic compounds or formaldehyde) may also exacerbate asthma and allergy (4–6). In addition, poor indoor ventilation may worsen asthma and rhinoconjunctivitis leading to a reduced ability to concentrate (7).

Textile materials such as mattresses and pillows are provided in preschools for daytime sleep periods, but these materials can act as reservoirs for dust mites, which may cause worsening of asthma and/or rhinitis in mite-allergic children (8).

Staff should be aware that allergies including food allergy reaction can present for the first time on school premises and those reactions may be severe (9). The most severe allergic reactions present as anaphylaxis (10) although severe asthma may also occur. Allergy to latex, insect venom or medicines occurs rarely at school. Allergic disease can reduce quality of life through fear of reactions and constrained life-style choices as well as lethargy caused by chronic inflammation, nasal obstruction and disturbed sleep (11, 12).

Overall, school performance might be affected and teachers should be aware of this. Preparation of school staff to cope with an allergic reaction is often inadequate. For example, in a UK survey, only 48% of schools with a child at risk of anaphylaxis had a teacher trained in its management, and only 12% of such schools had adrenaline available (13). A comprehensive approach to managing allergies in school is therefore essential in promoting good health and equality amongst allergic school children. School programmes for children with allergy already exist in some countries (e.g. France and Sweden).

Box 2: Action points for all children with allergic disease at school

1. Schools should enquire about allergic disease at the registration of new pupils, and parents should inform the school of any new allergy diagnosis.
2. A written allergy management plan should be obtained from the doctor, including allergens/triggers to avoid, medications and contact information (Box 4).
3. The allergic child should be readily identifiable to all school staff.
4. Reasonable measures should be instituted to ensure appropriate allergen avoidance.
5. Tobacco smoking should be banned.
6. School staff should be educated in allergen avoidance and recognition and emergency treatment of allergic reactions.
7. Relieving and emergency medication should be available at all times.
8. School staff should be indemnified against prosecution for the consequences of administering emergency or relieving medication.
9. Ensure protective measures continue on school trips/holidays.

After a description of the epidemiology of allergy in children, each individual allergic disease will be considered both for treatment of acute episodes and for long-term management.

Executive summary

1. Allergy affects at least one of four schoolchildren, it reduces quality of life and may impair school performance; there is a risk of severe reactions and, in rare cases, death.
2. Severe food-allergic reactions may present for the first time at school and overall 20% of food reactions occur at school.
3. Allergy is a multi-system disorder, and children often have several co-existing diseases, i.e. allergic rhinitis, asthma, eczema and food allergy.
4. Many schools are currently poorly prepared for children with allergy.
5. A cooperative partnership between doctors, community and school nurses, parents, school staff and the child will ensure allergic children are protected.
6. Schools should adopt a comprehensive approach to allergy training, ensuring all staff can prevent, recognize and initiate treatment of allergic reactions.

Epidemiology

The prevalence of allergic diseases

Asthma, eczema and rhinoconjunctivitis

Asthma, eczema and rhinitis frequently occur amongst European school-age children. In 6- to -7-years-olds, the annual

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Box 3: Roles of stakeholders

Role of the family:

1. Comply with recommended management including relevant allergen avoidance.

2. Know when and how to use their allergy medication and maintain medication within expiry dates especially adrenaline injections, this knowledge should be reinforced regularly.

3. Inform school of diagnosis e.g. a written letter to an identified staff member.

4. Where appropriate, obtain a written allergy management plan from the doctor and provide a copy for the school.

5. Ensure medication is provided to the school.

Role of the family doctor/allergist:

1. Diagnose or exclude allergies and communicate the results to the family.

2. Provide a written allergy management plan, in plain language with clear identification of the allergens, the main symptoms of an allergic reaction and how to treat them, with instructions for administration of emergency medication (Box 4).

3. Where possible liaise with the school authorities to provide training for staff in all aspects of allergy and asthma. Repeat the training regularly.

Role of the school:

1. The head teacher is responsible for school policy and planning for children with asthma and allergy.

2. Schools should arrange regular allergy training for staff, facilitated by liaison with relevant health care providers.

3. Staff should enquire about allergic disease at the registration of new pupils. There should be a mechanism by which temporary or new staff can identify the allergic child.

4. Implement a written allergy management plan.

5. Ensure that emergency and relieving medication is always available.

6. Ensure prevention and treatment continues on school trips/holidays.

7. Schools should aim to maintain healthy indoor and outdoor air quality, including environmental allergen control.

Role of patient organizations:

1. Provide advice, practical help and support to allergy sufferers with special reference to schooling.

2. Provide appropriate allergy advice and support and facilitate training for schools.

3. Act as advocate of allergy sufferers and lobby for improved services where they are found to be inadequate.

Role of policy makers:

1. Change legislation where it prevents school staff from providing life-saving medication to school children with allergy.

2. Develop a coordinated national strategy to facilitate education of school staff in allergy management establishing and harmonizing educational training programmes.

3. Provide adequate numbers of allergy specialists and trainees in each country.

Box 4: Individualized anaphylaxis management plan: specific issues (11)

1. Personal identification data: name and address; contact details of the parents, allergist, the family doctor and the local ambulance service; and preferably a photograph.

2. Clear identification of the allergens to be avoided; further information may be included on alternative names for allergens (e.g. lecithin for soya or arachis for peanut).

3. Copy of plan to be kept by the child, his/her relatives, preschool care givers, school nurse, school staff, family doctor and be stored with the emergency medication.

4. Individualized instructions:

Written clearly in simple, nonmedical language.

Stepwise approach with simple instructions for each step, e.g.:

- At the beginning of an allergic reaction (e.g. 'any swelling or redness of the face, itching of the mouth or nausea') immediately administer a liquid antihistamine.
- Monitor closely the child for signs of breathing problems or collapse.
- Call emergency numbers.
- Keep the child lying down on his/her side unless he/she has severe breathing problems.

Clear description of symptoms of bronchospasm and laryngeal oedema in nonmedical language (e.g. If there is wheezing or whistling from the chest, tightness in the throat or difficulty in breathing) so can rapidly administer adrenaline and call emergency medical services.

Detailed instructions, possibly with photographs, on how to correctly administer the child's particular self-injectable adrenaline device.

Recommendation to inject a second dose of adrenaline if there is no apparent improvement after 5–10 min.

5. Ensure that self-injectable adrenaline is readily accessible to every care-giver.

prevalence for wheezing varies considerably from 5% to 21% between different countries across Europe. The prevalence of rhinitis and eczema in 13- to -14-years-olds varies from 4.5% to 20.2% and 1.8 to 15.6, respectively, although the majority have mild disease (14). In general, there is an increase in the prevalence of allergic disease from south-eastern Europe where it is relatively low (e.g. in Albania) to the northwest (e.g. the United Kingdom) (14).

Anaphylaxis

It is estimated that anaphylaxis occurs at a rate of 1 episode per 10 000 children per year and 82% of such episodes occur in school-age children (15). For adults and children overall, hospital admissions for anaphylaxis in the United Kingdom has increased by sevenfold over the past decade (16, 17). According to a UK survey, 61% of schools had at least one child at risk of anaphylaxis (i.e. had a history of anaphylaxis or carried injectable adrenaline) (15). Between 10% and 18% of food allergy or anaphylaxis reactions occur at school (18, 19).

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Allergic diseases co-morbidity

Childhood is the time of greatest allergy burden, and children are often affected by more than one allergic disease at the same time. Fifteen per cent of 13- to 14-year-old children have a diagnosis of two or more allergic diseases such as wheezing, eczema and allergic rhinitis (17). Approximately 95% of children with peanut or nut allergy also has asthma/eczema/rhinitis (20). It is recognized that the presence of asthma, especially if poorly controlled may increase the severity of food-allergic reactions. Further, the presence of food allergies in asthmatic children predisposes to more severe asthma attacks after accidental food allergen exposure (21).

Allergens at school

The most frequent allergens involved in allergic reactions at school vary from region to region. In some countries, pollen and dust mite exposure triggering allergic rhinitis and asthma are responsible for the majority of allergy burden (8), whereas alternative inhalant allergens (e.g. of pets) may be more problematic in other regions (1, 2). Food allergens, mostly milk, egg, nuts, are often involved in allergic reactions and some (e.g. fruits) can cross react with pollens (oral allergy syndrome, where the immune system responds to similar proteins in pollens, fruit and some nuts). Contact with latex, medicines or insect venom is rare at school.

Asthma

Introduction

Asthma is a chronic lung condition characterized by reversible narrowing and excessive mucus production of the airways. This manifests as wheezing, coughing and breathlessness. Asthma is an important health cause of school absenteeism (22).

The majority of children have well-controlled asthma; however, under-recognition and inappropriate management may lead to considerable ill-health (23–25). For some children, exercise-induced asthma, night-time cough and sleep disturbance interfere with physical and educational activities thereby reducing their quality of life (26, 27). Considering the large number of students with asthma and the fact that children spend much of their time at school, it is important that asthma management is optimized in the school environment.

Asthma triggers

The most common asthma triggers in school children are viral infections (such as a common cold) and exercise, particularly if cold air is inhaled.

Children with allergic asthma may have acute attacks triggered by exposure to pollen or animal allergens at school (3). It should be recognized that wheezing may also be a feature of an acute food-allergic reaction (e.g. to peanut) during which visible features of urticaria or angioedema are not always present (11).

Exercise and asthma

All students with asthma should be encouraged to exercise, but children should be able to decline or stop exercise depending on their symptoms. Most children and adolescents with asthma will complain of exercise-induced symptoms at some time; however, repeated asthma attacks during physical activities may indicate that the asthma or associated rhinoconjunctivitis is under-treated. These children and their caregivers should be encouraged to see their allergy specialist or a physician with competence in allergy for treatment adjustment. Children should be allowed to use inhaled reliever medication before exercise, although a persistent requirement for this may be an indicator of inadequate asthma control.

Challenges for the school

The first step in school management is the identification of asthmatic students. Each child should then be individually managed to ensure that their specific needs are addressed, through a partnership between the child's doctor, parents and school staff (9). A model for 'asthma friendly schools' has been described (28).

Action points for the school

1. Identification of children with significant asthma.
2. Asthma education should ideally be provided to appropriate staff members.
3. For children with significant asthma, a written individualized management plan should be obtained from a physician including details regarding specific symptom triggers, an individualized emergency treatment plan, medication doses and emergency contact information.
4. An inhaled bronchodilator and spacer device should be available for emergency use in case of an asthma attack or before/during exercise.
5. Children with a suspected allergic component for their allergic asthma may benefit from reduction of indoor allergen exposure.
6. Students with frequent school absences, school health office or emergency department visits because of asthma should be identified and urged to contact their physician.
7. Schools should aim to include asthma education in the health curriculum.
8. Children with asthma benefit from normal physical exercise. Premedication with reliever medication, individualized and careful warming up and down can facilitate participation.
9. Encourage full participation in physical activities when students are well, offer reduced/modified activities if experiencing symptoms.

There are many examples of successful education programmes for school children with asthma which incorporate some of the above-mentioned principles (28–31).

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Eczema

Introduction

Eczema (atopic dermatitis) is a chronic inflammatory condition of the skin, which is common amongst school children and manifests with itching and excoriation. Eczema exacerbations may be provoked by allergens. Food allergens (e.g. egg) may cause acute eczema after inadvertent ingestion. Inhalant allergens (e.g. house-dust mite, cat dander) as well as staphylococcal skin infection may also contribute to poor eczema control.

Management of eczema is based on hydrating topical treatment topical anti-inflammatory treatment and avoidance of specific and nonspecific provocation factors (32).

Challenges for the school

The physical, psychological and social effects of childhood eczema are considerable and often underestimated. In contrast to children at risk of anaphylaxis or asthma, emergency situations do not play a role. However, chronic symptoms such as itching disturb daytime concentration and interfere with sleep leading to tiredness and mood changes, further worsening daytime functioning (32). Teasing, embarrassment and bullying cause social isolation and may lead to school avoidance. Stress during examinations may worsen eczema. Children with eczema require frequent application of topical treatments during the school day to prevent dryness, and subsequent scratching and infection. Eczema exacerbations occur most commonly after physical triggers (e.g. infection), but may also be provoked by allergen exposure (e.g. animal allergens).

Action points for the school

1. Eczema education may be provided for appropriate staff members.
2. Ensure that avoidance measures are in place (e.g. indoor allergen reduction) for specific provoking factors.
3. Allow children to apply topical eczema treatment at any time throughout the school day. Staff members might also be permitted to apply topical treatments to young children at a frequency recommended by the child's parents or doctor.
4. Ensure students are allowed to use alternatives to scratching, such as cool packs, at all times (even during tests).
5. With prior permission, the teacher may discuss eczema as a class topic, with the aim of dispelling myths about eczema (e.g. that is it contagious) and aim to reducing embarrassment and teasing.
6. Allow children to stop or temporarily reduce swimming pool exposure in special cases and to shower and reapply creams after physical education.

Rhinoconjunctivitis

Introduction

Rhinitis is defined as an inflammation of the lining of the nose and is characterized by nasal symptoms including rhinorrhoea (nasal secretions), sneezing, nasal blockage and/or itching of the nose. Allergic rhinitis is the most common form of noninfectious rhinitis and is usually associated with an IgE-mediated immune response against allergens e.g. grass pollen, house-dust mite or pets. It is often associated with eye symptoms (rhinoconjunctivitis) that may be the dominant problem.

Rhinitis is the most prevalent chronic allergic disease in children. It causes nasal irritation and blockage with secondary effects of reduced sleep and daytime sleepiness. Many patients with asthma have rhinitis, supporting the concept of 'one airway, one disease'. The presence of allergic rhinitis commonly exacerbates asthma, increasing the risk of asthma attacks, emergency visits and hospitalizations for asthma.

Challenges for the school

Although not life threatening, rhinoconjunctivitis has a significant detrimental effect on the quality of life and may exacerbate co-morbid allergies such as asthma (33, 34). A study from the United Kingdom showed impaired examination performance in teenagers with allergic rhinitis symptoms (12). Impairment of mental activity may also occur in children taking antihistamines.

Action points for the school

1. Students should be able to take reliever medication at school, as required.
2. Students should not be criticized for frequently displaying allergic symptoms such as sneezing or sniffing repeatedly, or using the 'allergic salute'.
3. Teachers should anticipate increased symptoms during outdoor exercise activities in peak seasons.
4. Schools should aim to maintain healthy indoor and outdoor air quality, including environmental allergen control.
5. Teachers should be aware that rhinoconjunctivitis can impair examination performance and worsen asthma. Schools are encouraged to make allowances for this.

Food allergy

Introduction

Food allergy is common amongst school children, with an estimated overall prevalence of 4–7%. The symptoms in a child with food allergy can affect many organ systems and may include hives or swelling (facial angioedema), vomiting, abdominal pain, and diarrhoea, hoarseness or voice changes, wheezing, dyspnoea and sneezing and/or cardiovascular problems as dizziness or loss of consciousness. Cow's milk, hen's egg, peanuts, tree nuts, wheat, soy, fish and crustaceans are the most common foods causing allergic reactions. In some countries, in addition, pollen-associated food allergies results in allergic reactions to fruits, nuts and vegetables and may cause mouth and throat swelling and itching. Cow's milk, egg allergy and wheat allergy may resolve by school age. When persistent, they may cause severe reactions as seen with peanut and tree nuts.

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Challenges for the school

Allergic food reactions can occur in the classroom or playground as well as in the canteen. The initial symptoms may be mild and are difficult to interpret without training. Food allergy has been presenting for the first time on school premises in a significant proportion of cases (10). It is not possible to predict the final severity of reactions from the initial symptoms, and allergy deaths have been associated with a delay in the administration of intramuscular adrenaline. All school staff should be trained in the early recognition and treatment of allergic reactions so that emergency medication may be administered without delay. There is, however, minimal risk of anaphylaxis from cutaneous contact with food allergens. Therefore, there is no need to separate children from their peers during mealtimes, although sharing or swapping of food must be prevented. Inhalation of aerosolized or other airborne food proteins e.g. fish, hen's egg or milk protein (powdered cheese) may cause wheezing in sensitive individuals, in particular, if they are suffering from asthma.

Action points for the school

1. Ensure there is a system to identify food-allergic children to staff, especially catering or new/temporary staff.
2. Clear allergen labelling should be available for any food provided by the school. Menus should be available to the family in advance with ingredients clearly stated.
3. Staff should be made aware of how to handle potential food allergens safely, including effective cleaning of surfaces and utensils.
4. Schools should avoid providing food containing peanuts and tree nuts and major allergens relevant to the country, e.g. sesame (including meals, snacks and vending machines). This measure should not be enforced in isolation, but should complement the educational and protective environment for allergic children.
5. Food-allergic children may benefit from an individually labelled box, containing allergen-free 'treat' foods for class celebrations or rewards.
6. Discourage trading or sharing food, and sharing utensils or containers.
7. Ensure lessons avoid the use of provoking food allergens (e.g. using peanuts during science or art lessons).
8. Educate classmates regarding allergen avoidance and recognition of food allergy reactions.
9. Separating children from their peers during mealtimes is unnecessary, provided the other measures described are instituted.

Anaphylaxis

Introduction

Overall, anaphylaxis is a rare event in school-age children, but anaphylaxis and food allergy deaths have been reported at school (35). The most common cause in this group is food allergy (36, 37) with peanuts/tree nuts and cow's milk being most often responsible for reactions. New allergens are emerging e.g. Kiwi fruit (38), lupine and mustard. Life-threatening reactions caused by insect stings, medications, latex rubber or exercise are uncommon in children (39, 40).

Although anaphylactic reactions are rare, a significant proportion of school-age children are at risk. It is not possible to identify with certainty in which individuals with relatively common conditions such as food allergies, these occur. A recent survey of 100 Scottish schools revealed 61% had at least one child at risk of anaphylaxis, defined by previous use of or provision of injectable adrenaline (13). Up to 24% of children with history of anaphylaxis have their first episode on school grounds (9); food allergens may be present in nearly all situations in schools such as lessons, science projects, mealtimes, playtimes and celebrations. Therefore, all schools should be prepared by training, regardless if they currently have pupils with a history of anaphylaxis (9).

Challenges for the school

Schools are currently poorly prepared. Information about allergies is often not communicated to the school, leaving the child exposed to avoidable risk (9). Where management plans are provided by allergists, they are often not implemented by the school especially during extraordinary activities such as school holidays/excursions (13). Emergency medication is often not made available, and teachers are poorly trained (41). Ideally, training should be provided by existing community or school nurses networks (where available), who themselves should be trained to deliver the training package to schools. This model takes advantage of the efficiency of the hub and spoke training models and ensures high quality and consistency of training. In some countries, these facilities are not available, and there is a need for political initiatives. Alternative training programmes need to be developed and resources should be directed towards achieving this goal.

Treatment of the acute episode in school

Intramuscular (IM) adrenaline is the initial treatment of choice for anaphylaxis (10, 42). This should be given by an adrenaline autoinjector into the vastus lateralis muscle of the thigh. A teacher or school nurse will necessarily perform and supervise initiation of treatment for anaphylaxis occurring at school. Suitably trained individuals must be present in schools as delay in administration of IM adrenaline is associated with death from anaphylaxis. School staff should be indemnified against prosecution for causing harm although administering emergency medication. For older (>10 years) children who have received suitable training, they may administer the injection themselves after parental consent. Oral antihistamines should also be administered, and the child should be brought into a position of comfort (lay the patient down, if there are respiratory symptoms they should sit up and bronchodilators given, if available). The child

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should be monitored and arrangements should be made to transport him/her to the nearest hospital emergency department, irrespective of treatment administered or apparent return to normal health (beware of biphasic reactions). The child should not be sent home.

Action points for the school

1. When a child at risk of anaphylaxis is newly identified by the allergy clinic, the school should receive written notification through the parents or doctor.
2. A written emergency treatment plan produced by the allergist (and agreed with the family doctor) should be adopted by the school.
3. Individually labelled emergency kits should be provided for schools, containing the emergency treatment plan, intramuscular adrenaline autoinjectors and oral antihistamines.
4. School staff should be aware of the location of emergency kits, and the expiration dates of medication should be checked regularly. Temporary or replacement staff should be alerted to allergic children and be made aware of measures to protect them.
5. Appropriately trained school staff should administer all emergency medication to young children. Older students should be allowed to self-medicate when they have reached sufficient maturity and after appropriate training.
6. School training should include all staff members and cover allergen avoidance, recognition and treatment of anaphylaxis.
7. All protective measures should continue during extracurricular activities such as school trips and holidays.
8. School staff should be retrained annually, to take account of changes in staff, students and protocols.
9. If a severe reaction occurs within the school, the headmaster should take responsibility to direct an investigation into what went wrong so that future mistakes can be prevented.
10. School staff should be indemnified against prosecution for the consequences of administering emergency medication.

Emergency medication recommendations for school

School staff should be prepared to treat an acute asthma attack or allergic reaction promptly, with the appropriate medication. This is facilitated by a physician-guided allergy management plan for each allergic student. The treatment of acute asthma requires inhaled beta-2-agonists. Other allergic symptoms rely on oral H1-antihistamines and corticosteroids. H1-antihistamines are indicated for the treatment of mild allergic symptoms, such as urticaria, angio-oedema, and rhinoconjunctivitis. A long-acting nonsedating antihistamine (e.g. cetirizine, loratadine or similar) should be used to prevent drowsiness at school. Short-acting inhaled beta-2-agonists should always be used to treat asthma symptoms; however, it should be stressed to school staff not to rely on inhaled beta-2-agonists only for more severe symptoms, or to delay the use of injected adrenaline in cases of anaphylaxis. Children with any severe allergic reaction, whether or not they have received intramuscular adrenaline must be transported to the local emergency department and observed for at least 6 h.

Legal aspects

There is currently no European legislation dealing specifically with the allergic child at school. National legislation alone therefore governs the management of children's health at school, and this varies considerably across Europe. A central issue is the conflict that exists between the teachers' legal responsibilities and liabilities in administering medication at school and the child's need for care and privacy.

Under current regulations, teachers have no specific duties in terms of child health protection as this responsibility lies entirely with the school/health care system. Their lack of responsibility is because of their lack of medical training. Teachers, therefore, do not have any particular liability above and beyond that of anyone who happens to be present when a child needs care.

However, given the high prevalence of allergy amongst school-age children and the need to deal with acute episodes at school more attention is now being paid to this issue. Indeed, according to an European Union (EU) Briefing Paper, 'Legal Framework of New Governance and Modern Policy in Education throughout Europe', many governments are now creating mechanisms for schools to become more accountable to parents and to government via the increased use of quality assurance mechanisms. In some cases running alongside this increased accountability, greater responsibility is delegated to each school and the school governors, often in the form of more financial control. This also means that the school and sometimes the school governors have to take greater legal responsibility for the management of their school, the quality of teaching, and the safety and well-being of their students.

It is important to point out that one of the purposes of the Legal Framework is to improve child health care at school via the more consistent promotion of quality and standards provided in every country. Two main models were identified. The continental European model appears to rely very much on central monitoring while the UK model is established, to a greater degree, on school autonomy and school liability.

We can therefore determine two concurrent liable parties in terms of school health care: one is the head teacher, who has the duty to call in the competent authorities (over structural and childcare issues) and the other is the Public Health Service, which has the more general medical duty to look after the psychophysical well-being of each student. There are several differences between legal systems within and outside the EU. In the United States, recently, the Food Allergy and Anaphylaxis Management Act was voted on by House on April 8, 2008, to provide schools with uniform guidance on how to create appropriate management and emergency plans for children in the allergy field. In addition, this act is soon to be enacted at a Federal level.

In Australia, the states Victoria and Tasmania have implemented legislation for managing allergies at school. In Victoria, from 2009, all teachers are required to be trained in allergy management. This model requires, by law, the completion, at enrolment, of a form regarding the child's health needs, the training of all teachers with a health professional

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and parents, and mandatory notification to the school by parents of any relevant changes. If the child's health problem can be managed with procedures that do not require the intervention of a fully trained health care professional, the school allows the presence of all instruments and qualified personnel needed to provide the required medical care. Ontario, Canada, has had a similar legislation since 2005.

It is desirable that EU bodies consider this issue a priority in the near future to promote a harmonized approach across Europe.

Conclusions

One of four school-age children in Europe lives with allergic disease. There is a broad spectrum of severity with some children at risk of severe asthma or anaphylaxis which on rare occasions may cause death, whilst others present with chronic allergic diseases and experience reduced quality of life and impaired school performance. All children with allergic diseases may experience acute exacerbations at school. Recognition of the allergic child is the first step in management. Schools should enquire about a diagnosis of allergy at the registration of any new child. There should be protocols in place to ensure rapid access to emergency medical care. The school may hold treatment protocols and allergy medication for emergency use, where allowed by national laws.

An education network involving families, health care and education providers is crucial in ensuring that children are identified, the school staff alerted and trained, and specific allergy management plans initiated. This should be achieved through the empowerment of key stakeholders and supported by continuing education of all school staff.

Appropriate legislation should be introduced to make safe the school environment for the allergic child as well as safeguarding educational workers. The implementation of these recommendations across diverse models of health care in Europe would ultimately protect and nurture all children with allergy whilst at school.

Addendum

Experts Group: Baiardini I, Bousquet J, Grimshaw K, Kalayci O, Warner JO. Patient's Organization Representatives: Reading D (Anaphylaxis UK), Podestà M (Food Allergy Italia), Timmermans F (Anaphylaxis the Netherlands). European Reference Group: Calvert M (Senior School Nurse, UK), De Swert L (Belgium), Du Bois A (the Netherlands), Halken S (Denmark), Hourihane J (Ireland), Pohunek P (Czech Republic), Salapatas M (Greece) and EFA Representative, Springer E (Poland), Szepfalusi Z (Austria), Vodusek V (Slovenia), Wassemberg J – Eigenmann P (Switzerland).

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The authors thank Mr. Jeremy Kemp for secretarial assistance.

Supporting Information

Additional Supporting Information may be found in the online version of this article:

Appendix S1. Plan particulier de mise en sûreté face aux risques majeurs.
Appendix S2. Managing life threatening food allergies in schools.
Appendix S3. European Union briefing paper: 'Legal Framework of New Governance and Modern Policy in Education throughout Europe'.

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PLAN PARTICULIER DE MISE EN SÛRETÉ FACE AUX RISQUES MAJEURS

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MEN - DESCO - DPATE

Texte adressé aux rectrices et recteurs d'académie ; aux inspectrices et inspecteurs d'académie, directrices et directeurs des services départementaux de l'éducation nationale ; aux inspectrices et inspecteurs chargés des circonscriptions du premier degré ; aux chefs d'établissement ; aux directrices et directeurs d'école

---

☐ Les sociétés modernes sont de plus en plus exigeantes à l'égard de ceux qui ont en charge les problèmes de sécurité, particulièrement concernant les situations dans lesquelles les enfants et les jeunes peuvent se trouver au premier rang des victimes. Les divers accidents majeurs, qui ont jalonné les années 2000 et 2001 en France ou à l'étranger, ont marqué les esprits par leur soudaineté, leur violence, le nombre des victimes et les dommages causés.
Les dégâts occasionnés sont de moins en moins souvent considérés comme une fatalité, y compris dans le cas de catastrophes naturelles ou technologiques majeures. C'est ainsi que, dans une perspective de prévention et/ou de protection, après les tempêtes de la fin de l'année 1999, des académies ou des départements ont commencé à produire des consignes, plans, plaquettes variés, parfois réalisés en liaison avec des collectivités territoriales.
Une première information vous avait déjà été fournie, au début de l'année 2000, concernant un plan d'organisation "des secours dans un établissement scolaire face à l'accident majeur" (SESAM). Ce plan de référence présente un dispositif très complet et détaillé dont la complexité n'a sans doute pas facilité la généralisation. C'est la raison pour laquelle, les ministères chargés de l'éducation nationale et de l'environnement ont décidé, en liaison avec l'Observatoire de la sécurité des établissements scolaires et d'enseignement supérieur (ONS), d'élaborer le présent guide dont les objectifs sont similaires à ceux du plan SESAM et qui en intègre certains aspects.

Une initiative nationale : un guide synthétique et pratique qui trouve localement une déclinaison dans des plans particuliers
Le travail conduit a été effectué en prenant appui sur la réglementation en vigueur qui est rappelée dans le guide. Ce document, destiné à aider les écoles et les établissements scolaires à définir un plan de prévention et de mise en sûreté face à l'accident majeur, comporte quatre pages qui présentent aussi clairement que possible les informations et la démarche pour la mise en place de mesures destinées à assurer la sécurité des élèves et des personnels, en attendant l'arrivée des secours. Il est complété par une série de fiches, directement utilisables, pour opérationnaliser les différentes étapes d'élaboration de ce plan. Il s'efforce de prendre en compte la diversité des situations, étant bien entendu que certains risques, comme la tempête ou les transports de matières dangereuses, peuvent survenir dans des lieux très divers alors que d'autres, en revanche, sont clairement identifiables localement.

Des relais académiques et départementaux
L'élaboration de ces *Plans particuliers de mise en sûreté* nécessite une implication forte des recteurs et des inspecteurs d'académie, directeurs des services départementaux de l'éducation nationale, en liaison étroite avec les préfets qui sont responsables de la réalisation des schémas départementaux d'analyse et de couverture des risques (SDACR) et des plans d'urgence des pouvoirs publics. Grâce aux relations que les services de l'éducation nationale entretiennent avec les autres services de l'État et les collectivités territoriales, ils sont en mesure d'identifier, auprès des préfectures et des mairies, les risques auxquels les écoles et les établissements peuvent se trouver prioritairement exposés, notamment dans le cas de sites classés SEVESO, et les en informer. Par ailleurs, ils doivent mobiliser les personnes ressources dont ils disposent en matière de sécurité et mettre en place des dispositifs de formation des différents acteurs. Enfin, ils mettront à disposition des préfets les plans de mise en sûreté que les écoles et les établissements leur auront fait parvenir.

Une aide pour élaborer les Plans particuliers de mise en sûreté, en assurer une coordination efficace

et accompagner leur mise en œuvre
Dans les académies et les départements, le réseau des **correspondants "sécurité"** assistés par des **coordonnateurs** ou des **formateurs "risques majeurs"** désignés par les recteurs et les inspecteurs d'académie apporte son concours à la mise en œuvre d'actions de sensibilisation ou de formation dans ce domaine.
Ces personnes ressources sont à même de fournir une aide précieuse pour élaborer un *Plan particulier de mise en sûreté*. La liste de ces personnes peut être obtenue auprès des services des rectorats et des inspections académiques ou sur le site internet **Éducation à la sécurité** de la direction de la technologie du ministère chargé de l'éducation nationale : **http://www.educnet.education.fr/securite/index.htm**
Le site du **ministère chargé de l'environnement** peut également être consulté utilement : **http://www.prim.net**
Dans les établissements, l'agent chargé de la mise en œuvre des mesures d'hygiène et de sécurité (ACMO), qui joue un rôle prépondérant dans la mise en œuvre des règles de sécurité, pourra apporter son concours à la réalisation du *Plan particulier de mise en sûreté*.

La réalisation du Plan particulier de mise en sûreté de l'école ou de l'établissement
Chaque *Plan particulier de mise en sûreté* devra nécessairement inclure, pour son élaboration :
- une définition des différentes missions à assurer lors de la gestion de crise et la constitution d'un groupe de personnes ressources entre lesquelles ces missions seront réparties ;
- une prise en compte de gradations possibles dans l'ampleur d'un accident et de la progressivité éventuelle des conséquences de celui-ci ;
- une prise en charge particulière des membres de la communauté scolaire, élèves et adultes lorsque :
. des activités se déroulent en dehors des locaux scolaires (piscine, gymnase, sorties, ...),
. il existe un internat,
. des élèves ou des adultes handicapés ou des élèves bénéficiant d'un projet d'accueil individualisé (PAI) sont intégrés dans l'école ou l'établissement ;
- une information des partenaires impliqués, élus, autorités, secours... réalisée préalablement, puis régulièrement renouvelée, afin que ces derniers aient la possibilité de s'associer à des simulations et à des actualisations du plan.
Ce *Plan particulier de mise en sûreté* est un document propre à chaque établissement scolaire, il devra être, lors de son élaboration puis annuellement, soumis à la commission d'hygiène et de sécurité de l'établissement, quand elle existe, au conseil d'administration de l'établissement, et présenté au conseil d'école.

L'information des familles : établir un climat de confiance et une communication explicite sur les risques et les conduites à tenir en cas d'accident majeur
Il est nécessaire que les directeurs et les chefs d'établissement puissent délivrer aux familles une information claire sur le *plan particulier de mise en sûreté* élaboré pour faire face aux risques majeurs auxquels l'école ou l'établissement que fréquente leur enfant peut être confronté(e). La qualité des échanges établis conditionnera de manière décisive l'adoption par chacun de comportements adaptés à la situation en cas d'accident majeur. À cet égard, un rapprochement, au plan local, avec les cellules d'analyse des risques et de l'information préventive (CARIP) placées auprès des préfets pourra s'avérer utile.

La dimension éducative : participer à la construction de la conscience citoyenne en sensibilisant aux risques majeurs
Une éducation à la sécurité, notamment dans le domaine des risques majeurs, doit être mise en œuvre, de l'école maternelle au lycée, dans le cadre des programmes scolaires, afin de permettre aux enfants de structurer le plus tôt possible des comportements réfléchis et adaptés. Elle ne représente pas une discipline constituée mais néanmoins, elle implique des apprentissages notionnels et comportementaux spécifiques. Les membres de la communauté scolaire aideront les élèves à mesurer les risques encourus, à appréhender les questions de sécurité et de responsabilité qui en résultent, individuellement et collectivement.

Une cohérence indispensable : dégager les articulations nécessaires entre les mesures à mettre en œuvre pour faire face aux différents risques
Le présent guide, bien que précisément ciblé sur les risques majeurs, attire à plusieurs reprises l'attention sur la bonne gestion des prescriptions relatives aux conduites à tenir face à divers risques, notamment en cas d'incendie. Ces conduites peuvent être diamétralement opposées, telles que l'évacuation ou le confinement. Le *Plan particulier de mise en sûreté* devra donc se situer dans une chaîne générale des secours et s'articuler avec les autres documents déjà produits et à disposition des écoles et établissements. Pour renforcer la cohérence des missions de chacun, ce guide fera l'objet d'une présentation aux inspecteurs hygiène et sécurité (IHS), aux comités d'hygiène et de sécurité académiques et départementaux

et aux agents chargés de la mise en œuvre des mesures d'hygiène et de sécurité (ACMO).

Une vigilance continue : vérifier la pertinence du Plan particulier de mise en sûreté, introduire les évolutions nécessaires

L'organisation d'exercices réguliers de simulation, au minimum une fois par an, doit permettre de confronter le *Plan particulier de mise en sûreté* à la situation réelle de l'école ou de l'établissement en "grandeur nature "et de vérifier le bien-fondé des mesures qu'il comporte.

Une réactualisation régulière de ce plan est également à prévoir, de nombreux paramètres pris en compte initialement étant susceptibles d'évoluer : composantes de l'école ou de l'établissement, éléments de l'environnement, progrès technologiques...

Ce document dynamique et évolutif ne pourra qu'être amélioré au fil du temps, l'ensemble des services concernés reste à votre disposition pour vous y aider.

Pour le ministre de la jeunesse, de l'éducation nationale et de la recherche
et par délégation,
Le directeur de l'enseignement scolaire
Jean-Paul de GAUDEMAR
La directrice des personnels administratifs, techniques et d'encadrement
Béatrice GILLE

B.O. hors-série n°3 du 30 mai 2002

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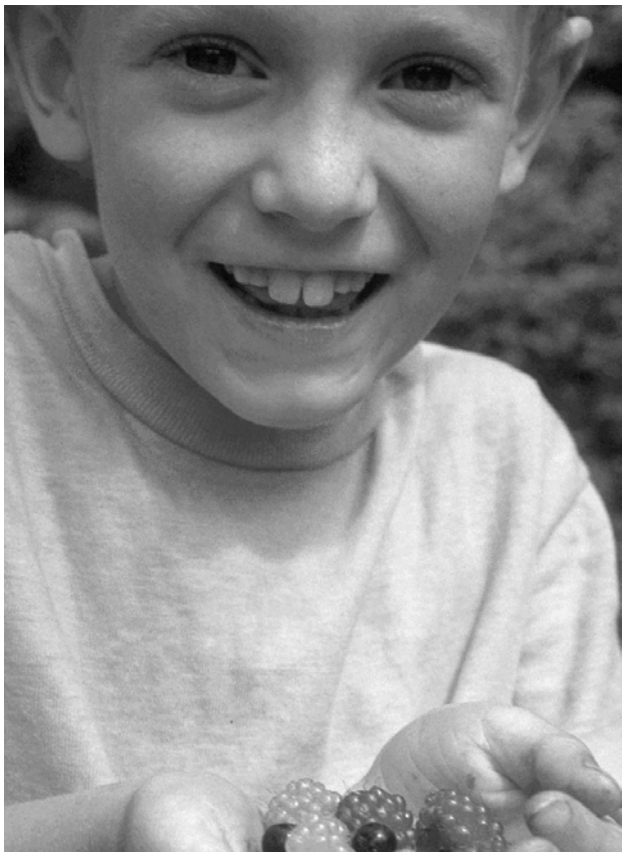

Managing Life Threatening Food Allergies in Schools

Massachusetts Department of Education

Massachusetts Department of Education

This document was prepared by the
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David P. Driscoll
Commissioner of Education

Fall 2002

Dear Superintendents and Other Interested Parties:

The number of students with life-threatening food allergies has increased substantially over the last 5 years. As with all children with special needs, it is important that students with life-threatening food allergies are able to access all education and education-related benefits. Because of the life-threatening nature of these allergies and the increasing prevalence, school districts and individual schools have the challenge to be ready for the entry of students with food allergies by making accommodations related to the school environment and other school and education activities.

To assist schools in developing and implementing policies and comprehensive protocols for the care of students with life-threatening food allergies, the Massachusetts Department of Education led a task force to develop this publication, *Managing Life Threatening Food Allergies in Schools.* The task force included recognized professionals in the area of food allergies, school physicians, school administration, school nutrition/food service directors, school nurses, teachers and Department staff. This group has worked diligently over the past year to create a document that provides background information and practical application regarding life-threatening food allergies in schools.

This guidance focuses on a team approach for addressing life-threatening food allergies and provides information on how to handle situations that may arise. Also included are an introduction on food allergies and anaphylaxis, strategies for issues and possible resolutions for certain areas of the school including the classroom and cafeteria, and various checklists for personnel and school activities.

Although this document covers several aspects of the school day and possible solutions to address the needs of students with life threatening food allergies, each school district will need to review the guide book for application to their district's needs. I hope that this guidance is helpful as you work on this important effort to provide students with life-threatening food allergies with a quality education in a safe environment.

Sincerely,

David P. Driscoll
Commissioner of Education

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GUIDELINES

MANAGING LIFE-THREATENING FOOD ALLERGIES IN THE SCHOOLS

Background

Development of these guidelines was a result of a collaborative effort of the Massachusetts Department of Education, the Asthma and Allergy Foundation of America Foundation: New England Chapter, the Massachusetts School Nurse Organization, the Massachusetts Food Service Association, the Massachusetts Committee of School Physicians, and parents of children with food allergies. Information and advice on this project was provided by the School Health Unit of the Massachusetts Department of Public Health.

Goal of the Guidelines

The guidelines are presented to assist Massachusetts school districts and nonpublic schools to develop and implement policies and comprehensive protocols for the care of students with life-threatening allergic conditions. The guidelines address:

- The scope of the problem of childhood allergies.
- Types of ***detailed*** policies and protocols that should be in place in every school to help prevent allergic reaction emergencies and deaths from anaphylaxis,
- The systematic planning and multi-disciplinary team approach needed prior to school entry by the student with life-threatening food allergies,
- The school's role in preventing exposure to specific allergens,
- Emergency management should a life-threatening allergic event occur, and
- The roles of specific staff members in the care of the student with a life-threatening allergic condition.

*While this document focuses on **food allergies,** treatment of anaphylaxis (a life-threatening allergic reaction) is the same whether caused by: insect sting; latex; or exercise induced.*

Overview

Food allergies are presenting increasing challenges for schools. Because of the life-threatening nature of these allergies and the increasing prevalence, school districts and individual schools need to be ready for the entry of students with food allergies.

Food Allergy Prevalence

- Food allergies affect 8% of children under age three, 6%-8% of school-age children and 2.5% of adults.*
- Food allergy prevalence has increased 55% in the last five years.*
- 40%-50% of those persons with a diagnosed food allergy are judged to have a high risk of anaphylaxis* (a life-threatening allergic reaction). *Every food allergy reaction has the possibility of developing into a life-threatening and potentially fatal anaphylactic reaction. This can occur within minutes of exposure to the allergen.*
- Children may be allergic to more than one food.

*(Sampson, HA, "Food Allergy", from *Biology Toward Therapy, Hospital Practice,* 2000: May.)

Characteristics of Food Allergy Reaction in Students

- Allergic reactions to foods vary among students and can range from mild to severe life-threatening anaphylactic reactions. Some students, who are very sensitive, may react to just touching or inhaling the allergen. For other students, consumption of as little as one five-thousandth of a teaspoon of an allergenic food can cause death.
- Eight foods (peanut, tree nut, milk, egg, soy, wheat, fish and shellfish) account for 90% of total food allergies, although any food has the potential to cause an allergic reaction.
- Most, but not all childhood allergies to milk, egg, soy and wheat are outgrown by age 5.
- Peanut and tree nuts account for 92% of severe and fatal reactions, and along with fish and shellfish, are often considered to be lifelong allergies.

Impact on the School

Every school district should expect at some point to have students with food allergies. Schools must be prepared to deal with food allergies and the potential for anaphylaxis.

- *Accidental* ingestion of the offending allergen occurs most often at school.
- A recent study from the journal, *Archives of Pediatrics and Adolescent Medicine*, states that 1 in 5 children with food allergies will have a reaction while in school.
- The student with an undiagnosed food allergy may experience his/her first food allergy reaction at school.
- When a physician assesses that a child's food allergy may result in anaphylaxis the child's condition meets the definition of "disability" and is covered under the Federal Americans with Disability Act (ADA), Section 504 of the Rehabilitation Act of 1973, and may be covered under Individuals with Disabilities Education Act (IDEA) if the allergy management affects the students ability to make educational progress.

The Role of the School in Preventing and Managing Life Threatening Food Allergies

Adequate plans and staff, who are knowledgeable regarding preventive measures and well prepared to handle severe allergic reactions, can save the life of a child. ***Total avoidance of the substance to which the student is allergic is the only means to prevent food allergy reactions.***

Every school building with a student at risk for anaphylaxis should have a fulltime school nurse.*

- School districts should develop policies and protocols regarding the care of students with life-threatening allergies. These policies and protocols should address: (a) measures to reduce exposure to allergens; and (b) procedures to treat allergic reactions. See Appendix A: *Suggested Components of a School District Policy and Protocols Addressing the Management of Students with Life-Threatening Allergies.*
- The school nurse should oversee the development of an Individualized Health Care Plan (IHCP) for each student with the diagnosis of a life-threatening allergic condition. The school nurse should be responsible for organizing and conducting a meeting with the student's parent(s), the student (if appropriate), the classroom teacher, food service manager and other personnel as determined by the student's needs. The IHCP must be developed prior to the student's entry into school or immediately after the diagnosis of a life-threatening condition and should include an Allergy Action Plan (AAP) that addresses the management of anaphylaxis (see Appendix G).
- Schools should ensure that all staff entrusted with the care of students receive basic education concerning food allergies (see Appendix C, *Information on Food Allergies and Anaphylaxis*), and have training in the prevention and management of allergic conditions (see Appendix D, *Prevention and Management of Allergic Conditions* and Appendix E, *Response to Emergencies*).
- An effective food allergy program needs the cooperation of parents, teachers, counselors, school nutrition food service director, administrators, school nurses, school physicians, primary care physicians, extracurricular advisors, bus/transportation personnel, and any staff that might be present where children can be exposed to the food allergens that can trigger their extreme reaction. See Appendix F for roles of Specific School Personnel in the Management of Children with Life-Threatening Allergies (LTA).
- Schools should be prepared to manage an anaphylactic emergency by:
  - (a) having responsible school personnel designated and trained to respond *(see Section V of the Massachusetts Regulations Governing the Administration of Epinephrine by Auto Injector to Students with Diagnosed Life-Threatening Allergic Conditions (LTA).*
  - (b) identifying clearly the student's needs.
  - (c) having the physician's orders on file.
  - (d) maintaining a current supply of epinephrine by auto-injector in at least two easily accessible locations and/or carried by the student when appropriate. *(Please note: epinephrine should never be kept in a locked cabinet.)*

*For the purposes of this document school nurse is a registered professional nurse certified by the MA Department of Education.

*Every school building with a student at risk for anaphylaxis should have a full time school nurse.**

The school should have a policy and protocol for the management of anaphylaxis in individuals with unknown allergies. This should include a protocol signed by the school physician authorizing administration of epinephrine by the school nurse. (Note: Since this process requires an assessment, only a registered nurse may administer the epinephrine to an individual with undiagnosed allergies.)

(e) having available a municipal emergency response team prepared to respond to a 911 call with epinephrine. *(It is important to be aware of what the local emergency medical services can provide as some ambulance services may not be permitted to administer epinephrine.)*

- Schools should be equipped with a reserve supply of epinephrine to accommodate the increasing prevalence of severe reactions in students with unknown allergic conditions.
- The school should have a policy and protocol for the management of anaphylaxis in individuals with unknown allergies. This should include a protocol signed by the school physician authorizing administration of epinephrine by the school nurse. *(Note: Since this process requires an assessment, only a registered nurse may administer the epinephrine to an individual with undiagnosed allergies.)*
- Many students with food allergies have experienced a life-threatening anaphylactic reaction and are aware of their own mortality. School policies and protocols must respect the physical safety ***and*** the emotional needs of these students.

Regulations Governing the Administration of Epinephrine by Auto Injector to Students with Diagnosed Life-Threatening Allergic Conditions

In 1996, recognizing the need for prompt response to an anaphylactic emergency, the Massachusetts Department of Public Health amended the regulations governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.000) to include a section on administration of epinephrine (see Appendix K, 105 CMR 210.000). *"Epinephrine is the first medication that should be used in the emergency management of a child having a potentially life-threatening allergic reaction. There are no contraindications for use of epinephrine for a life-threatening allergic reaction." (Position Statement: AAAAI Board of Directors, "Anaphylaxis in Schools and Other Child-Care Settings," J. Allergyclin. Immunol. 1998: 102:173-6)*

The amended regulations state that "A school or school district may register with the Department for the limited purpose of permitting properly trained school personnel to administer epinephrine by auto injector in a life-threatening situation, when a school nurse is not immediately available,"...provided certain conditions are met, as outlined in the regulations. To register to permit unlicensed personnel to administer the epinephrine, the school nurse should request an application in writing from the School Health Unit, Massachusetts Department of Public Health, 250 Washington Street, Boston, MA 02108.

The Department will then send an application, including the training curriculum (see Appendix J, MDPH Outline of Training Program for Unlicensed School Personnel to Administer Epinephrine by Auto Injector in Life-Threatening Allergic Conditions). The school nurse completes the application, obtains the appropriate signatures, and returns it to: MA Department of Public Health, School Health Unit, 250 Washington St., Boston, MA 02108. After review and approval, the Department issues the registration.

The Massachusetts Department of Public Health and the Department of Education strongly recommend that all schools and school districts, public and private, register with DPH to train non-licensed personnel to administer epinephrine by auto-injector to students with diagnosed life-threatening allergic conditions.

Each school district/school that plans to have the school nurse train unlicensed personnel to administer epinephrine by auto-injector to students with life-threatening allergic condition must register with MA Department of Public Health consistent with 105 CMR 210.000.

FOOD ALLERGY

WHAT IS FOOD ALLERGY?

People with allergies have over-reactive immune systems that target otherwise harmless elements of our diet and environment. During an allergic reaction to food, the immune system recognizes a specific food protein as a target. This initiates a sequence of events in the cells of the immune system resulting in the release of chemical mediators such as histamine. These chemical mediators trigger inflammatory reactions in the tissues of the skin (itching, hives, rash), the respiratory system (cough, difficulty breathing, wheezing), the gastrointestinal tract (vomiting, diarrhea, abdominal pain), and the cardiovascular system (decreased blood pressure, heartbeat irregularities, shock). When the symptoms are widespread and systemic, the reaction is termed "anaphylaxis," a potentially life-threatening event.

Consider the following scenarios:

A student with a milk allergy walks near the cafeteria where milk is being steamed and inhales the airborne milk protein, which causes hives, swelling, and respiratory distress.

A student with a peanut allergy is in his classroom and complains of itchy, swollen eyes and a tight chest only to discover later that the arts and crafts products in the classroom contain peanuts.

WHAT IS ANAPHYLAXIS?

Anaphylaxis is a potentially life-threatening medical condition occurring in allergic individuals after exposure to their specific allergens. Anaphylaxis refers to a collection of symptoms affecting multiple systems in the body. These symptoms may include one or more of the following:

- Hives
- Vomiting
- Itching (of any body part)
- Diarrhea
- Swelling (of any body part)
- Stomach cramps
- Red, watery eyes
- Change of voice
- Runny nose
- Coughing
- Difficulty swallowing
- Wheezing
- Difficulty breathing, shortness of breath
- Throat tightness or closing
- Sense of doom
- Itchy scratchy lips, tongue, mouth and/or throat
- Fainting or loss of consciousness
- Dizziness, change in mental status
- Flushed, pale skin, cyanotic (bluish) lips and mouth area

The most dangerous symptoms include breathing difficulties and a drop in blood pressure or shock, which are potentially fatal. Common examples of potentially life-threatening allergies are those to foods and stinging insects. Life-threatening allergic reactions may also occur to medications or latex rubber and in association with exercise. Approximately 50 deaths per year are caused by insect sting anaphylaxis and 150-200 deaths per year from food anaphylaxis, mostly from peanut and tree nut allergies. (*The Food Allergy Network*, "Information About Anaphylaxis" website at foodallergy.org.)

Anaphylaxis can occur immediately or up to two hours following allergen exposure. In about a third of anaphylactic reactions, the initial symptoms are followed by a delayed wave of symptoms two to four hours later. This combination of an early phase of symptoms followed by a late phase of symptoms is defined as a biphasic reaction. While the initial symptoms respond to epinephrine, the delayed biphasic response may not respond at all to epinephrine and may not be prevented by steroids. **Therefore, it is imperative that following the administration of epinephrine, the student be transported by emergency medical services to the nearest hospital emergency department even if the symptoms appear to have been resolved.** Students experiencing anaphylaxis should be observed in a hospital emergency department for a minimum of 4-6 hours after initial symptoms subside, to observe for a possible biphasic reaction. In the event a biphasic reaction occurs, intensive medical care could then be provided.

When in doubt, it is better to give the Epipen© (epinephrine) and seek medical attention. Fatalities occur when epinephrine is withheld.

For those students at risk for food-induced anaphylaxis, the most important aspect of the management in the school setting should be **prevention**. In the event of an anaphylactic reaction, epinephrine is the treatment of choice and should be given immediately. This shall require the training of unlicensed personnel, if nursing

When in doubt, it is better to give the Epipen© (epinephrine) and seek medical attention. Fatalities occur when epinephrine is withheld.

In many fatal reactions the initial symptoms of anaphylaxis were mistaken for asthma. This delayed appropriate treatment with epinephrine.

staff cannot be available immediately. Studies show that fatalities are frequently associated with not using epinephrine or delaying the use of epinephrine treatment.

Children with severe food allergies have a higher rate of other allergic disease including asthma and eczema. Anaphylaxis is more common in children whose food reactions have had respiratory features such as difficulty breathing and throat tightness. Fatal anaphylaxis is more common in children with food allergies who are asthmatic, even if the asthma is mild and well controlled. Anaphylaxis appears to be much more probable in children who have already experienced an anaphylactic reaction. Anaphylaxis does not require the presence of any skin symptoms such as itching and hives.

In many fatal reactions the initial symptoms of anaphylaxis were mistaken for asthma. This delayed appropriate treatment with epinephrine.

SUMMARY OF ANAPHYLAXIS

Every food allergy reaction has the potential of developing into a life-threatening event. Several factors may also increase the risk of a severe or fatal anaphylactic reaction: concomitant asthma; a previous history of anaphylaxis; peanut, tree nut, seed and/or shellfish allergies; and delay in the administration or failure to administer epinephrine. Food allergies are more prevalent in younger children.

The severity and explosive speed of food anaphylaxis emphasizes the need for an effective emergency plan that includes recognition of the symptoms of anaphylaxis, rapid administration of epinephrine and prompt transfer of the student by the emergency medical system to the closest hospital.

CHILDREN WITH FOOD ALLERGIES AND THEIR FAMILIES

Raising a child with food allergies is challenging. Parents must ensure strict food avoidance, understand food labeling and be on a constant alert to implement an emergency medical plan at any moment. These are just some of the challenges parents of children with food allergies deal with every day. With time, support and education, parents become skilled and are well prepared to keep their children safe. Perhaps the greatest challenge parents face is finding the balance between what is safe and what is normal when meeting the needs of their children. The balance works well until it is time to share the care of that child with others. It is at this time that the balance often shifts and parents must work to reestablish it.

Parents of children with food allergies have crafted ways to keep their children safe in a world that is not food allergic friendly. As their children grow and their world expands, so do the demands for parents to readjust their own thinking and strategies for maintaining a normal but safe environment for their children. The threat to this balance is never greater than when a child begins school. What had worked so well in their own home is now being given to unfamiliar people, some knowledgeable about food allergies and supportive of parents, others not. Some

schools may have adequate infrastructure whereas others have little ability to deal with medical emergencies. Some schools are well staffed, while others have limited staffing with school environments containing the very foods that parents have worked so diligently to avoid.

Parents are faced with the reality that if their child has a severe food allergy the child is at greatest risk for a life threatening and potentially fatal allergic reaction at school. The only way to provide a safe and healthy learning environment for these children is for schools to partner with parents, tap into their knowledge and expertise and develop a comprehensive approach that will ensure the safety and health of each and every child with food allergies.

With this approach, schools can help parents and their children make the very necessary transition of moving from the safety of their home environment into the expanding world of a school. When done well, this is one of the greatest lessons a child can learn; they are safe in a world outside of their own home.

Schools can provide invaluable resources to children with food allergies and their families by helping children feel accepted within the school community. They can teach children to:

- keep themselves safe
- ask for help, how to trust others
- develop healthy and strong friendships
- acquire social skills
- accept more responsibility
- improve their self-esteem
- increase their self confidence.

Adequate plans to handle severe allergic reaction can save the life of a child.

PLANNING

I. PLANNING FOR THE INDIVIDUAL STUDENT: ENTRY INTO SCHOOL

A. Individual Health Care Plan (IHCP)

Prior to entry into school (or, for a student who is already in school, immediately after the diagnosis of a life-threatening allergic condition), the parent/guardian should meet with the school nurse assigned to the student's building to develop an IHCP.

The parent/guardian should work with the school to create a strategy for management of a child's food allergy (See in Appendix A "Responsibilities of the Parents" for more detail).

The parent/guardian shall provide the following:

- Licensed provider documentation of food allergy
- Licensed provider order for epinephrine by auto-injector as well as other medications needed. Medication orders must be renewed at least annually and it is recommended that the order be from an asthma and allergy specialist.
- Parent/guardian's signed consent to administer all medications
- Parent/guardian's signed consent to share information with other school staff
- A minimum of two up-to-date EpiPens (More may be necessary based on the student's activities and travel during the school day.)
- The type of allergies (e.g., to milk, tree nuts, etc.)
- Description of the student's past allergic reactions, including triggers and warning signs
- A description of the student's emotional response to the condition and need for support
- Name/telephone number of the student's primary care provider and allergist
- Method to reach parent/parent designee should an emergency occur, e.g., telephone, cell-phone, beeper
- Age-appropriate ways to include a student in planning for care and implementing the plan
- Assessment for self-administration (It is important that students take more responsibility for their food allergies as they grow older and are developmentally ready to accept responsibility.)
- Parent/guardian's interest in participating in the training/orientation in the student's classroom

The school nurse will:

- Initiate an Individual Health Care Plan based on the information provided by the parent, as well as the nurse's assessment. The plan shall include the student's name, method of identifying the student, specific offending allergens, warning signs of reactions and emergency treatment. The plan should include, but not be limited to, risk reduction and emergency response at the following times: (a) travel to and from school, (b) the school day, and (c) before and after school programs, and field trips. The IHCP should be signed by the parent, school nurse, and if possible, by the student's physician.
- Initiate an Allergy Action Plan (AAP) which, with the parent's permission, will be with the student at all times and appropriate adults should know where the AAP is (e.g., in the classroom, cafeteria, etc.) The AAP should include the student's photo (if possible), the student's name, specific offending allergens, warning signs of reactions and emergency management, including medications and names of those trained to administer. The AAP should be signed by the parent, and school nurse (see Appendix G, Sample Allergy Action Plan Form adapted from the Food Allergy Network).
- Complete a medication care plan, which should include who is trained in administering the EpiPen, plans for field trips or short-term special events, where the epi-pens shall be stored (including a back-up storage) and how they should be monitored for currency. (The Medication Plan shall be in accordance with 105CMR 210.000, The Administration of Prescription Medications within Public and Private Schools.)
- Based on the student's age, class, etc., identify who will be part of the multidisciplinary team approval. (These may include but not be limited to the principal or designee, classroom teacher, student, food services director, counselor, school physician, physical education teacher, custodian, bus driver, local EMS, etc.)
- Assess the student for his/her ability to self-administer epinephrine. Criteria may include the student's capabilities and the safety of other students. (It is important that students assume more responsibility for their food allergies as they grow older and are more developmentally ready.)
- Determine the appropriateness for the student to carry his/her epinephrine.
- Provide information on the availability of a Medical Alert Bracelet.

The IHCP must include an Allergy Action Plan (AAP).

B. Multi-Disciplinary Team Approach

1. The school nurse, collaborating with the building principal, school physician, and parent/guardian, shall determine the best way to promote a multi-disciplinary approach to plan for the care of the student with a life-threatening allergic condition. The school nurse may meet individually with staff members to assist them in preparing for their responsibilities. If a meeting is scheduled, prior to the meeting the nurse will share those parts of this document that pertains to each staff member, e.g., Introduction, What Is a Food Allergy, Role of Specific Staff, etc.

The team may include but is not limited to:

- Administrative representative
- Food service director/staff
- Teachers and specialists (e.g., – art, music, science, computer, family and consumer sciences)
- School counselor
- Coaches and physical education teachers
- Custodian
- Bus driver
- Local EMS
- Other learning support staff and aides based on the student's curriculum and activities
- Student with food allergy (if age appropriate).

The school nurse may meet individually with staff members to assist them in preparing for their responsibilities.

2. The school nurse gives an overview of the food allergies, anaphylaxis and the student's Individual Health Care Plan.
3. The team should discuss the prevention and management of life-threatening food allergies. (Refer to Appendix C: Prevention and Management of Allergic Reactions, and Appendix D: Response to Emergencies.) The following questions should be considered and responsibility for implementation assigned:

Cafeteria Protocols/Guidelines

- What is the process for identifying students with life-threatening allergies?
- Is there a need for an allergen free table?
- Which personnel will have the responsibility for cleaning the tables, trays etc?
- What type of cleaning solution should be used?
- Who will provide training for cafeteria staff?
- Have the cafeteria monitors been informed?

Classroom Protocols/Guidelines

- Have all teachers, aides, volunteers, substitutes and students been educated about food allergies?
- Have all parents/guardians of students in the class been notified that there is a student with a life-threatening food allergy and what foods must not be brought to school?
- Are there guidelines for allowable foods for lunch, snacks, parties etc?
- If not, who shall establish these guidelines?
- Is there an allergen free table/desk in the student's classroom?
- What are the cleaning protocols for this area?
- What type of cleaning solution should be used?
- Is there an understanding that classroom project materials containing the allergen may not be used?
- Have the students been taught proper hand-washing techniques before and after eating?

Environmental Protocols/Guidelines

- What is the school policy for the presence of animals?
- Is there an awareness of multiple and related allergies, e.g., latex?
- What are the cleaning protocols for various areas of the school where allergens may be found?

Field Trip/School Bus Protocols/Guidelines

- How will the school nurse be notified about field trips in a timely manner?
- How will the Allergy Action Plan be communicated to responsible personnel on field trips, the school bus and after school programs? *(All issues relating to the classroom and environment should be reviewed as appropriate for these situations.)*
- Is the location of the field trip assessed to be safe for the student with allergies?
- Who will be trained to administer the epinephrine should an emergency occur? Is there a need for a registered nurse or aide to accompany the student?
- Should the student with allergies be seated near the driver, teacher or advisor?
- Is there a no-food policy for the bus? Is it enforced?
- Do personnel have a system for communicating (cell phone, walkie-talkies, etc.)?

Custodial Protocols/Guidelines

- What cleaning solution is used?
- How often are the areas cleaned?

Emergency Response Protocols/Guidelines

- Have all school personnel received education on life-threatening allergic conditions?
- Has the school registered with the Massachusetts Department of Public Health to train unlicensed personnel to administer epinephrine by auto injector?
- What specific personnel will be trained in the administration of epinephrine?
- Who will do the training?
- Will the parents be involved in the training?
- When will this training occur?
- What is the content of the training? *(Please refer to the training curriculum provided by the Massachusetts Department of Public Health.)*
- How often will it be repeated during the school year? *(The MDPH regulations require* EpiPen® *training twice a year at a minimum.)*
- Where will the list of trained personnel be kept?
- Have local emergency medical services been informed and has planning occurred to ensure the fastest possible response?
- Does the local EMS carry epinephrine and are they permitted to use it?
- When and how often are drills a part of the district-wide emergency response plan?
- In what unlocked area will epinephrine be stored?
- Where is the back-up supply?
- Is it appropriate for this student to carry his/her EpiPen®?

The team should refer to Appendix C: Suggested Components of a School District Policy on the Management of Students with Life Threatening Allergies (LTAs), to further develop the questions for the team meeting.

II. IMPLEMENTING THE PLAN

A. Prevention

- **Classroom**
- **School Field Trips**
- **School Bus**
- **Gym and Recess**
- **After School Activities**
- **Food Services/Cafeteria**

Protecting a student from exposure to offending allergens is the most important way to prevent life-threatening anaphylaxis. Most anaphylactic reactions occur when a child is accidentally exposed to a substance to which he/she is allergic, such as foods, medicines, insects and latex.

Accidental ingestion of the offending allergen occurs most often at school. This is understandably a high risk setting due to such factors as a large number of students, increased exposure of the food allergic student to food allergens, as well as cross contamination of tables, desks and other surfaces. Other high risk areas and activities for the student with food allergies include: the cafeteria; food sharing; hidden ingredients; craft, art and science projects; bus transportation; fundraisers; bake sales; parties and holiday celebrations; field trips; and substitute teaching staff being unaware of the food allergic student.

Ingestion of the food allergen is the principal route of exposure; however, it is possible for a student to react to tactile (touch) exposure or inhalation exposure. The amount of food needed to trigger a reaction depends on multiple variables. Each food allergic person's level of sensitivity may fluctuate over time. Not every ingestion exposure will result in anaphylaxis, though the potential always exists. Another variable that has been recently investigated is how the food is prepared. Raw egg is more allergenic than cooked egg. Roasted peanuts are more allergenic than boiled or fried. (Virtually all peanut products in the U.S. are roasted.) In addition, the symptoms of a food allergy reaction are specific to each individual. Milk may cause hives in one person and anaphylaxis in another.

Success in managing food allergies depends on allergen avoidance techniques. Scrupulous interpretation of ingredient statements on every item with every purchase is vital to prevent accidental exposure. Unfortunately, this is difficult due to manufacturing processes. Accidental exposure occurs due to cross contamination of equipment, omission of ingredients from the ingredient statement, substitution of ingredients, scientific and technical terminology (e.g., sodium caseinate for milk protein), nonspecific food terminology (e.g., natural ingredients) and disregarding precautionary allergen statements, such as "may contain."

Procedures shall be in place at school to address food allergy issues in the classrooms and gym, food services/cafeteria, for art, science and mathematics projects, crafts, outdoor activity areas, school buses, field trips and before and after school activities.

Protecting a student from exposure to offending allergens is the most important way to prevent life-threatening anaphylaxis.

Procedures shall be in place at school to address food allergy issues in the classrooms and gym, for art, science and mathematics projects, crafts, outdoor activity areas, school buses, field trips and before and after school activities.

CLASSROOMS

- Teachers must be familiar with the IHCP (Individual Health Care Plan) of students in their classes and respond to emergencies as per the emergency protocol documented in the Allergy Action Plan (AAP).
- In the event of an allergic reaction (where there is no known allergic history), the school nurse should be called and the school's Emergency Response Plan activated. The emergency medical services should be called immediately.
- The classroom should have easy communication with the school nurse by such means as functioning intercom, walkie-talkie or cell phone.
- Information should be kept about students' food allergies in the classroom. These foods should not be used for class projects, parties, holidays and celebrations, arts, crafts, science experiments, cooking, snacks, or other purposes.
- All students and their parents, teachers, aides, substitutes, and volunteers should be educated about the risk of food allergies.
- For rewards, non-food items should be used instead of candy.
- For birthday parties, consider a once-a-month celebration, with a non-food treat.
- A parent or guardian of a student with food allergies is responsible for providing classroom snacks for his/her own child. These snacks should be kept in a separate snack box or chest.
- If a student inadvertently brings a restricted food to the classroom, he/she will not be allowed to eat that snack in the classroom.
- Tables should be washed with soap and water in the morning if an event has been held in the classroom the night before.
- Sharing or trading food in the class should be prohibited.
- Proper handwashing technique by adults and children should be taught and required before and after the handling/consumption of food.
- Classroom animals can be problematic on many levels. If an animal is present in the classroom, special attention must be paid to the ingredients in their food as many animal feeds contain peanuts.
- In classrooms used for meals in schools with no central cafeteria:

  a. A "peanut-free" table should be established and maintained as an option for students with peanut allergies, as this is an extremely potent allergen and often a hidden ingredient. These tables should be designated by a universal symbol and it will be the responsibility of the principal or designee to take reasonable steps so that these areas are not contaminated.

  b. Other LTA (Life Threatening Allergen) -free tables should be provided and maintained as needed.

SCHOOL FIELD TRIPS

- The school nurse should be responsible for determining the appropriateness of each field trip and consideration of safety of the student with life-threatening allergies.
- Protocols for field trips should include timely notification to the nurse.
- Whenever students travel on field trips for school, the name and phone number of the nearest hospital will be part of the chaperone's emergency plan.
- Medications including epinephrine auto-injector and a copy of the student's AAP must accompany the student.
- A cell phone or other communication device must be available on the trip for emergency calls.
- Parents of a student at risk for anaphylaxis should be invited to accompany their child on school trips, in addition to the chaperone.
- In the absence of accompanying parents/guardian or nurse, another individual must be trained and assigned the task of watching out for the student's welfare and for handling any emergency. The adult carrying the epinephrine should be identified and introduced to the student as well as the other chaperones. (*Refer to Appendix E, Massachusetts Department of Public Health Regulations Governing Administration of Prescription Medications in Public and Private Schools, for information about obtaining an application from MDPH to register the school/school district to train unlicensed persons to administer medications when the school nurse is not available.)*
- Field trips need to be chosen carefully; no student should be excluded from a field trip due to risk of allergen exposure.
- Hand wipes should be used by students and staff after consuming food.

SCHOOL BUS

- Eating food should be prohibited on school buses.
- School bus drivers shall be trained by appropriate personnel in risk reduction procedures, recognition of allergic reaction, and implementation of bus emergency plan procedures.
- With parental permission, school bus drivers will be provided with the Allergy Action Plan of all students with LTAs. (See Appendix G.)
- The school bus must have a cell phone or other means of communication for emergency calls.

GYM AND RECESS

- Teachers and staff responsible for gym or recess should be trained by appropriate personnel to recognize and respond to exercise-induced anaphylaxis, as well as anaphylaxis caused by other allergens.
- Staff in the gym, playground and other sites used for recess should have a walkie-talkie, cell phone or similar communication device for emergency communication.
- If for safety reasons medical alert identification (i.e. ID bracelet) needs to be removed during specific activities, the student should be reminded to replace this identification immediately after the activity is completed.

- A current epinephrine by auto-injector should be readily accessible, and an adult staff member onsite should be trained in its use, for previously diagnosed students in schools registered with the MDPH.

AFTER SCHOOL ACTIVITIES

- Post instructions for accessing EMS in all activity areas.
- After school activities sponsored by the school must be consistent with school policies and procedures regarding life-threatening allergies.
- Identify who is responsible for keeping epinephrine by auto injector during sporting events.
- If for safety reasons medical alert identification, (ID bracelet) needs to be removed during specific activities, the student should be reminded to replace this identification immediately after the activity is completed.
- With written parental permission, the coach or adult staff member in charge will be provided with the Allergy Action Plan (AAP), of students who have life-threatening allergies. (See Appendix G).
- A current epinephrine by auto-injector should be readily accessible, and an adult staff member onsite should be trained in its use, for previously diagnosed students in schools registered with the MDPH.
- The staff member (or his/her designee) should maintain a current epinephrine auto-injector in the first aid kit, to be used by designated trained school personnel for previously diagnosed students.
- If bake sales are held on school grounds, consideration should be given to students with LTA. Food should be tightly wrapped or sealed. The display table should be washed after use.

FOOD SERVICES/CAFETERIA

Responsibilities of the Food Service Director

- Be prepared to discuss: menus (breakfast, lunch and after school snack); a la carte items; vending machines; recipes; food products and ingredients; food handling practices; cleaning and sanitation practices; and responsibility of various staff (or additional contract employees at individual school).
- Establish communications and training for all school food service staff and related personnel at the student's school.
- Be prepared to make food ingredient lists used in food production and service available.
- Maintain food labels from each food served to a child with allergies for at least 24 hours following service in case the student has a reaction from a food eaten in the cafeteria.
- Maintain contact information with vendors and purveyors to access food content information.
- Understand the laws protecting students with food allergies as they relate to food services (see Appendix H).

Food Label Reading

- **Read all food labels and recheck with each purchase for potential food allergens. (Manufacturers can change ingredients.)**
- **All food service staff should be trained how to read product labels and recognize food allergens.**
- **See Appendix B: Guidelines on Reading Food Labels.**

There are eight major food allergens: milk, eggs, peanuts, tree nuts (such as walnuts and almonds), soy, wheat, fish and shellfish. These eight foods are the most common food allergens and cause more than 90 percent of all food allergic reactions. Peanuts and tree nuts alone account for 92% of severe and fatal reactions. Among children, allergies to milk and eggs are most common. However, individuals can be allergic to any food. Some children may be allergic to more than one food.

Reading food labels to identify these ingredients in the products used by a school's food service department is an essential and ongoing process in prevention. As food manufacturers continuously refine and improve food products, food labels must be read for every product each time it is purchased.

In the school cafeteria, personnel should know their products and ingredients by carefully reading labels. Some students may react to a minute trace of these ingredients, so complete elimination is essential.

Many food manufacturers have consumer response departments to provide information about their products. If there are any questions about a product ingredient, call the consumer hot line number listed on most products food labels. Be specific. (For example, "Does your product include peanuts? Is there a risk of cross-contamination with peanuts in your food manufacturing process?" etc.)

Knowing how to read a food label helps avoid problems caused by ingredients in foods. Refer to Appendix B: *Guidelines on Reading Food Labels*.

Cross contamination of a food allergen poses a serious risk to a child with food allergies. Training for all food service personnel about cross contamination should be a part of your regularly scheduled sanitation program.

Food Handling

- Cross contamination of a food allergen poses a serious risk to a child with food allergies.
- Training for all food service personnel about cross contamination should be a part of the regularly scheduled sanitation program.

Cross Contamination

Cross contamination is the cooking or serving of different foods with the same utensils and surfaces. When preparing and serving food, it is critical to make sure that food preparation and serving utensils are not exposed to allergens and then used for another food. Food production surface areas should be cleaned before, during and after food preparation. Some examples of cross contamination would be:

- Lifting peanut butter cookies with a spatula and then using the same spatula to lift sugar cookies.
- Using a knife to make peanut butter sandwiches, wiping the knife and then using that same knife to spread mustard on a peanut allergic child's cheese sandwich.

Cleaning and Sanitation

Any surfaces used for the preparation and service of meals need to be properly cleaned and sanitized. For preparation areas, the work surface and all utensils and pots and pans need to be washed with hot soapy water (soap is used because it deactivates the protein that causes the allergy). The work surface areas, counters and cutting surfaces, need to be cleaned thoroughly between uses. The use of the color-coded cutting board system implemented for food safety can also help minimize risk of cross contamination when preparing foods for children with food allergies.

- After using a food slicer to slice cheese, the slicer must be cleaned thoroughly before being used to slice other foods to prevent contamination with cheese protein.
- Wash trays or cookie sheets after each use as oils can seep through wax paper or other liners and contaminate the next food cooked on the sheet or tray.

In the Cafeteria

- Consider creating a peanut-free table (same practice applies for other allergies).
- Train cafeteria monitors to take note of the situation surrounding a child with allergies and intervene quickly to help prevent trading of food or bullying.
- All students eating meals in the cafeteria should be encouraged to wash their hands before and after eating so that no traces of allergens will be left on their hands.
- After each meal service, all table and chairs should be thoroughly washed with soap and water.
- Use disposable wipes and dedicated water to avoid cross contamination.

Food for field trips

- Clearly specify any special meals needed before the field trip.
- Avoid meals that may be food allergy related.
- Package meals appropriately to avoid cross-contamination.
- Provide two hand wipes with each meal (for cleaning hands before and after meals).

III. RESPONSE TO EMERGENCIES

Every school shall include in it's emergency response plan a written plan outlining emergency procedures for managing life threatening allergic reactions. This plan shall identify personnel who will:

- Remain with the student.
- Assess the emergency at hand.
- Activate the emergency response team (building specific, system-wide).
- Refer to the student's Allergy Action Plan.
- Notify school nurse.
- Notify the emergency medical services.
- Administer the epinephrine.
- Notify the parent/guardians.
- Notify school administration.
- Notify student's primary care provider and/or allergy specialist.
- Attend to student's classmates.
- Manage crowd control.
- Meet emergency medical responders at school entrance.
- Direct emergency medical responders to site.
- Accompany student to emergency care facility.
- Assist student's re-entry into school.

Practice drills should be conducted periodically as part of the district's emergency response plan.

RETURNING TO SCHOOL AFTER A REACTION

Students who have experienced an allergic reaction at school need special consideration upon their return to school. The approach taken by the school is dependent upon the severity of the reaction, the student's age and whether their classmates witnessed it. A mild reaction may need little or no intervention other than speaking with the student and parents and re-examining the IHCP.

In the event that a student has a moderate to severe reaction, the following actions should be taken.

- Obtain as much accurate information as possible about the allergic reaction.
- Identify those who were involved in the medical intervention and those who witnessed the event.
- Meet with the adults to discuss what was seen and dispel any rumors.
- Provide factual information. Although the school may want to discuss this with the parents, factual information that does not identify the individual student can be provided to the school community without parental permission (e.g., a letter from the principal to parents and teachers that doesn't name names but reassures them the crisis is over, if appropriate.)
- If an allergic reaction is thought to be from a food provided by the school food service, request assistance of the Food Service Director to ascertain what potential food item was served/consumed. Review food labels from Food Service Director and staff.
- Agree on a plan to disseminate factual information and review knowledge about food allergies to schoolmates who witnessed or were involved in the allergic reaction, after both the parents and the student consent.
- Explanations shall be age appropriate
- Review the AAP described in the IHCP, or if a student does not have an IHCP then consider initiating one.
- Amend the student's AAP and/or the emergency response plan to address any changes that need to be made.
- Review what changes need to be made to prevent another reaction; do not assign blame.

SPECIAL CONSIDERATION FOR THE STUDENT

The student and parent(s) shall meet with the nurse/staff who were involved in the allergic reaction and be reassured about the student's safety, what happened and what changes will be made to prevent another reaction.

If a student demonstrates anxiety about returning to school, checking in with the student on a daily basis would be indicated until his/her anxiety is alleviated. If a child has a prolonged response to an anaphylactic event, strategies should be reviewed and clinical intervention may be recommended. Collaboration with the student's medical provider would be indicated to address any medication changes.

It is important to keep in mind that a student will continue to need to access help if another allergic reaction should occur; therefore, make sure a student feels comfortable enough to seek help if needed. You do not want a student to withhold information out of embarrassment or because of intimidation. Other students with food allergies in the school system may be in particular need of support.

IN THE EVENT OF A FATAL ALLERGIC REACTION

In the rare but plausible event of a fatal reaction the school's crisis plan for dealing with the death of a student should be implemented. Adults with knowledge of food allergies should be on hand to answer questions that may come up about food allergies. Organizations such as Asthma and Allergy Foundation of America (AAFA) and Food Allergy and Anaphylaxis Network (FAAN) may be able to provide resources.

APPENDIX A

ROLES OF SPECIFIC INDIVIDUALS IN THE MANAGMENT OF STUDENTS WITH LIFE-THREATENING ALLERGIES.

____ Students with Food Allergies

____ Parent of a Student with Food Allergies

____ School Nurse

____ School Administrators

____ Classroom Teacher/Specialist

____ Food Service Personnel

____ School Bus Company

____ Coaches and other Onsite Persons in Charge of Running School Activities

RESPONSIBILITIES OF THE STUDENT WITH FOOD ALLERGIES/ANAPHYLAXIS

____ Take as much responsibility as possible for avoiding allergens.

____ Do not trade or share foods.

____ Wash hands before and after eating.

____ Learn to recognize symptoms of an allergic reaction.

____ Promptly inform an adult as soon as accidental exposure occurs or symptoms appear.

____ Take more responsibility for your allergies as you get older (refer to parent responsibilities outline).

____ Develop a relationship with the school nurse and/or another trusted adult in the school to assist in identifying issues related to the management of the allergy in school.

RESPONSIBILITIES OF THE PARENTS/GUARDIANS OF A STUDENT WITH FOOD ALLERGIES

____ Inform the school nurse of your child's allergies prior to the opening of school (or as soon as possible after a diagnosis).

____ Provide the school with a way to reach you (cell phone, beeper, etc.).

____ Provide a list of foods and ingredients to avoid.

____ Consider providing a medical alert bracelet for your child.

____ Provide the school nurse with medication orders from the licensed provider.

____ Participate in developing an Individual Health Care Plan with the school nurse.

____ Provide the school nurse with at least annual updates on your child's allergy status.

____ Provide the school with up-to-date epinephrine auto-injectors.

____ Discuss with the school nurse the possibility of keeping the epinephrine auto-injector in the classroom with instructions (this can also be taken on field trips). [Refer to Appendix E, *Massachusetts Department of Public Health Regulations Governing Administration of Prescription Medications in Public and Private Schools*, for information about obtaining an application from MDPH to register the school/school district to train unlicensed persons to administer medications when the school nurse is not available.]

____ Decide if additional epinephrine auto-injectors will be kept in the school, aside from the one in the nurse's office, and if so, where.

____ Provide the school nurse with the licensed provider's statement if student no longer has allergies.

Participate in team meetings or communicate with all staff members who will be in contact with the child (preferably before the opening of school) to:

____ Discuss implementation of IHCP.

____ Establish prevention plan.

____ Periodically (halfway through the year) review prevention and emergency action plans with the team.

____ Help decide upon an "allergy-free" eating area in the classroom and/or cafeteria.

____ Leave a bag of "safe snacks" in your child's classroom so there is always something your child can choose from during an unplanned special event.

____ Provide a non-perishable lunch to keep in school, in case your child forgets lunch one day.

____ Be willing to provide safe foods for special occasions, e.g. bring in a treat for the entire class so that your child can participate.

____ Be willing to go on your child's field trips if possible and if requested.

Periodically teach your child to:

____ Recognize the first symptoms of an allergic/anaphylactic reaction.

____ Know where the epinephrine auto-injector is kept and who has access to the epinephrine.

____ Communicate clearly as soon as s/he feels a reaction is starting.

____ Carry his/her own epinephrine auto-injector when appropriate.

____ Not share snacks, lunches, or drinks.

____ Understand the importance of hand-washing before and after eating.

____ Report teasing, bullying and threats to an adult authority.

____ Take as much responsibility as possible for his/her own safety.

It is important that children take on more responsibility for their food allergies as they grow older and are developmentally ready. Consider teaching them to:

____ Communicate the seriousness of the allergy.

____ Communicate symptoms as they appear.

____ Read labels.

____ Carry own epinephrine auto-injector.

____ Administer own epinephrine auto-injector and be able to train others in its use.

Remember – the ultimate goal is that our children eventually learn to keep themselves safe.

RESPONSIBILITIES OF THE SCHOOL ADMINISTRATION (or delegate)

____ Include in the school's emergency response plan a written plan outlining emergency procedures for managing life-threatening allergic reactions. Modify the plan to meet special needs of individual students. Consider risk reduction for LTAs.

____ Support faculty, staff and parents in implementing all aspects of the LTA program.

____ Provide training and education for faculty and staff regarding:

- ____ Foods, insect stings, medications, latex.
- ____ Risk reduction procedures.
- ____ Emergency procedures.
- ____ How to administer an epinephrine auto-injector in an emergency.

____ Provide special training for food service personnel.

____ Provide emergency communication devices (two-way radio, intercom, walkie-talkie, cell phone) for all school activities, including transportation, that involve a student with life-threatening allergies.

____ A fulltime nurse should be available in every school with students with life-threatening allergies.

____ Inform parent/guardian if any student experiences an allergic reaction for the first time at school.

____ Make sure a contingency plan is in place in case of a substitute teacher, nurse or food service personnel.

____ Have a plan in place when there is no school nurse available.

____ Ensure that the student is placed in a classroom where the teacher is trained to administer an epi-pen, if needed.

Each school district/school that plans to have the school nurse train unlicensed personnel to administer epinephrine by auto-injector to students with a life-threatening allergic condition must register with MA Department of Public Health. consistent with 105 CMR 210.000.

RESPONSIBILITIES OF THE SCHOOL NURSE

___ Prior to entry into school (or, for a student who is already in school, immediately after the diagnosis of a life-threatening allergic condition), meet with the student's parent/guardian and develop an Individual Health Care Plan (IHCP) for the student.

___ Assure that the AAP includes the student's name, photo, allergens, symptoms of allergic reactions, risk reduction procedures, emergency procedures, and required signatures.

___ Arrange and convene a team meeting (preferably before the opening of school) to develop the plan with all staff who come in contact with the student with allergies, including principal, school physician, teachers, specialists, food service personnel, aides, physical education teacher, custodian, bus driver, local EMS, etc.

___ Familiarize teachers with the IHCPs and AAPs of their students by the opening of school, or as soon as the plans are written. Other staff members who have contact with students with LTAs should be familiar with their IHCPs and Allergy Action Plans on a need-to-know basis.

___ After the team meeting remind the parent to review prevention plans, symptoms and emergency procedures with their child.

___ Provide information about students with life-threatening allergies and their photos (if consent given by parent) to all staff on a need-to-know basis (including bus drivers).

___ Conduct inservice training and education for appropriate staff regarding a student's life-threatening allergens, symptoms, risk reduction procedures, emergency procedures, and how to administer an epinephrine auto-injector (refer to Appendix E).

___ Implement a periodic anaphylaxis drill similar to a fire drill as part of the periodic refresher course.

___ Educate new personnel as necessary.

___ Track inservice attendance of all involved parties to ensure that they have been trained.

___ Introduce yourself to the student and show him/her how to get to the nurse's office.

___ Post school district's emergency protocol and have available all IHCPs and AAPs in the nurse's office. Post location of epinephrine auto-injector.

___ Periodically check medications for expiration dates and arrange for them to be current.

___ Discuss with parents the possibility of keeping an epinephrine auto-injector in the classroom containing necessary instructions, and help to arrange if appropriate. This auto-injector can be taken on field trips.

___ Arrange periodic follow-up on semi-annual basis, or as often as necessary, to review effectiveness of the IHCP.

____ Make sure there is a contingency plan in place in the case of a substitute school nurse.

____ Meet with parents on a regular basis to discuss issues relating to plan implementation.

____ Communicate with local EMS about location of student and type of allergy. Assure the local EMS carry epinephrine and have permission to use it.

RESPONSIBILITIES OF THE CLASSROOM TEACHER/ SPECIALIST

____ Receive the AAP of any student(s) in your classroom with life-threatening allergies.

____ Request that the classroom has a functioning intercom, walkie-talkie or other communication device for communication with the school nurse.

____ Participate in a team meeting for the student with life-threatening allergies and in-service training regarding:

(1) Allergens that cause life-threatening allergies (such as foods, insect stings, medications, latex).

(2) Steps to take to prevent life-threatening reactions and accidental exposures to allergens.

(3) How to recognize symptoms of the student's life-threatening allergic reaction.

(4) Steps to manage an emergency.

(5) How to administer an epinephrine auto-injector.

____ Keep accessible the student's AAP with photo in classroom or keep with lesson plan.

____ Be sure volunteers, student teachers, aides, specialists and substitute teachers are informed of the student's food allergies and necessary safeguards (see Appendix D).

____ Leave information in an organized, prominent and accessible format for substitute teachers.

____ Coordinate with parent on providing a lesson plan about food allergies for the class and discuss anaphylaxis in age appropriate terms, with student's permission.

____ Educate classmates to avoid endangering, isolating, stigmatizing or harassing students with food allergies. Be aware of how the student with food allergies is being treated; enforce school rules about bullying and threats.

____ Work with the school nurse to educate other parents about the presence and needs of the child with life-threatening allergies in the classroom. Enlist their help in keeping certain foods out of the classroom (see Appendix D).

____ Inform parents of any school events where food will be served.

____ Participation with the planning for student's re-entry to school after a anaphylactic reaction.

____ Never question or hesitate to act if a student reports signs of an allergic reaction.

A. SNACKS/ LUNCHTIME

____ In the classroom, establish procedures to ensure that the student with life-threatening food allergies eats only what s/he brings from home.

____ Prohibit students from sharing or trading snacks.

____ Encourage parents/guardians to send in a box of "safe" snacks for their child.

____ Have parents/guardians provide a non-perishable safe lunch in case their child forgets lunch one day.

____ For the student's safety, encourage the student to take advantage of an eating area in the classroom that is free of the food to which s/he is allergic.

____ Avoid cross-contamination of foods by wiping down eating surfaces with soap and water before and after eating. Tables should also be washed with soap and water in the morning if an after-school event has been held in the classroom the day before.

____ Reinforce hand-washing before and after eating.

B. CLASSROOM ACTIVITIES

____ Avoid use of foods for classroom activities (e.g., arts and crafts, counting, science projects, parties, holidays and celebrations, cooking, or other projects).

____ Welcome parental involvement in organizing class parties and special events. Consider non-food treats.

____ Use stickers, pencils or other non-food items as rewards instead of food.

C. FIELD TRIPS (refer to Appendix F).

Collaborating with the school nurse, prior to planning a field trip to:

____ Ensure epinephrine auto-injectors and instructions are taken on field trips.

____ Ensure that functioning two-way radio, walkie talkie, cell phone or other communication device is taken on field trip.

____ Review plans for field trips; avoid high risk places. Consider eating situations on field trips and plan for prevention of exposure to the student's life-threatening foods.

____ Know where the closest medical facilities are located, 911 procedures and whether the ambulance carries epinephrine.

____ Invite parents of a student at risk for anaphylaxis to accompany their child on school trips, in addition to the chaperone. However, the student's safety or attendance must not be conditioned on the parent's presence.

____ One to two people on the field trip should be trained in recognizing symptoms of life-threatening allergic reactions, trained to use an epinephrine auto-injector, and trained in emergency procedures.

____ Consider ways to wash hands before and after eating (e.g. provision of hand wipes, etc.).

RESPONSIBILITIES OF THE FOOD SERVICES MANAGER

____ Attend the team meeting with appropriate members at the time of the student's registration for entry into school.

____ Post the student's Allergy Action Plan with consent of parent(s).

____ Review the legal protections for a student with life threatening allergies.

____ Read all food labels and recheck routinely for potential food allergens.

____ Train all food service staff and their substitutes to read product food labels and recognize food allergens.

____ Maintain contact information for manufacturers of food products (Consumer Hotline).

____ Review and follow sound food handling practices to avoid cross contamination with potential food allergens.

____ Strictly follow cleaning and sanitation protocol to avoid cross-contamination.

____ Set up policies for the cafeteria regarding food allergic students.

____ Create specific areas that will be allergen safe.

____ Train monitors.

____ Enforce hand washing for all students.

____ Thoroughly clean all tables, chairs and floors after each meal.

____ After receiving a doctor's note, make appropriate substitutions or modifications for meals served to students with food allergies.

____ Plan ahead to have safe meals for field trips.

____ Avoid the use of latex gloves by food service personnel. Use non-latex gloves instead.

____ Provide advance copies of the menu to parents/guardian and notification if menu is changed.

____ Have at least two people in the eating area trained to administer epinephrine by auto-injector.

____ Have readily accessible epinephrine auto-injector.

____ Have a functioning intercom, walkie-talkie or other communication device to support emergencies.

____ Take all complaints seriously from any student with a life-threatening allergy.

____ Be prepared to take emergency action.

RESPONSIBILITIES OF THE SCHOOL BUS COMPANY

____ Provide a representative from the bus company for Team meetings to discuss implementation of a student's IHCP.

____ Provide training for all school bus drivers on managing life-threatening allergies (provide own training or contract with school).

____ Provide functioning emergency communication device (e.g., cell phone, two-way radio, walkie-talkie or similar).

____ Know local Emergency Medical Services procedures.

____ Maintain policy of no food eating allowed on school buses.

RESPONSIBILITIES OF COACHES AND OTHER ONSITE PERSONS IN CHARGE OF CONDUCTING AFTER SCHOOL ACTIVITIES

____ Participate in Team meetings to determine how to implement students Individual Health Care Plan.

____ Conduct that activities in accordance with all school policies and procedures regarding life threatening allergies.

____ With parent's consent, keep a copy of the Allergy Action Plan and photo of students with life threatening allergies.

____ Make certain that emergency communication device (e.g. walkie-talkie, intercom, cell phone, etc.) is always present.

____ One to two people should be present who have been trained to administer epinephrine auto-injector.

____ Maintain a current epinephrine auto-injector in the first aid kit.

____ Establish emergency medical procedures with EMS.

____ Clearly identify who is responsible for keeping the first aid kit.

____ If for safety reasons medical alert identification needs to be removed during specific activities, the student should be reminded to replace this identification immediately after the activity is completed.

APPENDIX B

APPENDIX: READING FOOD LABELS

Knowing how to read a food label will help to avoid food allergy problems caused by ingredients in foods. The following terms are "labelese" for common foods. You may find it helpful to keep these lists handy when you order foods. The lists are updated frequently. Contact The Food Allergy Network for current lists.

Terms that indicate the presence of cow's MILK:

Artificial butter flavor

Butter, butter fat, butter oil

Buttermilk

Casein

Caseinates (ammonium, calcium, magnesium, potassium, sodium)

Cheese

Cream

Cottage cheese

Curds

Custard

Ghee

Half & Half ®

Hydrolysates (casein, milk protein, protein, whey, whey protein)

Lactalbumin, lactalbumin phosphate

Lactoglobulin

Lactose

Lactulose

Milk (derivative, powder, protein, solids, malted, condensed, evaporated, dry, whole, low-fat, non-fat, skimmed and goat's milk)

Nougat

Pudding

Rennet casein

Sour cream, sour cream solids

Sour milk solids

Whey (in all forms, including sweet, delactosed, protein concentrate)

Yogurt

The letter "D" on the front label of a product indicates the product may contain cow's milk protein.

Terms that may indicate presence of MILK protein:

Chocolate
High protein flour
Luncheon meat, hot dogs, sausages
Margarine
Natural and artificial flavoring: Simplesse®

Terms that indicate the presence of EGG protein:

Albumin
Egg (white, yolk, dried, powdered, solids)
Egg substitutes
Egg Nog
Globulin
Livetin
Lysozyme (used in Europe)
Macaroni
Mayonnaise
Meringue
Ovalbumin
Ovomucin
Ovomucoid
Simplesse®
Surimi

Terms that indicate the presence of PEANUT protein:

Beer nuts
Cold pressed, expelled, or extruded peanut oil
Ground nuts
Mixed nuts
Monkey nuts
Nu-Nuts®
Nut pieces
Peanuts
Peanut butter
Peanut flour

Terms that may indicate the presence of PEANUT protein:

African, Chinese, Indonesian, Thai and Vietnamese dishes
Marzipan
Natural and artificial flavoring
Egg rolls
Hydrolyzed plant protein
Hydrolyzed vegetable protein
Baked goods
Candy
Chocolate (candies, candy bars)
Nougat
Sunflower seeds

Terms that indicate the presence of SOYBEAN protein:

Edamame
Hydrolyzed soy protein
Miso
Shoyu Sauce
Soy (albumin, flour, grits, milk, nuts, sprouts)
Soy Protein (concentrate, isolate)
Soy sauce
Soybean (granules, curds)
Tamari
Tempeh
Textured vegetable protein (TVP)
Tofu

Terms that may indicate the presence of SOYBEAN protein:

Hydrolyzed protein
Natural and artificial flavoring
Vegetable gum
Vegetable starch
Vegetable broth

Terms that indicate the presence of WHEAT protein:

Bran
Bread crumbs
Bulgur
Cereal extract
Couscous
Cracker meal
Durum, durum flour
Farina
Gluten
Seitan
Semolina
Spelt
Vital gluten
Wheat (bran, germ, gluten, malt, starch)
Whole wheat berries
Whole wheat flour
Flour (all purpose, enriched graham, high gluten, high protein, pastry, soft wheat)

Terms that may indicate the presence of WHEAT protein:

Gelatinized starch
Soy sauce
Starch
Hydrolyzed vegetable protein
Modified food starch
Modified starch
Natural and artificial flavoring
Vegetable gum
Vegetable starch

Terms that indicate the presence of SHELLFISH protein:

Abalone
Clams (cherrystone, littleneck, pismo, quahog)
Oysters
Prawns
Scallops
Shrimp (crevette)
Snails (escargot)
Squid (calamari)
Mussels
Octopus
Cockle (periwinkle, sea urchin)
Crab
Crawfish (crayfish, ecrevisse)
Mollusks
Lobster (Langouste, langousine, scampo, Coral, tomalley)

Terms that may indicate the presence of SHELLFISH:

Bouillabaisse
Fish stock
Natural and artificial flavoring
Seafood flavoring (such as crab or clam extract)
Surimi

Terms that indicate the presence of CORN protein:

Baking powder
Corn
Corn alcohol
Corn flour
Cornstarch
Corn sweetener
Corn syrup solids
Cornmeal
Grits
Hominy
Maize

Terms that may indicate the presence of CORN protein:

Food starch
Vegetable gum
Modified food starch
Vegetable starch

APPENDIX C

Suggested Components of a School District Policy on the Management of Students with Life-Threatening Allergies (LTA)

It is recommended that school districts develop system-wide policies that outline the requirements of a program to manage students with life-threatening allergies. The following content should be included:

- Registration with the MDPH if the school nurse plans to train unlicensed personnel to administer epinephrine by auto-injector to students with diagnosed life-threatening allergic conditions, consistent with 105 CMR 210.000.
- Provision of education and training for school personnel on the management of students with life-threatening allergies.
- Development of a system-wide plan for addressing life threatening allergic reactions.
- Development of Individualized Health Care Plan (IHCP) and Allergy Action Plan (AAP) for every student with a life threatening allergy.
- Development of protocols to prevent exposure to allergens.
- Standing orders/protocols for licensed personnel (school nurses) to administer epinephrine to individuals with undiagnosed allergies.

Suggested Elements to Consider in Developing School District Protocols on the Management of Life Threatening Allergies

Training/education (general LTA education)

Who is trained (e.g., teachers, aides, volunteers, substitutes, students, parents of students, food service personnel, custodial staff, transportation personnel). Assistance and information on training can be obtained through MA DPH School Health Unit.

- What information
- Frequency of training
- Parent involvement in training
- Responsibility for scheduling

Student Education

- Food sharing
- Personal hygiene (handwashing/brushing teeth)

IHCP/AAP Development

- Process for development/review
  - Plan for team meeting
  - Membership of team
  - Frequency of reviewing IHCP
- Parent involvement
- Information to be included
- Where AAP is posted
- How information communicated for field trips, school bus personnel, after school activities, etc.

Cafeteria protocols

- Process for identifying students with LTA
- Allergen free tables
- Personnel responsibilities (e.g., seating, cleaning)
- Cleaning protocols (e.g., frequency, type of cleaning solution, etc.)

Classroom protocols

- Lunches/snacks/parties/classroom projects (guidelines for allowable foods)
- How are guidelines for allowable foods determined
- Allergen-free table if required
- Cleaning protocols (e.g., frequency, type of cleaning solution, etc.)
- Student hygiene practices
- Education of classmates
- Communication with parents of other children
  - What information communicated
  - Who is responsible for notifying parents
- Guidelines on presence of animals

Custodial protocols

- Cleaning protocols (e.g., frequency, type of cleaning solution, etc.)

Field trip management

- Planning process
  - Location of field trip safe for student
  - Location of nearest medical facility determined
- Guidelines for storage/administration of EpiPen®
- Plan for activating EMS and notifying parent
- Availability of AAP

School bus management

- Communication systems (e.g., cell phones)
- Driver training
- Student placement
- Availability/location of EpiPen®
- Food policy on bus

Emergency response protocols

- Personnel responsibilities
- Communication procedures
- Emergency drills

Coordination with Emergency Services

- Availability of EpiPens®

EpiPens®

- Who is trained
- Who conducts training
- Frequency of training (specified by MDPH)
- Content of training (determined by MDPH)
- Location of EpiPens®
- Location of list of trained personnel
- Policy on students carrying EpiPens®
- Standing orders/protocols for licensed personnel (school nurse) to administer epinephrine to individuals with undiagnosed allergies
- Mechanism to review expiration dates of EpiPens®

Policies regarding students self-administration

APPENDIX D

SAMPLE LETTERS

Sample Food Allergy Letter for Classmates and Parents

- If parent agrees, as food allergies are a confidential health condition, a letter should be sent home with classmates to inform families of the school's peanut/nut or other food allergy policy.
- A letter should be written on school stationery by school nurse, teacher and/or principal. Parents may help in composing the letter, but it must come from the school.
- The school nurse, teacher(s) and/or principal should sign the letter.
- Include a cut off portion for parents of classmates to return to the school so that the staff is aware that the parents of classmates have received the information.

SAMPLE

Date:

Dear Parents,

This letter is to inform you that a student in your child's classroom has a severe peanut/nut allergy. Strict avoidance of peanut/nut products is the only way to prevent a life threatening allergic reaction. We are asking your assistance in providing the student with a safe learning environment.

If exposed to peanuts/nuts the student may develop a life-threatening allergic reaction that requires emergency medical treatment. The greatest potential for exposure at school is to peanut products and nut products. To reduce the risk of exposure, the classroom will be peanut/nut free. Please do not send any peanut or nut containing products for your child to eat during snack in the classroom. Any exposure to peanuts or nuts through contact or ingestion can cause a severe reaction. If your child has eaten peanut or nut prior to coming to school, please be sure your child's hands have been thoroughly washed prior to entering the school.

Since lunch is eaten in the cafeteria, your child may bring peanut butter, peanut or nut products for lunch. In the cafeteria there will be a designated peanut-free table where any classmate without peanut or nut products can sit. If your child sits at this table with a peanut or nut product, s/he will be asked to move to another table. This plan will help to maintain safety in the classroom while allowing non allergic classmates to enjoy peanut/nut products in a controlled environment. Following lunch, the children will wash their hands prior to going to recess (or returning to the class.) The tables will be cleaned with soap, water and paper towels after each lunch.

We appreciate your support of these procedures. Please complete and return this form so that we are certain that every family has received this information. If you have any questions, please contact me.

x_____

Signature of Principal/Teacher/Nurse

I have read and understand the peanut/nut free classroom procedures. I agree to do my part in keeping the classroom peanut and nut free.

Child's Name:_____

Parent's Signature:_____

Date:_____

Sample Letter for Substitute Teachers, Volunteers, etc.

Substitute teachers are an important link in the school staff. They must be included in the information chain regarding safety measures designed to protect the students with food allergies they supervise.

Substitute teachers must receive written information that the students with food allergies are in the class, information about peanut-free tables or other special modifications, and the resources available if a student has an allergic reaction. Here is a sample letter which teachers can leave with their lesson plans for the substitute:

Dear Substitute Teacher,

The students listed below in this class have severe life-threatening food allergies.

Please maintain the food allergy avoidance strategies that we have developed to protect these students.

Should a student ingest, touch or inhale the substance to which they are allergic, (the allergen), a severe reaction (anaphylaxis) may follow requiring the administration of epinephrine (Epi-pen®).

The Allergy Action Plan, which states who has been trained to administer epinephrine, is located _____.
Epinephrine is a life-preserving medication and should be given in the first minutes of a reaction.

Student	Allergies

Please treat this information confidentially to protect the privacy of the students.

Your cooperation is essential to ensure their safety. Should you have any question

please contact the school nurse _____,

or the principal _____.

_____

Classroom teacher

APPENDIX E

Massachusetts Department of Public Health
Bureau of Family and Community Health
School Health Unit

PART I

MDPH OUTLINE OF TRAINING PROGRAM FOR UNLICENSED SCHOOL PERSONNEL TO ADMINISTER EPINEPHRINE BY AUTO-INJECTOR IN LIFE-THREATENING SITUATIONS

PURPOSE: To provide unlicensed school personnel with basic knowledge and skills to administer epinephrine by auto-injector in a life-threatening situation.

INSTRUCTOR: School Nurse or Physician

TIME: Two hours

OBJECTIVES: Upon completion of the training the participants will demonstrate the following competencies:

- identify common causes of allergic emergencies;
- accurately recognize general and student-specific warning signs of allergic emergency;
- accurately identify student for whom the epinephrine is prescribed:
- accurately read and interpret the emergency medication administration plan;
- correctly follow directions on the medication administration plan;
- accurately read the epinephrine label and follow directions from the label;
- administer epinephrine by auto-injector;
- safely handle epinephrine in an auto-injector;
- accurately describe the school's plan for responding to emergencies;
- access resources appropriately, including emergency medical services, school nurse, parents and physician.

Epinephrine is available in two different dosages: EpiPen 0.3 mg (1: 1000) and Epi Pen Jr. 0.15 mg (1: 2000)

CONTENT: School nurse and parents, if possible, shall meet with the selected unlicensed school personnel to explain:

(a) the student's allergy;

(b) past reactions and associated symptoms; and

(c) measures taken to reduce exposure to the allergens in the school setting and off-campus activities. (See Part II for introduction to the student.)

Describe common causes of allergic emergencies.

Explain use of epinephrine.

How it works: Epinephrine is the treatment of choice for allergic emergencies because it quickly constricts blood vessels, relaxes smooth muscles in the lungs to improve breathing, stimulates the heartbeat, and works to reverse hives and swelling around the face and lips.

Effects of the injection begin to wear off after 10 to 20 minutes; therefore immediate activation of the emergency medical system (911 or, if not available, the local community's emergency medical response system) is essential.

How to handle and store epinephrine: The auto-injector is quite durable, but may be damaged if mishandled. It is stable at room temperature until the marked expiration date. It should not be refrigerated, frozen or exposed to extreme heat or sunlight; light and heat cause it to oxidize and go bad, turning brown. Before using, make sure the solution is clear and colorless; if brown, replace immediately. NOTE: Accidental injection into the hands or feet may result in loss of blood flow to the affected area and will require immediate treatment in the Emergency Room.

After use, place auto-injector in an impermeable container, if available, and give to Emergency Medical personnel to take to the Emergency Room. Inform them of the time of injection.

HOW TO ADMINISTER:

Check to identify: right student (e.g., use photo on student's emergency plan)
right medication*
right dose*
right route
right time (based on student's symptoms, e.g., hives spreading over the body, wheezing, difficulty swallowing or breathing, swelling in face or neck, tingling/swelling of tongue, vomiting, signs of shock such as extreme paleness/gray color, clammy skin, loss of consciousness or any other child specific known symptoms).

PLEASE NOTE: Epinephrine is available in two different dosages: EpiPen 0.3mg (1: 1000) and EpiPen Jr. 0.15mg (1: 2000)

Practice with the specific auto-injector trainer that corresponds with the auto-injector provided by the specific student. Refer to specific manufacturer's instructions.

CAUTION: Accidental injection into the hands or feet may result in loss of blood flow to the affected area. Seek treatment immediately in the nearest Emergency Room.

Review emergency plan of school

Emergency telephone numbers and where posted (EMS, student's parent/guardian, student's physician); emphasize the need to activate immediately in order for student to be further evaluated in an Emergency Room.

Names of CPR-certified personnel and where located.

Plan for field trips: Trained personnel must take the epinephrine auto-injector on all field trips in which the student is participating. Make sure phone is close by if needed. Keep epinephrine at room temperature.

Question/answer session.

School nurse shall complete the competency skill check list for each person trained.

PART II

DEVELOPMENT OF A PARTNERSHIP BETWEEN THE TRAINED UNLICENSED SCHOOL PERSONNEL AND THE STUDENT WITH AN ALLERGIC CONDITION

PURPOSE: To provide the student and unlicensed trained school personnel with an opportunity to develop a relationship prior to an emergency situation and to encourage the student to begin to learn responsibility for managing his/her own health care. This process will continue to engage the parent and student as working partners in the health team.

TIME: One hour.

OBJECTIVES: Upon completion of the introductory session and appropriate to his/her developmental level, the student will:

1. Have met the trained school personnel and they will know how to identify each other; have an opportunity to identify to the unlicensed school personnel what allergens precipitate a reaction and the symptoms experienced and understand.

(a) the support system available to him/her.

(b) the responsibility for alerting the teacher/classmates of symptoms.

(c) understand the importance of using Medi-Alert bracelets.

(d) and explore possibilities for developing a "buddy system" within his/her class.

CONTENT: Collaborating with the parent and student, as appropriate, the school nurses should:

- facilitate the comfort level of the parent and student, recognizing the importance of such individual factors as
  - (a) whether the family has understood and accepted the student's condition,
  - (b) age of the student,
  - (c) level of anxiety/fear, and
  - (d) relationship with the school nurse and trained unlicensed personnel;
- review the location of the auto-injectors and back-up supplies;
- identify and discuss the symptoms; (Based on the age of the student, a picture or word showing the foods or insects precipitating an allergic reaction may be given to the student to wear so that a visual connection may be made.)
- Explore the possibility of teaching the student's classmates and teacher about allergic responses and developing a "buddy system" for responding to an emergency.

OTHER SUGGESTIONS:

Training:

Provide a periodic refresher course, at a minimum of twice a year, for any unlicensed staff trained to administer epinephrine by auto-injector in a life-threatening allergic reaction.

Implement a periodic anaphylaxis drill similar to a fire drill as part of the periodic refresher course. (During the anaphylaxis drill a student may be identified as theoretically having a life-threatening allergic reaction and staff will be expected to take the appropriate actions, e.g., locating the epinephrine, describing how they would give it in an emergency, describing whom they would notify, including the number for the emergency response team, etc.)

Storage:

If the epinephrine auto-injector is to be useful in the time of an emergency, it needs to be stored in a clearly visible location and have the student's name on it or it may be carried by the student if appropriate. The location of the auto-injector and back-up should be written in the health care plan. All staff trained in its use should know exactly where it is located.

The location should be determined based on the anticipated needs of the student. A plan must be in place stating who obtains it while the trained staff member stays with the student.

Key staff members such as the teacher, principal, cafeteria staff, etc., should know where the auto-injector is stored even if they are not trained to administer it.

Emergency Response Preparation:
Suggested numbers of school staff trained in cardio-pulmonary resuscitation (CPR) include a minimum of 3 per school building; for those buildings with more than 300 students, there should be at least one additional CPR-trained staff member per 100 students.

Names of CPR-trained staff members should be available to all faculty in the school.

Inform local emergency medical respondents of the possible need for their rapid response to students at risk for life-threatening allergic reactions. Provide EMS personnel with the address and the location of school entrances. Identify a school staff member to be responsible for meeting EMS at entrance and leading them to the student with the reaction.

Clearly mark telephones with emergency response phone numbers as well as how to access an outside line. (e.g. 9-911)

Training Materials:

The School Food Allergy Program includes a video, training manual, poster, etc. (The cost is $75.00 plus $9.50 shipping and handling.) It may be ordered from The Food Allergy Network, 10400 Eaton Place, Suite 107, Fairfax, VA 22030 (1-800-929-4040). Other booklets and videos about food allergies ("Alexander: The Elephant Who Couldn't Eat Nuts" and "It Only Takes One Bite") are available.

EpiPen Trainers, EpiPen Brochures are available at no cost from:

Dey Laboratories
2751 Napa Valley Corporate Drive
Napa, CA 94558
(1-800-755-5560) or (1-800-869-9005)

11/2001 MDPH School Health Unit

Massachusetts Department of Public Health
Bureau of Family and Community Health
School Health Unit

EPINEPHRINE COMPETENCY SKILL CHECK LIST

Name and Title of Staff Person: _____

The following competencies have been demonstrated by staff person:

States the responsibilities of the school nurse for training and supervision _____

Identifies common causes of allergic emergencies _____

Describes general and student-specific warning signs of allergic emergency _____

Demonstrates how to activate the school's plan for responding to emergencies _____

Identifies student for whom the epinephrine is prescribed _____

Interprets accurately the emergency medication administration plan _____

Follows the directions on the medication administration plan _____

Reads the label on the epinephrine auto-injector, assuring the correct dosage _____

Demonstrates safe handling of epinephrine auto-injector _____

Demonstrates the correct procedure for giving epinephrine by auto-injector_____

Describes how to access emergency medical services, school nurse, student's parents (or other persons), student's physician _____

Comments:

Signatures: Supervised by_____RN

Staff Person_____

Date: _____

12/96

APPENDIX F

105 CMR 210.000, The Administration of Prescription Medications in Public and Private Schools

105 CMR: DEPARTMENT OF PUBLIC HEALTH

105 CMR 210.000: THE ADMINISTRATION OF PRESCRIPTION MEDICATIONS IN PUBLIC AND PRIVATE SCHOOLS

Section

210.001: Purpose

210.002: Definitions

210.003: Policies Governing the Administration of Prescription Medications in Schools

210.004: Policies Regarding Delegation of Prescription Medication Administration

210.005: Responsibilities of the School Nurse Regarding Prescription Medication Administration

210.006: Self-Administration of Prescription Medications

210.007: Training of School Personnel Responsible for Administering Prescription Medications

210.008: Handling, Storage and Disposal of Prescription Medications

210.009: Documentation and Record-Keeping

210.100: Administration of Epinephrine

210.001: Purpose

The purpose of 105 CMR 210.000 is to provide minimum standards for the safe and proper administration of prescription medications to students in the Commonwealth's public and private primary and secondary schools. 105 CMR. 210.000 permit school nurses to delegate responsibility for administration of prescription medications to trained, nursing-supervised school personnel, provided the school district or private school registers with the Department of Public Health. The aim of 105 CMR 2I0.000 is to ensure that students requiring prescription medication administration during the school day will be able to attend school and to ensure that prescription medications are safely administered in schools. 105 CMR 210.000 encourages collaboration between parents or guardians and the school in this effort.

210.002: Definitions

As used in 105 CMR 210.000, the following words, unless the context clearly requires otherwise, shall have the following meanings:

Administration of Medication means the direct application of a prescription medication by inhalation, ingestion, or by any other means to the body of a person.

Prescription Medication means any medication which by federal law may be obtained only by prescription.

Cumulative Health Record means the cumulative health record of a pupil as specified under M.G.L. c. 71.

Department means the Massachusetts Department of Public Health.

Investigational New Drug means any medication with an approved investigational new drug (IND) application on file with the Food and Drug Administration (FDA) which is being scientifically tested and clinically evaluated to determine its efficacy, safety and side effects and which has not yet received FDA approval.

Licensed Practical Nurse means an individual who is a graduate of an approved practical nursing program, and who is currently licensed as a practical nurse pursuant to M.G.L. c. 112.

Licensed Prescriber means a health care provider who is legally authorized to prescribe medication pursuant to M~G.L c. 94C and applicable federal laws and regulations.

Parental Medication means any medication administered in a manner other than by the digestive tract or topical application, as by intravenous, intramuscular, subcutaneous, or intradermal injection.

Physician means a doctor of medicine or osteopathy licensed to practice medicine in Massachusetts or in another state.

School Nurse means a nurse practicing in a school setting, who is:

(1) a graduate of an approved school for professional nursing;

(2) currently licensed as a Registered Nurse pursuant to M.G.L c. 112; and

(3) appointed by a School Committee or a Board of Health in accordance with M.GL. c. 71, §§ 53, 53A, and 53B or, in the case of a private school, by the Board of Trustees.

School Physician means a physician appointed by a School Committee or Board of Health in accordance with M.G.L c. 71, §§ 53, 53A, and 53B or, in the case of a private school, by the Board of Trustees.

Supervision means guidance by a qualified school nurse to accomplish a task, with initial direction and instruction concerning the task and periodic inspection and oversight of activities related to the task.

Teacher for the purpose of 105 CMR 210.000, means a professional school employee who:

(1) instructs students or serves in the role of administrator below the rank of superintendent; and

(2) is employed by a School Committee or Board of Trustees.

210.003:
Policies Governing the Administration of Prescription Medications in Schools

(A) The School Committee or Board of Trustees, consulting with the Board of Health where appropriate, shall adopt policies and procedures governing the administration of prescription medications and self administration of prescription medications within the school system, following development of a proposal by the school nurse, in consultation with the school physician. Review and revision of such policies and procedures shall occur as needed but at least every two years. At a minimum, these policies shall include:

(1) designation of a school nurse as supervisor of the prescription medication administration program in a school;

(2) documentation of the administration of prescription medications;

(3) response to a medication emergency;

(4) storage of prescription medications;

(5) reporting and documentation of medication errors;

(6) dissemination of information to parents or guardians. Such information shall include an outline of a school's medication policies and shall be available to parents and guardians upon request;

(7) procedures for resolving questions between the school and a parent or guardian

regarding administration of medications. Such procedures shall provide for and encourage the participation of the parent or guardian. Existing procedures for resolution of differences may be used whenever appropriate.

(B) The School Committee or Board of Trustees shall submit these policies and procedures to the Department of Public Health upon request.

210.004:
Policies Regarding Delegation of Prescription Medication Administration

(A) The School Committee or Board of Trustees, consulting with the Board of Health where appropriate, may approve a proposal developed by the school nurse and school physician, to permit the administration of prescription medications to be delegated by the school nurse to unlicensed school personnel. Such delegation may occur only if the school district registers with the Department of Public Health pursuant to the applicable provisions of 105 CMR 700.000 and complies with the requirements of 105 CMR 210.000.

(B) In accordance with the proposal of the school nurse and school physician, the School Committee or Board of Trustees may approve categories of unlicensed school personnel to whom the school nurse may delegate responsibility for prescription medication administration.

(1) Said categories of personnel may include administrative and teaching staff, licensed health personnel, health aides and secretaries.

(a) For the purposes of 105 CMR 210.000, health aide shall mean an unlicensed employee of the school district who is generally supervised by the school nurse and performs those health-related duties defined by the school nurse, the School Committee, Board of Health or Board of Trustees.

(b) For the purpose of administering emergency prescription medication to an individual child, including parental administration of medication pursuant to 103 CMR 2l0.004(B)(4), the school nurse may identify individual school personnel or additional categories. Said school personnel shall be listed on the medication administration plan developed in accordance with 105 CMR 2 10.005(E) and receive training in the administration of emergency medication to a specific child.

(2) An individual in an approved category may be authorized to administer prescription medication if he/she meets the following criteria:

(a) is a high school graduate or its equivalent;

(b) demonstrates sound judgment;

(c) is able to read and write English;

(d) is able to communicate with the student receiving the prescription medication or

has ready access to an interpreter when needed;

(e) is able to meet the requirements of 105 CMR 210.000 and follow nursing supervision;

(f) is able to respect and protect the student's confidentiality; and

(g) has completed an approved training program pursuant to 105 CMR 210.007.

(3) A school nurse shall be on duty in the school system while prescription medications are being administered by designated unlicensed school personnel, and available by telephone should consultation be required.

(4) The administration of parental medications may not be delegated, with the exception of epinephrine or other medication to be administered in a life-threatening situation where the child has a known allergy or pre-existing medical condition and there is an order for administration of the medication from a licensed prescriber and written consent of the parent or guardian.

(5) Prescription medications to be administered pursuant to p.r.n. ("as needed") orders may be administered by authorized school personnel after an assessment by or consultation with the school nurse for each dose.

(6) For each school, an updated list of unlicensed school personnel who have been trained in the administration of prescription medications shall be maintained. Upon request, a parent shall be provided with a list of school personnel authorized to administer prescription medications.

210.005: Responsibilities of the School Nurse Regarding Prescription Medication Administration

(A) The school nurse, in consultation with the school physician and the school health advisory committee, if established, shall develop policies and procedures consistent with 105 CMR 210.000 for approval by the School Committee or Board of Trustees, in consultation with the Board of Health where appropriate.

(B) The school nurse shall have responsibility for the development and management of the prescription medication administration program. Such responsibility shall be delineated in policies and procedures adopted by the School Committee or Board of Trustees, in consultation with the-Board of Health where appropriate.

(C) The school nurse, in consultation with the school physician, shall have final decision-making authority with respect to delegating administration of prescription medications to unlicensed personnel in school

systems registered with the Department of Public Health.

(D) Medication Orders.

(1) The school nurse shall ensure that there is a proper medication order from a licensed prescriber which is renewed as necessary including the beginning of each academic year. A telephone order or an order for any change in prescription medication shall be received only by the school nurse. Any verbal order must be followed by a written order within three school days. Whenever possible, the medication order shall be obtained, and the medication administration plan specified in 105 CMR 210.005(E) shall be developed before the student enters or re-enters school.

(a) In accordance with standard medical practice, a medication order from a licensed prescriber shall contain:

1. the student's name;

2. the name and signature of the licensed prescriber and business and emergency phone numbers;

3. the name, route and dosage of medication;

4. the frequency and time of medication administration;

5. the date of the order;

6. a diagnosis and any other medical condition(s) requiring medication, if not a violation of confidentiality or if not contrary to the request of a parent, guardian or student to keep confidential;

7. specific directions for administration.

(b) Every effort shall be made to obtain from the licensed prescriber the following additional information, as appropriate:

1. any special side effects, contraindications and adverse reactions to be observed;

2. any other medications being taken by the student;

3. the date of return visit, if applicable.

(2) Special Medication Situations

(a) For short-term prescription medications, i.e., those requiring administration for ten school days or fewer, the pharmacy-labeled container may be used in lieu of a licensed prescriber's order. If the nurse has a question, she may request a licensed prescriber's order.

(b) For "over-the-counter" medications, i.e., non-prescription medications, the school nurse shall follow the Board of Registration in Nursing's protocols regarding administration of over-the-counter medications in schools.

(c) Investigational new drugs may be administered in the schools with (1) a written order by a licensed prescriber, (2) written consent of the parent or guardian, and (3) a pharmacy-labeled container for dispensing. If there is a question, the school nurse may seek consultation and/or approval from the school physician to administer the medication in a school setting.

(3) The school nurse shall ensure that there is a written authorization by the parent or guardian which contains:

(a) the parent or guardian's printed name and signature and a home

and emergency phone number;

(b) a list of all medications the student is currently receiving, if not a violation of confidentiality or contrary to the request of the parent, guardian or student that such medication not be documented;

(c) approval to have the school nurse or school personnel designated by the school nurse administer the prescription medication;

(d) persons to be notified in case of a medication emergency in addition to the parent or guardian and licensed prescriber.

(E) Medication Administration Plan: The school nurse, in collaboration with the parent or guardian whenever possible, shall establish a medication administration plan for each student receiving a prescription medication. Whenever possible, a student who understands the issues of medication administration shall be involved in the decision-making process and his/her preferences respected to the maximum extent possible. If appropriate, the medication administration plan shall be referenced in any other health or educational plan developed pursuant to St. 1972, c. 766 the Massachusetts Special Education Law (Individual Education Plan under Chapter 766) or federal laws, such as the Individuals with Disabilities Education Act (IDEA) or Section 504 of the Rehabilitation Act of 1973.

(1) Prior to the initial administration of the prescription medication, the school nurse shall assess the child's health status and develop a medication administration plan which includes:

(a) the name of the student,

(b) a medication order from a licensed prescriber, which meets the requirements of 105 CMR 210.005(D)(1);

(c) the signed authorization of the parent or guardian, which meets the requirements of 105 CMR 210.005(D)(3);

(d) any known allergies to food or medications;

(e) the diagnosis, unless a violation of confidentiality or the parent, guardian or student requests that it not be documented;

(f) any possible side effects, adverse reactions or contraindications;

(g) the quantity of prescription medication to be received by the school from the parent or guardian;

(h) the required storage conditions;

(i) the duration of the prescription;

(j) the designation of unlicensed school personnel, if any, who will administer the prescription medication to the student in the absence of the nurse, and plans for back-up if the designated personnel arc unavailable;

(k) plans, if any, for teaching self administration of the prescription medication;

(1) with parental permission, other persons, including teachers, to be notified of medication administration and possible adverse effects of the medication;

(m) when appropriate, the location where the administration of the prescription medication will take place;

(n) a plan for monitoring the effects of the medication;

(o) provision for prescription medication administration in the case of field trips and other short-term special school events. Every effort shall be made to obtain a nurse or school staff member trained in prescription medication administration to accompany students at special school events. When this is not possible, the school nurse may delegate prescription medication administration to another responsible adult. Written consent from the parent or guardian for the named responsible adult to administer the prescription medication shall be obtained. The school nurse shall instruct the responsible adult on how to administer the prescription medication to the child.

(F) Developing Procedures for Administration of Prescription Medications.

(1) The school nurse shall develop procedures for the administration of prescription medications which shall include the following:

(a) A procedure to ensure the positive identification of the student who receives the medication;

(b) A system for documentation and record-keeping which meets the requirements of 105 CMR 210.009.

(2) The school nurse shall develop a system of documenting observations by the nurse or school personnel and communicating significant observations relating to prescription medication effectiveness and adverse reactions or other harmful effects to the child's parent or guardian and/or licensed prescriber:

(3) The school nurse shall develop and implement procedures regarding receipt and safe storage of prescription medications;

(4) The school nurse shall develop procedures for responding to medication emergencies, i.e.. any reaction or condition related to administration of medication which poses an immediate threat to the health or well-being of the student. This includes maintaining a list of persons, with their phone numbers, to be contacted as appropriate, in addition to the parent/guardian, school nurse, licensed prescriber and other persons designated in the medication administration plan. Such persons may include other school personnel, the school physician, clinic or emergency room staff, ambulance services and the local poison control center,

(5) The school nurse shall develop procedures and forms for documenting and reporting prescription medication errors. The procedures shall specify persons to be notified in addition to the parent or guardian and nurse, including the licensed prescriber or school physician if there is a question of potential harm to the student. A medication error includes any failure to administer prescription medication as prescribed for a particular student, including failure to administer the prescription medication:

(a) within appropriate time frames;

(b) in the correct dosage;

(c) in accordance with accepted practice;

(d) to the correct student.

(6) The school nurse shall develop procedures to review reports of

medication errors and take necessary steps to ensure appropriate prescription medication administration in the future.

(G) Delegation/Supervision. When a School Committee or Board of Trustees, in consultation with the Board of Health where appropriate, has registered with the Department of Public Health and authorized categories of unlicensed school personnel to administer prescription medications, such personnel shall be under the supervision of the school nurse for the purposes of 105 CMR 210.000. The School Committee or Board of Trustees, in consultation with the Board of Health where appropriate, shall provide assurance that sufficient school nurse(s) are available to provide proper supervision of unlicensed school personnel. Responsibilities for supervision, at a minimum, shall include the following:

(1) After consultation with the principal or administrator responsible for a given school, the school nurse shall select, train and supervise the specific individuals, in those categories of school personnel approved by the School Committee or Board of Trustees, in consultation with the Board of Health where appropriate, who may administer prescription medications. When necessary to protect student health and safety, the school nurse may rescind such selection.

(2) The number of unlicensed school personnel to whom responsibility for prescription medication administration may be delegated is to be determined by:

(a) the number, of unlicensed school personnel the school nurse can adequately supervise on a weekly basis, as determined by the school nurse;

(b) the number of unlicensed school personnel necessary, in the nurse's judgment, to ensure that the prescription medications arc properly administered to each student.

(3) The school nurse shall support and assist persons who have completed the training specified in 105 CMR 210.007 to prepare for and implement their responsibilities related to the administration of prescription medication.

(4) The first time that an unlicensed school personnel administers medication, the delegating nurse shall provide supervision at the work site.

(5) The degree of supervision required for each student shall be determined by the school nurse after an evaluation of the appropriate factors involved in protecting the student's health, including but not limited to the following:

(a) health condition and ability of the student;

(b) the extent of training and capability of the unlicensed school personnel to whom the prescription medication administration is delegated;

(c) the type of prescription medication; and

(d) the proximity and availability of the school nurse to the unlicensed person who is performing the prescription medication administration.

(6) For the individual child, the school nurse shall:

(a) determine whether or not it is medically safe and appropriate to delegate prescription medication administration;

(b) administer the first dose of the prescription medication, if: 1. there is reason to believe there is a risk to the child as indicated by the health assessment, or 2. the student has not previously received this prescription medication in any setting;

(c) review the initial orders, possible side effects, adverse reactions and other pertinent information with the person to whom prescription medication administration has been delegated;

(d) provide supervision and consultation as needed to ensure that the student is receiving the prescription medication appropriately. Supervision and consultation may include record review, on-site observation and/or assessment;

(e) review all documentation pertaining to prescription medication administration on a biweekly basis or more often if necessary.

(H) In accordance with standard nursing practice, the school nurse may refuse to administer or allow to be administered any prescription medication which, based on her/his individual assessment and professional judgment, has the potential to be harmful, dangerous or inappropriate. In these cases, the parent/guardian and licensed prescriber shall be notified immediately by the school nurse.

(1) For the purposes of 105 CMR 210.000, a Licensed Practical Nurse functions under the general supervision of the school nurse who has delegating authority.

(J) The school nurse shall have a current pharmaceutical reference available for her/his use, such as the Physician's Desk Reference (P.D.R.) or U.S.P. DI (Dispensing Information), Facts and Comparisons.

210.006: Self Administration of Prescription Medications

(A) Consistent with school policy, students may self administer prescription medication provided that certain conditions are met. For the purposes of 105 CMR 210.000, "self administration" shall mean that the student is able to consume or apply prescription medication in the manner directed by the licensed prescriber, without additional assistance or direction.

(B) The school nurse may permit self medication of prescription medication by a student provided that the following requirements are met:

(1) the student, school nurse and parent/guardian, where appropriate, enter into an agreement which specifies the conditions under which prescription medication may be self administered;

(2) the school nurse, as appropriate, develops a medication administration plan (105 CMR 2 10.005(E) which contains only those elements necessary to ensure safe self administration of prescription medication;

(3) the school nurse evaluates the student's health status and abilities and deems self administration safe and appropriate. As necessary, the school nurse shall observe initial self-administration of the prescription medication;

(4) the school nurse is reasonably assured that the student is able to

identify the appropriate prescription medication, knows the frequency and time of day for which the prescription medication is ordered, and follows the school self administration protocols;

(5) there is written authorization from the student's parent or guardian that the student may self medicate, unless the student has consented to treatment under M.G.L c. 112, § 12F or other authority permitting the student to consent to medical treatment without parental permission;

(6) if requested by the school nurse, the licensed prescriber provides a written order for self administration;

(7) the student follows a procedure for documentation of self-administration of prescription medication;

(8) the school nurse establishes a policy for the safe storage of self-administered prescription medication and, as necessary, consults with teachers, the student and parent/guardian, if appropriate, to determine a safe place for storing the prescription medication for the individual student, while providing for accessibility if the student's health needs require it. This information shall be included in the medication administration plan. In the case of an inhaler or other preventive or emergency medication,, whenever possible, a backup supply of the prescription medication shall be kept in the health room or a second readily available location;

(9) the school nurse develops and implements a plan to monitor the student's self administration, based on the student's abilities and health status. Monitoring may include teaching the student the correct way of taking the prescription medication, reminding the student to take the prescription medication, visual observation to ensure compliance, recording that the prescription medication was taken, and notifying the parent, guardian or licensed prescriber of any side effects, variation from the plan, or the student's refusal or failure to take the prescription medication;

(10) with parental/guardian and student permission, as appropriate, the school nurse may inform appropriate teachers and administrators that the student is self-administering a prescription medication.

<u>210.007: Training of School Personnel Responsible for Administering Prescription Medications</u>

(A) All prescription medications shall be administered by properly trained and supervised school personnel under the direction of the school nurse.

(B) Training shall be provided under the direction of the school nurse.

(C) At a minimum, the training program shall include content standards and a test of competency developed and approved by the Department of Public Health in consultation with the Board of Registration in Nursing and practicing school nurses.

(D) Personnel designated to administer prescription medications shall

be provided with the names and locations of school personnel who have documented certification in cardiopulmonary resuscitation. Schools should make every effort to have a minimum of two school staff members with documented certification in cardiopulmonary resuscitation present in each school building throughout the day.

(E) The school nurse shall document the training and evidence of competency of unlicensed personnel designated to assume the responsibility for prescription medication administration.

(F) The school nurse shall provide a training review and informational update at least annually for those school staff authorized to administer prescription medications.

210.008: Handling. Storage and Disposal of Prescription Medications

(A) A parent, guardian or parent/guardian-designated responsible adult shall deliver all prescription medications to be administered by school personnel or to be taken by self-medicating students, if required by the self-administration agreement (105 CMR 210.006(B)), to the school nurse or other responsible person designated by the school nurse.

(1) The prescription medication must be in a pharmacy or manufacturer labeled container.

(2) The school nurse or other responsible person receiving the prescription medication shall document the quantity of the prescription medication delivered.

(3) In extenuating circumstances, as determined by the school nurse, the prescription medication may be delivered by other persons; provided, however, that the nurse is notified in advance by the parent or guardian of the arrangement and the quantity of prescription medication being delivered to the school.

(B) All prescription medications shall lie stored in their original pharmacy or manufacturer labeled containers and in such manner as to render them safe and effective.

(C) All prescription medications to be administered by school personnel shall be kept in a securely locked cabinet used exclusively for medications, which is kept locked except when opened to obtain medications. The cabinet shall be substantially constructed and anchored securely to a solid surface. Prescription medications requiring refrigeration shall be stored in either a locked box in a refrigerator or in a locked refrigerator maintained at temperatures of 380F to 420F.

(D) Access to stored prescription medications shall be limited to persons authorized to administer prescription medications and to self-medicating students, to the extent permitted by school policy developed pursuant to 105 CMR 210.006(B)(8). Access to keys and knowledge of the location of keys shall be restricted to the maximum extent possible. Students who are self-medicating shall not have access to other students' medications.

(E Parents or guardians may retrieve the prescription medications from the school at any time.

(F) No more than a 30 school day supply of the prescription medication

for a student shall be stored at the school.

(G) Where possible, all unused, discontinued or outdated prescription medications shall be returned to the parent or guardian and the return appropriately documented. In extenuating circumstances, with parental consent when possible, such prescription medications may be destroyed by the school nurse in accordance with any applicable policies of the Massachusetts Department of Public Health, Division of Food and Drugs.

210.009: Documentation and Record-Keeping

(A) Each school where prescription medications are administered by school personnel shall maintain a medication administration record for each student who receives prescription medication during school hours.

(1) Such record at a minimum shall include a daily log and a medication administration plan, including the medication order and parent/guardian authorization.

(2)The medication administration plan shall include the information as described in 105 CMR 210.005(E).

(3) The daily log shall contain:

(a) the dose or amount of prescription medication administered;

(b) the date and time of administration or omission of administration, including the reason for omission;

(c) the full signature of the nurse or designated unlicensed school personnel administering the prescription medication. If the prescription medication is given more than once by the same person, he/she may initial the record, subsequent to signing a full signature.

(4) The school nurse shall document in the medication administration record significant observations of the prescription medication's effectiveness, as appropriate, and any adverse reactions or other harmful effects, as well as any action taken.

(5) All documentation shall be recorded in ink and shall not be altered.

(6) With the consent of the parent, guardian, or student where appropriate, the completed prescription medication administration record and records pertinent to self administration shall be filed in the student's cumulative health record. When the parent, guardian or student, where appropriate, objects, these records shall be regarded as confidential medical notes and shall be kept confidential, except as provided in 105 CMR 210.000.

(B) Medication errors, as defined in 105 CMR 210.005(F)(5), shall be documented by the school nurse on an accident/incident report form. These reports shall be retained in a location as determined by school policy and made available to the Department of Public Health upon request. All suspected diversion or tampering of drugs shall be reported to the Department of Public Health, Division of Food and Drugs. All medication errors resulting in serious illness requiring medical care shall be reported to the Department of Public Health, Bureau of Family and Community Health.

(C) The school district shall comply with the Department of Public

Health's reporting requirements for prescription medication administration in the schools.

(D) The Department of Public Health may inspect any individual student medication record or record relating to the administration or storage of prescription medications without prior notice to ensure compliance with 105 CMR 210.000.

210.100: Administration of Epinephrine

A school or school district may register with the Department for the limited purpose of permitting properly trained school personnel to administer epinephrine by auto injector in a life threatening situation, when a school nurse is not immediately available, provided that the following conditions are met:

(A) the school committee or, in the case of a private school, the chief administrative officer, approves policies developed by the school nurse governing administration of epinephrine by auto injector, and renews approval every two years;

(B) the school committee or chief administrative officer provides an assurance to the Department that sufficient school nurses are available to provide proper oversight of the program, and provides such back-up documentation as required by the Department;

(C) in consultation with the school physician, the school nurse manages and has final decision making authority about the program and selects the persons authorized to administer epinephrine by auto injector,

(D) the school personnel authorized to administer epinephrine by auto injector are trained by a physician or school nurse, and tested for competency, in accordance with standards and a curriculum established by the Department,

(1) the school nurse shall document the training and testing of competency,

(2) the school nurse shall provide a training review and informational update at least twice a year,

(3) the training, at a minimum, shall include:

(a) proper use of the device;

(b) the importance of consulting and following the medication administration plan;

(c) recognition of the symptoms of a severe allergic reaction and

(d) requirements for proper storage and security, notification of appropriate persons following administration, and record keeping,

(4) the school shall maintain and make available upon request by parents or staff a list of those school personnel authorized and trained to administer epinephrine by auto injector in an emergency, when the school nurse is not immediately available;

(E) epinephrine shall be administered only in accordance with a medication administration plan satisfying the applicable requirements of 105 CMR 210.005(E) and 210.009(A)(6), updated every year, which includes the following:

(1) a diagnosis by a physician that the child is at high risk of a life

threatening allergic reaction, and a medication order containing indications for administration of epinephrine;

(2) written authorization by a parent or guardian;

(3) a home and emergency number for the parents, as well as the name(s) and phone number(s) of any other person(s) to be notified if the parents are unavailable;

(4) identification of places where the epinephrine is to be stored, following consideration of the need for storage at places where the student may be most at risk. The epinephrine may be stored at more than one location or carried by the student when appropriate;

(5) consideration of the ways and places epinephrine can be stored so as to limit access to appropriate persons, which shall not require the epinephrine to be kept under lock and key;

(6 a list of the school personnel who would administer the epinephrine to the student in a life threatening situation;

(7) a plan for risk reduction for the student, including a plan for teaching self-management, where appropriate;

(F) when epinephrine is administered, there shall be immediate notification of the local emergency medical services system (generally 911), followed by notification of the school nurse, student's parents or, if the parents are not available, any other designated person(s), and the student's physician;

(G) there shall be procedures, in accordance with any standards established by the Department, for:

(1) developing the medication administration plan;

(2) properly storing medication, including limiting access to persons authorized to administer the medication and returning unused or outdated medication to a parent or guardian whenever possible;

(3) recording receipt and return of medication by the school nurse;

(4) documenting the date and time of administration;

(5) notifying appropriate parties of administration;

(6) reporting medication errors in accordance with 105 CMR 210.005(F)(5);

(7) reviewing any incident involving administration of epinephrine to determine the adequacy of the response and to consider ways of reducing risks for the particular student and the student body in general;

(8) planning and working with the emergency medical system to ensure the fastest possible response;

(H) the Department of Public Health is permitted to inspect any record related to the administration of epinephrine without prior notice, to ensure compliance with 105 CMR 210.100.

REGULATORY AUTHORITY

105 CMR 210.000: M.G.L. c. 94C, § 7(g); c. 71, § 54B.

APPENDIX G

SAMPLE ALLERGY ACTION PLAN ADAPTED FROM THE FOOD ALLERGY NETWORK

Place Child's Picture Here

ALLERGY TO: _____

Student's Name: _____

D.O.B.: _____ Teacher _____

Asthmatic Yes* ❑ No❑ *High risk for severe reaction

• SIGNS OF AN ALLERGIC REACTION •

Systems:	**Symptoms:**
• MOUTH	itching & swelling of the lips, tongue, or mouth.
• THROAT*	itching an/or a sense of tightness in the throat, hoarseness, and hacking cough.
• SKIN	hives, itchy rash, and/or swelling about the face or extremities.
• GUT	nausea, abdominal cramps, vomiting and/or diarrhea.
• LUNG*	shortness of breath, repetitive coughing, and/or wheezing.
• HEART*	"thready" pulse, "passing-out".

The severity of symptoms can quickly change.
***All above symptoms can potentially progress to a life-threatening situation.**

1. **If ingestion is suspected and/or symptoms) are:**

_____,

give _____IMMEDIATELY!
medication/dose/route

Then call:

2. Rescue Squad (ask for advanced life support).

3. Parent/Guardian _____,
or emergency contacts.

4. Dr. _____ at _____

DO NOT HESITATE TO CALL RESCUE SQUAD!

Parent/Guardian's Signature _____ Date _____

School Nurse Signature _____ Date _____

School Nurse's Phone Number _____

Medication order from a licensed provider on file. ☐ YES

EMERGENCY CONTACTS

1. _____

Relation: _____

Phone: _____

2. _____

Relation: _____

Phone: _____

3. _____

Relation: _____

Phone: _____

TRAINED STAFF MEMBERS

1. _____

Room _____

2. _____

Room _____

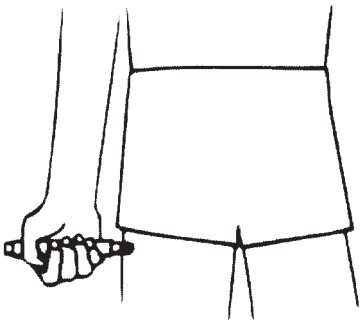
2. _____

Room _____

EPIPEN® AND EPIPEN® JR. DIRECTIONS

1. Pull off gray activation cap.

2. Hold black tip near outer thigh (always apply to thigh).



3. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. The EpiPen® unit should then be removed and taken with you to the Emergency Room. Massage the injection area for 10 seconds

For children with multiple food allergies, use one form for each food.

Adapted from the Food Allergy and Anaphylaxis Network.

APPENDIX H

UNDERSTANDING THE LAW AS IT RELATES TO STUDENTS WITH FOOD ALLERGIES

Legal Concerns and Liability

Federal Law entitles students with disabilities have the same rights and privileges, and the same access to benefits, such as school meals, as nondisabled students. Consequently, schools which do not make appropriate program accommodations for students with disabilities could be found in violation of federal civil rights laws.

School administrators and nutrition staff should be aware of two issues involving liability: (1) the school's responsibility for providing program accommodations for students with disabilities and (2) the question of personal responsibility in cases of negligence. These two issues are discussed below.

A. School Responsibility to Make Accommodations

Section 504 - Rehabilitation Act of 1973

Section 504 of the Rehabilitation Act of 1973 specifically mandates that

> "...no otherwise qualified individual with a disability shall solely by reason of his or her disability be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

This mandate has been incorporated in 7 CFR Part 15b, USDA regulations implementing this law, as well as the Department of Education's Section 504 regulation at 34 CFR Part 104. Thus, schools receiving Federal funding must make accommodations to enable students with disabilities to participate in the child nutrition programs.

B. Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA) assists States and school districts in making a **"free appropriate public education"** available to eligible students.

Under IDEA, a "free appropriate public education" means special education and related services provided under public supervision and direction, in conformity with an individualized education program, at no cost to parents.

A student who has a food allergy and who is making effective educational progress in the regular education program, does not need a special education evaluation, an IEP, or special education services. Whether such a student is in regular education or special education, however s/he has the right to have the school make reasonable accommodations for his/her disability, under section 504 (discussed above) and the ADH (discussed next page).

American with Disabilities Act - Title II

Title II of the Americans with Disabilities Act (ADA), enacted in 1990, prohibits discrimination against qualified individuals with disabilities in state and local government programs and services, including public schools.

In this respect, the ADA tracks the requirements of Section 504, prohibiting discrimination on the basis of disability by programs receiving Federal funding, such as reimbursement under the school meal programs.

Title II of the ADA does not impose any major new requirements on school districts because the requirements of Title II and Section 504 are similar. Virtually all school districts receive Federal financial assistance and have been required to comply with Section 504 since the 1970's.

Americans With Disabilities Act - Title III

Title III of the ADA extends requirements for public accommodations to privately owned facilities.

Thus, all private schools participating in the federally funded child nutrition programs must make accommodations to enable children with disabilities to receive school meals.

USDA Federal Regulation - 7 CFR 210.10

(*1) Exceptions for medical or special dietary needs.* Schools must make substitutions in lunches and afterschool snacks for students who are considered to have a disability under 7 CFR part 15b and whose disability restricts their diet. Schools may also make substitutions for students who do not have a disability but who cannot consume the regular lunch or afterschool snack because of medical or other special dietary needs. Substitutions must be made on a case by case basis only when supported by a statement of the need for substitutions that includes recommended alternate foods, unless otherwise exempted by FNS. Such statement must, in the case of a student with a disability, be signed by a physician or, in the case of a student who is not disabled, by a recognized medical authority.

Massachusetts General Laws Chapter 71, Section 55A

No public school teacher and no collaborative school teacher, no principal, secretary to the principal, nurse or collaborative school employee who, in good faith, renders emergency first aid or transportation to a student who has become injured or incapacitated in a public school building or collaborative school building or on the grounds thereof shall be liable in a suit for damages as a result of his acts or omissions either for such first aid or as a result of providing emergency transportation to a place of safety, nor shall such person be liable to a hospital for its expenses if under such emergency conditions he causes the admission of such injured or incapacitated student, nor shall he be subject to any disciplinary action by the school committee, or collaborative board of such collaborative for such emergency first aid or transportation. *Added by St.1938, c.265, s.3: amended by St.1973, c.660; St.1983, c.114; St1984, c.328; St.1985, c.111.*

Sample Responses to Address Possible Situations Involving Students with Life-Threatening Food Allergies

Situation: A child has a life-threatening allergy, that causes an anaphylactic (allergic) reaction to peanuts. The slightest contact with peanuts or peanut derivatives, such as peanut oil, could be fatal. To what lengths must the food service go to accommodate the child? Is it sufficient for the school food service to avoid obvious foods, such as peanut butter, or must school food service staff research every ingredient and additive in processed foods or regularly post all of the ingredients used in recipes?

Response: The school has the responsibility to provide a "safe" non-allergic meal to the student if it is determined that the condition is disabling. To do so, school food service staff must make reasonable efforts to ensure that all food items offered to the student with allergies must meet prescribed guidelines and are free of foods that are suspected of causing the allergic reaction.

This means that the food labels or food specifications need to be checked to ensure that they do not contain traces of such ingredients. In some cases, the labels will provide enough information to make a reasoned judgment possible. If they do not provide an obvious answer, school food service should take due care to obtain the necessary information so that no allergic substances are present in the food served.

In some cases, it may be necessary to contact the supplier or the manufacturer. Private organizations, such as the Food Allergy and Anaphylaxis Network, may also be consulted for information and advice. It is also wise to check with parents about certain foods and even provide them with advance copies of menus.

The general rule in these situations is to exercise caution at all times. Do not serve foods to students at risk for anaphylactic reactions if you do not know what is in the foods. It is important to recognize that a student may be provided a meal that is equivalent to the meal served to other students, but not necessarily the same meal.

Sometimes it will be advisable to prepare a separate meal "from scratch" using ingredients that are allowed on the special diet rather than serving a meal using processed foods.

RESOURCES

Food Allergy Resource Books

"The Peanut Allergy Answer Book," by Michael C. Young, M.D. Fair Winds Press 2001.

"Caring for Your Child with Severe Food Allergies," Lisa Cipriano Collins. John Wiley&Sons, 2000.

"The Parents Guide to Food Allergies," Marianne S. Barber. Henry Holt and Company, 2001.

Food Allergy Network FAAN offers a variety of pamphlets, books, school and daycare programs, and videos. e-mail faan@foodallergy.org or www.foodallergy.org Tel # (800)929-4040.

"Special Diet Solutions" and **"Special Diet Celebrations,"** Carol Fenster, Ph.D. Savory Palate, Inc 1999.

"No Nuts for Me,"Aaron Zevy. Tumbleweed Press, 1995

Food Allergy Resources

Asthma and Allergy Foundation of America/New England Chapter (AAFA/New England)
220 Boylston St
Chestnut Hill, MA 02467
Phone: (617) 965-7771 Toll-Free (877)2-ASTHMA Fax: (617)965-8886
E-mail: *aafane@aol.com*
website: *http://www.asthmaandallergies.org*

Food Allergy and Anaphylaxis Network (FAAN)
10400 Eaton Place, Suite 107
Fairfax, VA 22030-2208
Phone: (800) 929-4040 Fax: (703) 691-2713
http://www.foodallergy.org

American Academy of Allergy, Asthma, and Immunology (AAAAI)
611 Wells St.
Milwaukee, WI 53202
Phone: (414) 272-6071 Toll Free: (800) 822-2762 Fax (414) 272-6070
Web Site: *www.aaaai.org*

American College of Asthma, Allergy and Immunology
85 West Algonquin Rd
Arlington Heights, IL 60005
Phone: (847) 427-1200
Web site: *http://allergy.mcg.edu*

American Academy of Pediatrics
141 Northwest Point
Elk Grove Village, IL 60007
Phone: (847) 434-4000 Fax: (847) 434-8000
http://www.aap.org

Dey Laboratories-manufacturer of Epi-Pen auto-injectors
Phone: (800) 755-5560 Fax: (800) 869-9005
http://www.deyinc.com

MedicAlert
2323 Colorado Ave
Turlock, CA 95382
Phone: (800) 4325378
http://www.medicalert.org

Massachusetts Department of Public Health, Bureau of Family and Community Health, School Health Unit
250 Washington St
Boston, MA 02108-4619
Phone: (617) 624-5470
anne.sheetz@state.ma.us
Website: *www.state.ma.us/dph*

Massachusetts Department of Education, Nutrition Programs and Services
Kathleen Millett, Administrator
350 Main Street
Malden, MA 02148
Phone: 781/338-6498
Kmillett@doe.mass.edu
Website: *www.doe.mass.edu/cnp*

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Sicherer SH, "Clinical Update on Peanut Allergy", *Annals of Allergy, Asthma & Immunology* 2002: April;88:350-361.

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TASK FORCE

The Life-Threatening Food Allergies in Schools Task Force:

A Collaboration of the Massachusetts Department of Education, the Asthma and Allergy Foundation of America/New England Chapter, the Massachusetts School Nurse Organization, the Massachusetts Committee of School Physicians, and parents of children with food allergies.

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Kimberly Flanagan, parent.

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The European Commission
Community Research
Improving Human Research Potential
& the Socio-economic Knowledge Base

New Perspectives for Learning - Briefing Paper 53

Legal Framework of New Governance and Modern Policy in Education throughout Europe

Updated June 2004

Context of the Research

Relationships between schools, government, parents and students are changing within education systems across Europe. Many governments are creating mechanisms for schools to become more accountable to parents and to government through the increased use of quality assurance mechanisms. In some cases running alongside this increased accountability, is the delegation of greater responsibility to individual schools and school governors, often in the form of greater financial control. This also involves the individual school and sometimes volunteer school governors having to take greater legal responsibility for the management of their school, the quality of teaching, and the safety and well-being of their students.

Underpinning all these changes is the legal and legislative framework established in education and other laws – which vary considerably across Europe.

This project has established a network of partners from Belgium (Flanders), the Netherlands, Greece, France, United Kingdom and Germany and other experts from Lithuania, Slovenia, Estonia, Romania, Sweden, the Russian Federation and Austria. It is comparing the various national education systems from a legal perspective in order to identify the best and most used legislative instruments focusing on quality, safety, responsibility and liability.

The key areas of concern of this project include:

- Enhancing the quality of compulsory education.
- Encouraging the use of appropriate means of self-assessment and self-evaluation.
- Promoting greater equity and enhanced access through the assurance of quality in all schools.
- Reducing inappropriate barriers for mobility in Europe at school level through establishing a more consistent promotion of quality and standards.

Initial Conclusions

1. Although there is a general trend in many countries towards a greater emphasis on measuring the “outputs” of the process of education in schools, it

has only reached a high level of intensity in the UK and to a lesser extent the Netherlands, where features of a “market” system are in operation.

2. One of the reasons for the development of targets and performance indicators is to enable judgements to be made about the relative performance of schools, as measured by the results of the pupils. However, for this system of intense scrutiny and accountability to work effectively, it needs to be underpinned by a degree of regulation.

3. As the quality ‘loop’ is also dependent on the inputs – such as the teachers, the curriculum and the school buildings/facilities – these too need to be subject to standards prescribed by law.

4. The use of school inspection regimes of various degrees of intensity and diverse organisational patterns (local or national), combined with rules about the qualification of teachers, form part of national educational traditions. However, it was possible to identify two models that did have comparable elements, but also have quite distinctive characteristics:

- The Continental model – relies very much on central inspection and control and operates principally by disciplinary and control measures and not by the establishment of school liability;

- The UK Model – is based on strong elements of central direction, but organises schools as a decentralised market with strong elements of school autonomy and school liability.

5. Under the UK model, the rules on inspection and teacher qualification have become intensified because these matters are seen as integral aspects of the new quality agenda for schools. At the same time, new risks of civil liability have emerged, related to issues of quality in education.

6. States that decide to adopt the UK model as a means to driving up standards of education in their schools will need to expect that an increase in legal claims is a possibility.

7. Concrete and clear provisions governing transferability of general educational qualifications at pre-university level remain conspicuously absent from the European social policy agenda.

8. Whether it would be possible to prescribe or recommend on a Europe-wide level certain minimum institutional and regulatory requirements to ensure that all states take effective steps to improve, monitor and enforce standards of education in their schools is very difficult to assess.

9. Although Article 126 of the EU Treaty makes provision for common European issues to be the subject of broad regulatory aims, it is very much dependent on “political will”. There is a potential conflict with the “principle of subsidiarity”

and the risk that it might undermine national autonomy in terms of cultural and national identity.

10. However, although there may be concern about loss of national identity related to a State's curriculum, it is less clear that national identity would be undermined if there was European Union legislation on matters like school inspections or performance measures.

11. Equally though, it is unclear how EU requirements on those matters would support the aims of free movement and the inculcation of a sense of common European identity, thereby making them incompatible with the subsidiarity principle.

12. In any event, it is difficult to determine whether such a pan-European initiative would be necessary given the strong political, social and economic imperatives to maintain an effective school system, underpinned by national legislation and, in many cases, constitutional requirements.

Initial Recommendations

So far the project recommends that all states should commit themselves to the following minimum general requirements concerning responsibility and liability for education:

1. Legislation should provide for the goal of high standards in the provision of education and the development of mechanisms and policies, and adequate allocations of public funding, to support this aim; but it would probably need to leave the degree of specificity for national standards to be determined by individual states.

2. In relation to all schools (whether in the public or private sector), states should prescribe and enforce minimum standards for the quality and safety of school buildings and premises and should require that teachers have a contractual or statutory duty to ensure the safety of school pupils.

3. Adequate arrangements should be required in every state, at national or local level, to ensure that there is proper insurance cover in respect of accidents to pupils (and staff, if not covered by teaching association or other schemes) in the course of educational and associated recreational activities at all schools or during school excursions.

4. Europe-wide minimum qualifications for qualified teacher status and for entry to the teaching profession could be specified, building on EC legislation on mutual recognition of professional qualifications; but the legal status of teachers as either employees or civil servants does not appear to need attention at present.

5. States could be required to make provision for regular government-independent school inspections and to ensure that appropriate action is taken with schools that are not meeting their requirements.

6. National legislation could stipulate that information relevant to the quality of educational provision in schools, including the results of examinations aggregated at school level, should be made publicly available. However, results should also take into account pupils' backgrounds and their progress over time.

7. Issues of legal liability, while of growing importance, are unsuitable for prescription at an international level given the distinct legal cultures and traditions in different states. However, these issues should continue to be monitored closely, particularly those concerned with the emergent field of liability for breach of professional duties of teachers in areas such as teaching, meeting the special needs of pupils, discipline and pupil welfare.

8. The relevant forms of liability need to be better understood by teachers and other staff, including administrators, to help ensure that educational practice can operate in a lawful manner and with due respect to the rights of school pupils and their parents. Therefore, the initial and further training of teachers (and the further training of head teachers and senior administrators) should include coverage of the legal context to teaching and should focus on issues of liability.

Further Information

The full title of the project is: "Legal Framework of New Governance and Modern Policy in Education throughout Europe". The final report is due in July 2004.

Further details are also on the project web site at http://www.lawandeducation.com

Partner details

Key Publications

Books

Glenn Ch. & De Groof J., *Freedom, Autonomy and Accountabiliy in Education*, Lemma, 2002, Volume 1, 595 p., Volume 2, 528 p

De Groof J., Lauwers Gr., Dondelinger G., *Globalisation and Competition in Education*, Wolf Legal Publishers, 2003, 318 p.

Articles in a journal

Volume 6 of the European Journal of Education Law and Policy is dedicated to the issues of responsibility and liability in education EJELP, Vol. 6, no. 1/2, Kluwer, 2002

- Responsabilité civile et pénale des personnels de l'enseignement primaire et secondaire en cas d'accidents : Etat des lieux et perspectives - Martine Denis-Linton
- General developments in our society linked to responsibility and liability - Charles Glenn
- Civil liability within the education system : The Belgian Framework - Daniëlle Deli
- Liability under education law in the UK – How much further can it go? - Neville Harris
- La sécurité des établissements scolaires : Etat et collectivités face au partage de responsabilités - Jean Marie Schleret
- Occupational accidents in education - Ria Janvier
- Responsibility and Liability for the Behaviour of Minors - E.M.V. Dubelaar
- Liability issues in American Schools - Charles Russo
- The new challenges of education and the law - Kishore Singh
- Responsibility and liability in education in Austria - Werner Hauser
- Responsibility and liability in education in England and Wales - Paul Meredith
- Réponse Française au questionnaire - André Legrand
- Liability and responsibility in education. A German perspective - Georgios Gounalakis
- Responsibility and Liability in Education in Greece - Panayiotis Poulis and Theodore Fortsakis
- Responsibility and liability in education in Ireland - Dympna Glendenning

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