

2014

Anaphylaxis Policy Handbook



Connecticut

National Association of State
Boards of Education

November 2014

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This work is made possible through the generous support from Mylan Specialty L.P. Please contact the National Association of State Boards of Education, 2121 Crystal Drive Suite 350, Arlington, Virginia 22202 or call 800-220-5183 for information.

Introduction

In 2013 the National Association of State Boards of Education (NASBE) launched an initiative to help state boards of education develop student health policies regarding anaphylaxis and epinephrine access and use. Soon after, NASBE published *Anaphylaxis and Schools: Developing Policies for Treating Students with Severe Allergic Reactions*, a discussion guide that explains the issue and sets the stage for policy development. This year, NASBE develops customized policy handbooks to help select states improve their policies.

Rise in Food Allergies among Children

An increasing number of children in the United States suffer from food allergies. According to a report from the Centers for Disease Control and Prevention (CDC), the number of children with food allergies rose about 50 percent between 1997 and 2011.¹ Nearly 6 million children in the United States, or 8 percent, have allergies, and young children are most affected.²

Allergic reactions can significantly affect children, their families, and the schools they attend. Of the 8 percent of U.S. children with allergies, 38.7 percent had a history of severe reactions and 30.4 percent had multiple allergies.³

Anaphylaxis is a sudden, life-threatening allergic reaction whose incidence in the United States has risen, especially among the young.⁴ Ambulatory care visits caused by food allergies tripled between 1993 and 2006. From 2003 to 2006, an estimated annual average of 317,000 food allergy–related, ambulatory care visits by those under 18 was reported.⁵

There are multiple triggers for anaphylaxis. Food allergies are the most common, followed by insect stings, medications, and latex exposure. Approximately 1,500 deaths attributed to allergic reactions occur annually in the United States.⁶

Because there is no cure for food allergies, strict avoidance of food allergens and early recognition and management of allergic reactions are important preventive measures. Experts agree that prompt administration of the drug epinephrine can greatly increase positive outcomes for individuals experiencing life-threatening allergic reactions.⁷

In 2006, about 88 percent of schools had one or more students with food allergies.⁸ Many schools are putting systems in place to prevent exposure to allergens and to respond effectively to children experiencing anaphylaxis. Studies show that 16 to 18 percent of children with food allergies have experienced a reaction because of something they ate while at school.⁹ What's more, 25 percent of those who experienced a life-threatening reaction at school had never been diagnosed with a food allergy.¹⁰

What is Anaphylaxis?

Anaphylaxis is a severe, life-threatening allergic reaction that is rapid in onset and may cause death.²

What are common triggers?

Food (most common)
Insect stings
Medications
Latex

Top Food Allergens That Trigger Anaphylaxis

Peanuts (most common)
Shellfish (second most common)
Milk (third most common)
Tree nuts
Fish
Soy products
Wheat products

Anaphylaxis Symptoms

A single or multiple organs can be affected during a reaction. Organs affected and common symptoms include the following:

Skin – swelling, rash, or itching of any body part

Respiratory – difficulty swallowing or breathing; shortness of breath; runny nose, coughing, or wheezing and change in voice

Gastrointestinal – itchy tongue, mouth, or throat; vomiting, diarrhea, or nausea; abdominal cramps

Cardiovascular – flushed, pale skin; coughing with bluish lips and mouth; fainting or loss of consciousness; dizziness or change in mental status

Other – sense of impending doom or anxiety; itchy, red, watery eyes

To keep children safe, school staff should be ready to address the needs of those with known food allergies. They should also be prepared to respond effectively to the emergency needs of children who are not known to have food allergies but who exhibit allergic signs and symptoms. Experts agree that efforts should be made to both eliminate allergens and ensure epinephrine is accessible. To reach this goal, state and local policymakers, educators, health practitioners, and parents can work closely together to develop comprehensive anaphylaxis and food allergy policies or guidelines. Yet only a handful of states have such policies, and laws governing stocking of epinephrine for students without known allergies are limited.¹¹ Although many

schools have implemented some steps to manage food allergies, systematic planning for prevention and emergency response remains incomplete and inconsistent.¹²

NASBE's policy handbooks on anaphylaxis are designed to enable individual state boards and their partners to discuss relevant existing policies in their states, identify policy gaps, and recommend action. They also should build the capacity of state policymakers to lead a discussion around anaphylaxis issues at school.

How State Policy Changes Can Save Children

In 2012, a first grader in Chesterfield, Virginia, died at school after suffering a severe allergic reaction to a peanut a classmate gave her on the playground during recess. She was sent to school clinic immediately, but she did not have an epinephrine auto-injector, and the school didn't have it in stock either. By the time the emergency crew arrived, the girl was no longer breathing.

Three months later, Virginia General Assembly passed House Bill 1107/Senate Bill 656, required local school boards to adopt and implement policies for the possession and administration of epinephrine in Virginia public schools by the beginning of the 2012-2013 school year. The Department of Health (VDH), in conjunction with the Departments of Education (DOE) and Health Professions, established a stakeholder workgroup which developed revised guidelines for the recognition and treatment of anaphylaxis in the school setting. These revisions were incorporated into the existing "Virginia School Health Guidelines". The statute required the workgroup to address: the issuance and implementation of oral or written orders or standing protocols; consideration as to who may prescribe and/or issue standing protocols for the possession, storage, and administration of epinephrine; specification of training needs and requirements for the administration of epinephrine; appropriate liability protections; and any issues requiring statutory or regulatory amendment. House Bill 1468 enacted by the 2013 General Assembly amended the Code to include "an employee of a local governing body, or an employee of a local health department" to the list of entities in Code to be included in school policies for possession and administration of epinephrine, be exempt from liability, and with authorization by a prescriber and training may possess and administer epinephrine to students believed to be having anaphylactic reaction.¹³

What is Epinephrine?

Epinephrine—also known as adrenaline—is a hormone that the body produces in response to stress. When given by injection, it rapidly improves breathing, increases heart rate, and reduces swelling of the face, lips, and throat. It must be administered by injection and is available in self-administration devices that can be managed by allergic individuals themselves and those responsible for their care.

Over a decade ago, the death of two students prompted Massachusetts to become the first state to address anaphylaxis management at school. Since then, many states have taken action of varying degrees, though not all have enacted legislation or developed guidelines. A number of shortcomings have been cited in schools' responses with respect to treatment and awareness. These include the following gaps in training, medicine availability, and procedures:

- Many schools do not provide their staff with education on how to prevent allergic reactions, such as by reading food labels, or how to respond to life-threatening events with appropriate use of epinephrine.¹⁴
- Treatment is sometimes delayed because staff do not recognize severe allergic reactions.¹⁵
- Epinephrine is not always available¹⁶ or is administered unsuccessfully.¹⁷
- Epinephrine is not stocked or the student experiences a first reaction at school.¹⁸
- Written, student-specific emergency plans for staff to follow are not always available or used.¹⁹

There is no doubt that these problems have led to deaths and near-fatal emergencies. The next chapter examines the elements of a comprehensive plan that states, school districts, and schools can use to address this issue.

Federal Policy

The 2011 FDA Food Safety Modernization Act required the secretary of health and human services to “develop guidelines ... to manage the risk of food allergy and anaphylaxis in schools and early childhood education programs” and “make such guidelines available to local educational agencies, schools ... and other interested entities and individuals.” In response, the CDC developed the Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs, which were released in October 2013. While much of the information is helpful to state-level policymakers, the guidelines are not specifically targeted to this group. Among the topics covered:

- Parental obligations for notifying school officials about their child's allergies;
- Creation and maintenance of individual plans for food allergy management;
- Strategies to reduce the risk of exposure to allergens in school;
- Food allergy management training of school personnel who regularly come into contact with children with life-threatening food allergies and the authorization and training of personnel to administer epinephrine when the nurse is not immediately available; and
- Timely accessibility of epinephrine by school personnel when the nurse is not immediately available.

The School Access to Emergency Epinephrine Act, which President Obama signed into law on November 13, 2013, provides an incentive for states to pass legislation that allows schools to keep stocks of epinephrine on hand for use if students or staff show symptoms of severe allergic reactions. The act also encourages states to adopt Good Samaritan laws that shield trained school personnel who administer epinephrine from civil liability. Under the act, states that have such laws will be given an additional preference when they apply for federal asthma-related grants for child health services.

Other federal laws help protect children at risk of anaphylaxis, such as Section 504 of the Rehabilitation Act of 1973, Individuals with Disabilities Education Act (IDEA), American with Disabilities Act (ADA), and US Department of Agriculture (USDA) regulations (7 CFR Part 15b). When a physician diagnoses a child with a food allergy that is potentially life threatening, the condition can be classified as a hidden disability under Section 504. IDEA requires that a free and appropriate public education be provided for individuals with disabilities that impact a student's ability to learn. If a student has a learning disability and a life-threatening allergy, IDEA may apply. The US Department of Education has information about the rights of students with hidden disabilities at www2.ed.gov/about/offices/list/ocr/docs/hq5269.html.

The ADA extends Section 504 coverage beyond the public school setting to include private, parochial, religious schools, and day care centers. The USDA regulation requires substitutions or modifications in school meals for students whose disabilities restrict their diet. When considering what regulations and laws apply to a given circumstance, it is suggested that officials seek legal counsel as necessary.

Elements of a Comprehensive Policy¹⁷

Keeping children safe from life-threatening food allergies at school takes more than stocking epinephrine auto-injectors at every school. NASBE's discussion guide highlighted elements that constitute a comprehensive policy. This handbook outlines three categories of a broad approach to addressing anaphylaxis in schools:

- Management and Prevention
- Awareness and Training
- Medication and Treatment

Many states are working in these three areas to alleviate and eliminate anaphylaxis incidence. This handbook highlights what a comprehensive policy approach could look like, based on data collected from the literature and actual state policies and implementation strategies. Within each category, a variety of policies and strategies can support school personnel, students, and parents as they work to eliminate exposure to allergens, train personnel in emergency response, and

expand access to appropriate medication. The subsequent chapter highlights how a selected state has approached the issue.

Management and Prevention

Typical elements of allergy management policies involve multidisciplinary teams, written protocols to lessen exposure to allergens and to follow in the event of an emergency, and identification and reporting systems. Preventing ingestion is the best way to ensure a student does not experience anaphylaxis. Prevention requires looking across multiple locations and areas of activity on a school campus where a student may come in contact with food. In addition to the cafeteria, high-risk areas and activities for consideration include food sharing, hidden ingredients, craft and science projects, bus transportation, field trips, fundraisers and bake sales, parties and holiday celebrations, and substitute teachers, who may be unaware of a student with a known allergy.

Management and prevention strategies identified in state comprehensive policies address the following:

- Directions for school districts to create written, comprehensive policies that at least cover emergency response, medication management, training, and prevention;
- State guidance, resources, and support for school districts to develop such policies;
- Development of state-level systems to identify students with allergies (i.e., health records) and processes for periodically updating the system;
- State systems for incident reporting; and
- State annual reports on anaphylaxis incidence, medication administered, and overall policy implementation.

Awareness and Training

Policies for awareness and training should include minimum training requirements for all school staff, and it should address the availability of training to recognize the signs and symptoms of anaphylaxis and understand the protocol for responding to an emergency, particularly if the school nurse is not always available. Staff who might be with a child during a reaction include the following: teachers, food service providers, bus drivers, recess or playground monitors, field trip chaperones, physical education teachers, and coaches.

Awareness and training strategies should address the following:

- Requirements that school districts create comprehensive awareness campaign to include clinical staff, school personnel, parents, community partners and students) and training efforts for appropriate school personnel;

- Guidance and resources on awareness and training regimes for local level/school districts; and
- Funding to support these training regimes.

Medication and Treatment

Many states have guidelines that dictate who can administer epinephrine. Self-administration by a student who is of a certain age and maturity is common. Some individual health care action plans allow for any authorized and trained personnel to administer epinephrine, while many states specify that school nurses are the only authorized personnel. Stocking of epinephrine onsite at schools has become a more common practice, both for use by students known to have allergies and those who aren't known to have an allergy. This practice of supplying the drug to students experiencing their first reactions is known as a school-based prescription. Some epinephrine policies require that the drug be coded, tracked, and easily accessible. In a few cases, the drug is stored in multiple sites such as the cafeteria, classroom, and front office to ensure fast response. Many policies also require that epinephrine not be kept locked and that all staff members know where to find it.²⁰

Medication and treatment strategies address the following:

- Students' right to carry and self-administer medication;
- Good Samaritan laws that shield trained school personnel who administer epinephrine from civil liability in the event of unintentional injuries associated with medication administration;
- Provisions at a minimum for schools to maintain a general supply of epinephrine to administer to a child experiencing anaphylaxis with no known allergy; and
- Policies to allow trained school personnel to administer medication.

State Profile-Connecticut (As of November 2014)

Policy Overview

Connecticut has comprehensive relevant policies in place. In the 2014 State Honor Roll of Asthma and Allergy Policies for Schools Report, which was developed by the Asthma and Allergy Foundation of America, Connecticut was an honoree state, meeting 21 of 23 core policy standards and 8 of 12 extra-credit indicators.²⁰

The Connecticut State Department of Education and State Department of Public Health developed **Guidelines for Managing Life-Threatening Food Allergies in Connecticut Schools (2006, revised in 2012)** to help public school districts and nonpublic schools meet the requirements of state statutes in effectively managing the health and safety of students with life-threatening allergies. Just recently, Connecticut passed **Substitute House Bill No. 5521, Public Act No. 14-176**, an Act Concerning the Storage and Administration of Epinephrine at Public Schools. This bill requires schools to designate and train nonmedical staff to administer emergency epinephrine in Epi-pens to students having allergic reactions who were not previously known to have serious allergies. It authorizes the emergency use of Epi-pens by nonmedical staff only if (1) the school nurse is not present or available and (2) certain conditions are met.

In addition, Connecticut also has the following major policies:

- C.G.S. 10-212c Life-threatening food allergies: Guidelines, district plans
- C.G.S. 10-212a Administration of Medications in Schools
- Section (d) of C.G.S. 10-212a Administration of Medications in Schools by a paraprofessional
- The Regulations of Connecticut State Agencies Section 10-212a-1 through 10-212a-10 Administration of Medications by School Personnel and Administration of Medication During Before- and After-School Programs and School Readiness Programs
- C.G.S. 10-220i Transportation of Students carrying cartridge injectors
- C.G.S. 52-557b Good Samaritan Law
- Section (a) (5) C.G.S. 10-220a In-service training. Professional development committees. Institutes for educators. Cooperating teacher program, regulations

Detailed policy breakdowns will be provided in next section.

Policy Breakdown

Connecticut has been leading the country in development of anaphylaxis policy in schools. Below is a table with a breakdown of all relevant policies in the three categories as outlined in the Elements of a Comprehensive Policy section.

Connecticut	
Management and Prevention	
<p>Directions for school districts to create written, comprehensive policies that at least cover emergency response, medication management, training, and prevention</p>	<p>Statute Chapter 169, Section 10-212c http://www.cga.ct.gov/2011/PUB/chap169.htm#Sec10-212c.htm (b) ... each local and regional board of education shall: (1) Implement a plan based on the guidelines developed pursuant to subsection (a) of this section for the management of students with life-threatening food allergies and glycogen storage disease enrolled in the schools under its jurisdiction; (2) make such plan available on such board’s website or the website of each school under such board’s jurisdiction, or if such websites do not exist, make such plan publicly available through other practicable means as determined by such board; and (3) provide notice of such plan in conjunction with the annual written statement provided to parents and guardians as required by subsection (b) of section 10-231c. The superintendent of schools for each school district shall annually attest to the Department of Education that such school district is implementing such plan in accordance with the provisions of this section.</p>
<p>State guidance, resources, and support for school districts to develop such policies</p>	<p>Statute Chapter 169, Section 10-212c http://www.cga.ct.gov/2011/PUB/chap169.htm#Sec10-212c.htm (a) ... the Department of Education, in conjunction with the Department of Public Health, shall develop and make available to each local and regional board of education guidelines for the management of students with life-threatening food allergies and glycogen storage disease. The guidelines shall include, but need not be limited to: (1) Education and training for school personnel on the management of students with life-threatening food allergies and glycogen storage disease, including training related to the administration of medication with a cartridge injector pursuant to subsection (d) of section 10-212a, and the provision of food or dietary supplements; (2) procedures for responding to life-threatening allergic reactions to food; (3) a process for the development of individualized health care and food allergy action plans for every student with a life-threatening food allergy ... and (5) protocols to prevent exposure to food allergens.</p>
<p>Development of state-level systems to identify students with allergies (i.e., health records) and processes for periodically updating</p>	<p>Statute Chapter 169 Sec. 10-206 http://www.cga.ct.gov/2011/PUB/chap169.htm#Sec10-206.htm. Health assessments. (a) Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments pursuant to the provisions of this section.... (b) Each local or regional board of education shall require each child to have a health assessment prior to public school enrollment.</p>

the system	
State systems for incident reporting	No state policy
State annual reports on anaphylaxis incidence, medication administered, and overall policy implementation	No state policy
Awareness and Training	
Requirements that school districts create comprehensive awareness campaigns to include clinical staff, school personnel, parents, community partners and students and training efforts for appropriate school personnel	<p>Noted in Statute Chapter 169, Section 10-212c (http://www.cga.ct.gov/2011/PUB/chap169.htm#Sec10-212c.htm) (1) Education and training for school personnel on the management of students with life-threatening food allergies and glycogen storage disease, including training related to the administration of medication with a cartridge injector pursuant to subsection (d) of section 10-212a, and the provision of food or dietary supplements,</p>
Guidance and resources on awareness and training regimes for local level/school districts	<p>Statute Chapter 169, Section 10-212c (http://www.cga.ct.gov/2011/PUB/chap169.htm#Sec10-212c.htm) (a) ... the Department of Education, in conjunction with the Department of Public Health, shall develop and make available to each local and regional board of education guidelines for the management of students with life-threatening food allergies and glycogen storage disease. The guidelines shall include, but need not be limited to: (1) Education and training for school personnel on the management of students with life-threatening food allergies and glycogen storage disease, including training related to the administration of medication with a cartridge injector pursuant to subsection (d) of section 10-212a, and the provision of food or dietary supplements, (2) procedures for responding to life-threatening allergic reactions to food, (3) a process for the development of individualized health care and food allergy action plans for every student with a life-threatening food allergy ... and (5) protocols to prevent exposure to food allergens.</p> <p>H.B.5521. Sec 2 (http://www.cga.ct.gov/2014/act/pa/pdf/2014PA-00176-</p>

	<p>R00HB-05521-PA.pdf): Not later than December 31, 2014, the Departments of Education and Public Health shall jointly develop, in consultation with the School Nurse Advisory Council, established pursuant to section 10-212f of the general statutes, an annual training program regarding emergency first aid to students who experience allergic reactions. Such annual training program shall include instruction in (1) cardiopulmonary resuscitation, (2) first aid, (3) food allergies, (4) the signs and symptoms of anaphylaxis, (5) prevention and risk-reduction strategies regarding allergic reactions, (6) emergency management and administration of epinephrine, (7) follow-up and reporting procedures after a student has experienced an allergic reaction....The Department of Education shall make such annual training program available to local and regional boards of education.</p>
<p>Medication and Treatment</p>	
<p>Students’ right to carry and self-administer medication</p>	<p>Regulations for the Administration of Medications by School Personnel and Administration of Medication During Before- and After-School Programs and School Readiness Programs Section 10-212a-4 http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Medication_Administration_Regs.pdf) requires that students who have a verified chronic medical condition and are deemed capable to self-administer prescribed emergency medication, including rescue asthma inhalers and cartridge injectors for medically diagnosed allergies, to self-administer such medication. Students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student’s parent or guardian or eligible student.</p> <p>Statute Section 10-220i http://www.cga.ct.gov/2011/pub/Chap170.htm#Sec10-220i.htm) Transportation of students carrying cartridge injectors. This statute states that students with life-threatening allergies cannot be denied access to school transportation solely due to the need to carry a cartridge injector while traveling on a vehicle used for school transportation.</p>
<p>Good Samaritan laws that shield trained school personnel who administer epinephrine from civil liability in the event of unintentional injuries associated with medication</p>	<p>Sec. 10-212a (http://www.cga.ct.gov/2011/pub/chap169.htm#Sec10-212a.htm). Administration of medications in schools, at athletic events and to children in school readiness programs.... The statute also provides for immunity from liability for those administering medicines, with the exception of omissions of gross, willful, or wanton negligence.</p>

<p>administration</p>	
<p>Provisions at a minimum for schools to maintain a general supply of epinephrine to administer to a child experiencing anaphylaxis with no known allergy</p>	<p>Section 10-212a-5 (b) of the Regulations of the Connecticut State Agencies (http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Medication_Administration_Regs.pdf)</p> <p>Emergency medications will be locked beyond the regular school day or program hours, except as otherwise determined by a student’s emergency care plan.... Therefore, to promote rapid, life-saving steps in an emergency, emergency medications such as Epi-pens for anaphylaxis ... should not be locked during the school day. While they must not be accessible to any student or unauthorized staff member, they should be kept in a safe, accessible, and reasonably secure location that can be properly supervised by a nurse or other authorized and trained staff member.</p> <p>Section 10-212a (d) (2) (http://www.cga.ct.gov/2014/act/pa/pdf/2014PA-00176-R00HB-05521-PA.pdf)</p> <p>A school nurse or, in the absence of a school nurse, a qualified school employee shall maintain epinephrine in cartridge injectors for the purpose of emergency first aid to students who experience allergic reactions and do not have a prior written authorization of a parent or guardian or a prior written order of a qualified medical professional for the administration of epinephrine.</p> <p>Statute Chapter 170 Sec. 10-220f (http://www.cga.ct.gov/2011/pub/Chap170.htm#Sec10-220f.htm) allows local and regional boards of education to establish school district safety committees to review the adequacy of emergency response procedures at each school.</p> <p>The State Board of Education's Position Statement on Student Support Services (http://www.sde.ct.gov/sde/LIB/sde/pdf/board/stusuptserv.pdf) recommends school districts establish school-based and/or districtwide support services teams to assess the health and mental health needs of schools and coordinate the delivery of an array of services, including crisis response.</p>
<p>Policies to allow trained school personnel to administer medication</p>	<p>Sec. 10-212a (http://www.cga.ct.gov/2011/pub/chap169.htm#Sec10-212a.htm).</p> <p>Administration of medications in schools, at athletic events, and to children in school readiness programs. Allows a school nurse or, in the absence of such nurse, any other licensed nurse, including a nurse employed by or providing services under the direction of a local or regional board of education at a school-based health clinic, who shall administer medicines only to students</p>

	<p>enrolled in a school-based health clinic. In the absence of a school nurse, the principal, any teacher, licensed athletic trainer, licensed physical or occupational therapist employed by a school district, or coach of intramural and interscholastic athletics of a school may administer prescribed medicinal preparations. The administration of medicines by any of the aforementioned employees must be under the general supervision of a school nurse.</p> <p>Sec.10-212a (d) (2) (http://www.cga.ct.gov/2014/act/pa/pdf/2014PA-00176-R00HB-05521-PA.pdf)</p> <p>A school nurse or a school principal shall select qualified school employees to administer such epinephrine under this subdivision, and there shall be at least one such qualified school employee on the grounds of the school during regular school hours in the absence of a school nurse. A school nurse or, in the absence of such school nurse, such qualified school employee may administer epinephrine under this subdivision.</p> <p>Amended statute Regulations for the Administration of Medications by School Personnel and Administration of Medication During Before- and After-School Programs and School Readiness Programs Section 10-212a-3 (http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/Medication_Administration_Regs.pdf)</p> <p>Training of school personnel. The training should include: 1) the general principles of safe administration of medication; (2) the procedural aspects of the administration of medication, including the safe handling and storage of medications, and documentation; and (3) specific information related to each student’s medication and each student’s medication plan, including the name and generic name of the medication, indications for medication, dosage, routes, time and frequency of administration, therapeutic effects of the medication, potential side effects, overdose or missed dose of the medication, and when to implement emergency interventions.</p>
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Policy Discussion

Connecticut has one of the nation’s most comprehensive set of policies. The intent of this handbook is to offer guidance on an inclusive policy approach and to highlight policies that states could adopt.

Connecticut could look at the following options that have been identified in the literature or adopted in other states:

- anaphylaxis reporting
- guidance on a training protocol
- inclusion of anaphylaxis in health assessment language

Anaphylaxis reporting

Incidence reporting can be a powerful indicator of school response, policy implementation, and policy effectiveness. The Connecticut State Department of Education (CSDE) for the last decade has collected data annually regarding school health services provided as part of its ongoing efforts to support and expand school health services. The data are used to help the CSDE understand the status of school health services in Connecticut school districts, the needs of school districts and students in the area of school health services, and progress being made in these areas. The indicators related to anaphylaxis show an increase in 911 calls and the gradual increase in provision of individual health care plans, individual emergency plans, and staff training to meet individual health needs. Additionally, it was reported that 47.5 percent of school districts administered epinephrine, 91 percent of schools had a standing order for it, and 102 students were administered epinephrine in the preceding year. However, the total number of school districts reporting the existence of a comprehensive policy to address anaphylaxis and the total number of school districts reporting anaphylaxis training for school personnel was not included.

Training protocol guidance

By understanding the compliance rate for both creating a policy and providing training, state and local policymakers can identify areas of improvement and needs for policy revision. A great example of this is the recent revision of Statute Chapter 169, Section 10-212c, to include language specific to glycogen storage disease and the inclusion of needed policies and training to prepare school personnel for supporting students with this condition. Additionally, there has been recent legislation, H.B. 5521, that allows for unlicensed school personnel to administer epinephrine under the guidance and training of a licensed provider.

While the guidelines laid out by the Department of Education, in conjunction with the Department of Public Health, for Managing Life-threatening Food Allergies and Glycogen Storage Disease provide guidance on building awareness and support, there were no guidelines provided on the frequency, intensity, or training protocol for licensed or unlicensed personnel.

Inclusion of anaphylaxis in health assessment language

Statute Chapter 169 Sec. 10-206, on health assessments, describes the necessary assessments required for enrollment in public school. However, there is no specific mention of anaphylaxis or history of food allergies in the current legislation.

Funding

Funding is an important policymaking factor, not only in Connecticut, but also in many other states. This handbook recognizes the importance, but funding decisions are made by states, there will be no discussion about it.

Implementation

As the Connecticut State Board of Education looks to inform policy and rule making for students with life threatening allergies and school personnel supporting these students the above referenced areas of opportunity Anaphylaxis reporting, guidance on training protocol, and inclusion of anaphylaxis in health assessment language are suggested. The Connecticut State Department of Education currently collects data and reports on health services, as referenced above, additionally data on policy development and training implementation may be helpful in understanding barriers school districts are facing and to identify solutions to overcome those barriers.

Close collaboration with the Association of School Nurses of Connecticut will continue to be essential as the state begins implementation of the recent legislation H.B 5521 that allows for unlicensed personnel to be trained to administer epinephrine. Many states have adopted a policy to allow for unlicensed personnel to administer epinephrine, in response to such a policy the creation of training materials, curriculum guidelines, certificate programs and online databases to highlight authorized providers to provide trainings have been created. In North Carolina school districts can access an online database that gives them access to 151 licensed providers around the state authorized to provide training on medication administration by unlicensed personnel. Both Tennessee and Alaska have developed curriculum guidelines, training materials to support school districts. Maine developed a handbook, Instructor's manual and training video to support medication administration by unlicensed personnel. Finally, in response to Senate Bill 611 which passed in 2013 and added new terms to Oregon Revised Statute 339.869, Oregon created a certificate process that stipulates what is required to be certified and when a certified individual can administer epinephrine.

The development of policies and guidelines for schools on anaphylaxis involve complex issues and requires buy-in from multiple stakeholders. Policymakers without medical backgrounds might be reluctant to discuss technical issues around prevention and treatment of anaphylaxis. Yet by asking probing questions, non-experts can help clarify ambiguities and stimulate helpful answers to practical issues of policy and implementation. Education leaders can also convene state-level stakeholders. Throughout the process, it will be helpful to keep the goal in mind: Appropriate policies and guidelines could save the life of a child experiencing a life-threatening allergic reaction.

Here are some suggestions for state board members:

1. Ask questions based on the worksheets (appendix A) in the NASBE's anaphylaxis discussion guide.
2. Convene stakeholders:
 - a. school district representative
 - b. Department of Education leads
 - c. parent advocacy representative
 - d. state asthma/allergy foundation
 - e. food service association
 - f. school nurse association
 - g. school physician association or state medical association
 - h. parent teacher association/organization
 - i. concerned parents and affected students

3. The state board of education provides expert testimony at committee hearings on proposed legislation and/or disseminates evidenced-based and best-practice examples of comprehensive anaphylaxis policy.

Resources that Support Actions

It is a complex process to develop a comprehensive policy for anaphylaxis in schools with guidelines for districts and schools to follow. Many states are in the implementation and evaluation phases of their policies and have expertise to share with states that are still grappling with the issue. In addition, leading organizations are working in this area, providing not only medical knowledge and resources but also blueprints and toolkits for state policymakers. This section highlights some model states that experts have identified, and some organizations and support groups that would support state action.

Other Model States:²¹

Mississippi

In 2008 the Mississippi Department of Education developed the publication *Managing Food Allergies in Mississippi Schools* to help Mississippi school districts and public schools develop effective preventive measures to control the incidence of exposure to food allergens and manage the health and safety needs of school-aged children with life-threatening allergic conditions.

In 2013 Mississippi acted decisively to replace a 2010 law that would have expired by passing the Mississippi Asthma and Anaphylaxis Child Safety Act. The act extends many of the asthma management provisions of the 2010 law and adds authority for schools to stock epinephrine auto-injectors to address emergencies. The result of a successful collaboration by asthma, school nurse, physician leaders, and legislative sponsors, the new law is stronger and more comprehensive.

Effective on July 1, 2014, the law requires school districts to allow students to possess and self-administer asthma and anaphylaxis medications; requires written instructions from a physician for asthma/anaphylaxis medication in schools; requires each child to have an asthma action plan on file at school, updated annually, that includes information about medication dosage and delivery, instructions to the school if the student is coughing or wheezing, and a recommendation for whether the student should self-administer medication. Further, it provides for emergency protocols for asthma; requires schools to conduct an indoor air quality assessment, develop long-range maintenance plans that include specific indoor air quality components, and implement a wellness policy that reduces children's exposure to asthma environmental irritants. Indoor environment requirements direct schools to implement an integrated pest management program and minimize the use of pesticides, provide comprehensive in-service training on asthma for teachers and other staff, minimize harmful cleaning products, and adopt construction containment procedures for pollutants that trigger asthma

Guidelines can be found here:

http://www.healthyschoolsms.org/health_services/documents/GuidelinesforManagingFoodAllergies.pdf

In its 2014 report, the Asthma and Allergy Foundation of America honored Mississippi for meeting 18 of 23 core policy standards and 5 of 12 extra-credit indicators

(<http://www.aafa.org/display.cfm?ID=5&sub=105&cont=776>).

New Jersey

In 2007 the New Jersey state legislature amended relevant policies to require that the Department of Education (DOE)—in consultation with the Department of Health and Senior Services (DHSS), medical experts, school nurses, principals, teachers, and the food allergy community—establish and disseminate guidelines for school districts or nonpublic schools to develop policies for food allergy management in the school setting and for the emergency administration of epinephrine to students for anaphylaxis. According to the legislation, each board of education and chief school administrator of a nonpublic school is required to implement these guidelines, which have been developed in accordance with the statutory requirements. The *Guidelines for the Management of Life-Threatening Food Allergies in Schools* can be accessed here: <http://www.state.nj.us/education/students/safety/health/services/allergies.pdf>

New Jersey has been selected for State Honor Roll since 2008 by Asthma and Allergy Foundation of America. This year New Jersey met 20 of 23 core policy standards and 8 of 12 extra-credit indicators. (<http://www.aafa.org/display.cfm?ID=5&sub=105&cont=655>).

Vermont

In May 2006 the Vermont legislature passed Act 158 – An Act Relating to Life-Threatening Allergies & Chronic Illnesses in Schools. The Department of Education and the Vermont Department of Health are now required to prepare and distribute policies, training materials, and school guidelines for managing students with life-threatening allergies and chronic illnesses. A 2008 document provides school personnel with more detailed information about life-threatening allergies and best practices for schools, students and families (http://education.vermont.gov/documents/food_allergies_manual_0608.pdf). The Department of Education is working with Vermont School Boards Association to draft a model policy.

In 2013 Vermont passed a law allowing schools to stock epinephrine auto-injectors and health care professionals to prescribe epinephrine auto-injectors to a school and requiring health care professionals to issue protocols for assessing a potentially life-threatening emergency, administering the medication, and caring for individuals after administration. The bill also allows pharmacists to dispense the medication to a school and includes a provision immunizing school personnel from liability related to administration and student self-administration. (No. 68, <http://www.leg.state.vt.us/docs/2014/Acts/ACT068.pdf>)

Vermont has also been selected for the Asthma and Allergy Foundation of America's State Honor Roll every year since 2008 (<http://www.aafa.org/display.cfm?ID=5&sub=105&cont=657>).

Washington

The 2007 Washington state legislature appropriated \$45,000 for the Office of Superintendent of Public Instruction (OSPI) “to convene a workgroup to develop school food allergy guidelines and policies for school district implementation in 2008–09.” The guidelines were completed and reported to the legislature on March 31, 2008, and disseminated to all public and private school districts. The legislature appropriated an additional \$45,000 for OSPI, in consultation with the Washington State Department of Health (DOH), “to develop policy guidelines for schools to prevent anaphylaxis and deal with medical emergencies resulting from it” (<http://app.leg.wa.gov/rcw/default.aspx?cite=28A.210.380>). An anaphylaxis workgroup met, reviewed, and amended the *Guidelines for the Care of Students with Life-Threatening Food Allergies* (March 2009) to reflect the broader scope of care encompassing all students

with anaphylaxis. This document provides useful, comprehensive guidelines for schools, parents, students, and their medical providers, and can be found here:

<http://www.k12.wa.us/HealthServices/pubdocs/GuidelinesforCareofStudentswithAnaphylaxis2009.pdf>

In 2013 Washington passed an Epinephrine Auto Injector Law (S.B. 5104, <http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Senate%20Passed%20Legislature/5104.PL.pdf>) that allows schools to maintain a supply of epinephrine auto-injectors based on the number of students enrolled. The law also required the office of the superintendent of public instruction to review the state's anaphylaxis policy guidelines and make recommendations to the education committees of the legislature regarding school policies on epinephrine auto-injectors in emergencies.

Washington has been selected for the Asthma and Allergy Foundation of America's State Honor Roll since 2008 (<http://www.aafa.org/display.cfm?ID=5&sub=105&cont=658>).

National Organizations:

FARE

Food Allergy Research and Education (FARE) works on behalf of the 15 million Americans with food allergies, including those at risk for life-threatening anaphylaxis. FARE is a 501(c) (3) nonprofit organization that was formed in 2012 as the result of a merger between the Food Allergy and Anaphylaxis Network and the Food Allergy Initiative. FARE's mission is to find a cure for food allergies and to keep individuals with food allergies safe and included.

State Guidelines: <http://www.foodallergy.org/laws-and-regulations/guidelines-for-schools>

School Access to Epinephrine Map by State, which includes guidelines, policies, and pending bills by state: <http://www.foodallergy.org/advocacy/epinephrine/map>

AAFA

The Asthma and Allergy Foundation of America (AAFA) is the leading patient organization for people with asthma and allergies and the oldest asthma and allergy patient group in the world. AAFA is dedicated to improving the quality of life for people with asthma and allergic diseases through education, advocacy, and research.

AAFA provides practical information, community-based services and support to people through a network of regional chapters, support groups, and other local partners around the United States. AAFA develops health education, organizes state and national advocacy efforts, and funds research to find better treatments and cures. In addition, the mission of AAFA's website is to provide online access to AAFA's reliable, validated asthma and allergy information and tools to families, patients, parents, healthcare providers, policymakers, and others.

State Honor Roll Report 2014—see how your state scores in AAFA report:

<http://www.aafa.org/display.cfm?id=5&sub=105&cont=649>

AAAAI

The American Academy of Allergy, Asthma, and Immunology (AAAAI) is a professional organization with more than 6,800 members in the United States, Canada, and 72 other countries. This membership includes allergist/immunologists, other medical specialists, and allied health and related healthcare professionals—all with a special interest in the research and treatment of allergic and immunologic diseases.

<http://www.aaaai.org/home.aspx>

AANMA

Allergy & Asthma Network Mothers of Asthmatics (AANMA) is the leading nonprofit family health organization; its mission is to eliminate unnecessary suffering and death due to asthma, allergies, and related conditions through education, advocacy, and outreach.

AANMA has a history of success implementing practical, family-friendly change. Their annual Asthma Awareness Day Capitol Hill highlights critical issues that need national attention. Most recently, AANMA led the campaign to ensure students' rights to carry and self-administer asthma and anaphylaxis medications at school. <http://www.aanma.org/about-aanma/#sthash.gGeujV1W.dpuf>

Training Resources:**American Red Cross Course in Anaphylaxis**

<http://www.redcross.org/news/article/Red-Cross-Epi-Auto-Injector-Training-Likely-to-Climb-with-New-Law>

A preview of online classes is available here:

https://www.shopstaywell.com/OA_HTML/ARCHTML/previewkits.html

People can register by going to redcross.org/take-a-class, entering their zip code and selecting the “First Aid, CPR, AED for Lay Responder” search category.

National Association of School Nurses: Get Trained in Anaphylaxis

<http://www.nasn.org/ToolsResources/FoodAllergyandAnaphylaxis/GetTrained>

This is a program intended to be used as a tool and resource for scripted training of unlicensed school staff to administer epinephrine via an auto-injector during an anaphylactic emergency. The program recommendations and content are based on best practices. Each school nurse must exercise independent professional judgment when practicing and conducting training. Because nursing practice differs from state to state, each school nurse must ensure before presenting the training that it is consistent with applicable state laws and regulations, including those governing delegation, as well as applicable school district policies and procedures.

Connecticut Anaphylaxis Support Groups:

National Association of School Nurses, Connecticut

Contact an Epinephrine Resource School Nurse (ERSN) in Connecticut for professional development and/or technical assistance:

Andrea Dillon, MEd, RN, BC
adillon@crec.org

Faine B. Gauthier, BSN, RN, NCSN
fainebg@aol.com

Patricia Krin, MSN, APRN, FNP-BC, NCSN
patkrin@snet.net

Suzanne Levasseur, SPRN, CPNP
slevasseur@westport.k12.ct.us

Food Allergy Education Network

Contact Name: Erin Spaulding
Contact Email: FAEdNetwork@gmail.com
City: Branford, CT
Website: <http://FoodAllergyEdNetwork.org>

Mission: We are a food allergy support and advocacy group, and believe that food allergies not only affect individuals and families, but whole communities. We offer a monthly parent/caregiver support group as well as 'Food Allergy Friends', a monthly group for children age 5-10 living with food allergies. We advocate at the local and state level and provide workshops to schools, community groups, and organizations upon request.

H.E.A.R.T (Helping Eliminate Allergic Reactions Together)

Contact Name: C. Barton
Contact Email: heartinct@aol.com
City: Westbrook, CT
Mission: To share recipes, educate the community about food allergies.

No Nuts Moms Group

Contact Name: Lisa Rutter
Contact Email: nonutsmomsgroup@hotmail.com
City: Simsbury, CT
Website: <http://nonutsmomsgroup.weebly.com>

Mission: We have several peanut and nut free groups throughout the US and one in Canada. We provide online support as well as peanut and nut free play groups for all ages. The play groups are a great way to form lifelong connections with others in your area. We also have an online forum and support group for all food allergic families suffering from food allergies. Our face book community page offers up to date food allergy news as well as online support. We also set up food allergy awareness tables at schools and play places in order to raise awareness and educate the community.

Anaphylaxis Community Experts (ACE)

ACE from Allergy & Asthma Network, in partnership with the American College of Allergy, Asthma & Immunology, American School Health Association, and the National Association of School Nurses work on providing technical assistance on anaphylaxis.

<http://www.aanma.org/advocacy/usanaphylaxis/connecticut/>

Katharine Mignone
Greenwich, CT

Carol Ott, RN, BSN of [Guilford Public Schools](#)
Guilford, CT

Christopher Randolph, MD of the [Center for Allergy, Asthma and Immunology](#)
Waterbury, CT

Margy Clark, RN of [Capitol Region Education Council, University of Hartford Magnet School](#) and
Andrea Dillon, RNBC, M.Ed. of Capitol Region Education Council
West Hartford and Windsor, CT

Appendices

Appendix A: State Worksheets

Appendix B: Sample Letter for Classmates and Parents

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Appendix A: State Worksheets¹⁷

Worksheet 1: Policy Development Planning	
<p>There are many policy elements that must come together to ensure students are protected from the consequences of a severe allergic reaction—simply ensuring that a stock of epinephrine is available is necessary but not nearly sufficient. Following are some key issues to consider when developing a policy development plan.</p>	
	Questions to Ask When Considering Policy Action
Policy Development Planning	<ul style="list-style-type: none"> • Who needs to be at the table to discuss this issue? For example: Department of education Department of health State asthma/allergy foundation Food service association School nurse association School physician association or state medical association Parent teacher association/organization Concerned parents and affected students Others? • What is the main goal of this process? To raise public awareness? To develop, revise, improve guidelines for schools? To advocate for new or revised laws that address the use of medication at schools? Or is this in response to a legislative mandate? If this is in response to a mandate, what is the particular focus? • What do state and local data say about how frequently anaphylaxis occurs? How well have the schools responded to emergencies? • What do the experts recommend? • What are the major implementation challenges?

Worksheet 2: Management Strategies

A comprehensive approach to managing anaphylaxis requires strategies that work together—at the state and the school levels—to bring the system to the desired end. Boards will need to consider every aspect of the issue: acquisition and storage of stand-by epinephrine; handling of students’ medications; prevention of exposure to allergens by students known to have severe allergies; staff training needs; protocols for emergency response at school and away from school; and reporting and evaluation of incidents.

	Who Has Authority Over This Part of the System?	Questions to Ask When Considering Policy Action
Management Strategies		<ul style="list-style-type: none"> • Does the state require that school districts or schools develop their own policies and protocols? • Does the state provide model policies and guidance on best practices for managing life-threatening allergies in school? • Is the use of an individualized health care plan common place? Is additional school staff training necessary? • Is a multi-disciplinary management team approach being used in schools to address the needs of students who have a life-threatening allergy? If not, should this be a requirement?

Worksheet 3: Awareness planning and School Staff Training		
<p>Training all school staff to recognize the signs and symptoms of anaphylaxis and be able to respond appropriately is a key aspect of a comprehensive plan.*</p>		
	Who Has Authority Over This Part of the System?	Questions to Ask When Considering Policy Action
Awareness Planning and School Staff Training		<ul style="list-style-type: none"> • Are there existing guidelines or requirements for districts or individual schools about training staff to recognize the signs of anaphylaxis and to appropriately respond in an emergency? • Is there a need for separate trainings for school transportation staff? School foodservice workers? Athletic program coaches? Or do they fall under the same guidelines as all school staff? Is contracted services staff included? • Are there training programs in the state that could be replicated or expanded statewide? • Is there an opportunity to use innovative technology to disseminate trainings (e.g., web-based technology, streaming videos, or online courses)?*

* Several organizations offer online training on anaphylaxis and epinephrine auto-injection, including the National Association of School Nurses (www.nasn.org/ToolsResources/FoodAllergyandAnaphylaxis/GetTrained) and the American Red Cross (www.redcross.org/courses/index.jsp?_requestid=506892).

Worksheet 4: School Environment Modification

Changes to school environments may be necessary to ensure those with severe allergies avoid consuming allergens or coming into direct skin contact with allergens.

	Who Has Authority Over This Part of the System?	Questions to Ask When Considering Policy Action
School Environment Modification		<ul style="list-style-type: none"> • Are there guidelines in place for non-food fundraisers, celebrations, and other activities that could involve food? • Are there guidelines in place for addressing the use of food items in school projects, crafts, science classes? • Are there sample letters to families available that teachers can use to explain why and how the school is managing exposure to allergens? • Are there guidelines in place to assure regular and thorough cleaning of surfaces students come into contact with, and for minimizing cross-contamination of allergens?

Worksheet 5: Medication and Treatment

Giving schools authority to stock epinephrine for use in emergencies is a vital state policy that can save the lives of students having a severe allergic reaction. Other important policies include how and where epinephrine should be stored, who is authorized to administer medications, and protocols for handling emergencies off site (such as during field trips and sporting events).

	Who Has Authority Over This Part of the System?	Questions to Ask When Considering Policy Action
Medication and Treatment		<ul style="list-style-type: none"> • What are the existing laws that govern use of epinephrine in school settings? • Who in a school is authorized to administer medication? If it is only the school nurse, what happens when they are not present in an emergency? Who may administer epinephrine during off site activities? • Are there current laws about the storage of epinephrine? Can the epinephrine be easily accessed in an emergency? • Do schools have the ability to stock epinephrine for use in an emergency situation with a student who has had no previous allergy (known as a “school prescription”)? • What are the state laws that govern the liability of school staff who administer epinephrine? • Should the state board (or the board in conjunction with other education, health, and parent groups) advocate for legislative action regarding epinephrine access? • Who has authority over administration of medications at schools (i.e., the department of education or department of health)? • Have any nurse “train the trainer” programs been effective in the state? Is that a consideration?

Worksheet 6: Evaluation and Accountability

Evaluation and review of new policies and programs are necessary to ensure these measures are having their intended effects in the most effective and efficient way possible. At the same time, evaluations can identify any unintended negative consequences and provide suggestions for needed adjustments.

	Who Has Authority Over This Part of the System?	Questions to Ask When Considering Policy Action
Evaluation and Accountability		<ul style="list-style-type: none"> • How will the state board measure success of the policy? • If there are mandates for stocking epinephrine included in the policy (rather than just guidelines), what will the accountability mechanism be (e.g., through the school or district accreditation process)? • What are the requirements for schools or districts to report anaphylaxis emergencies and staff responses? • Who or what entity will conduct an evaluation and when would this occur? • Will the evaluation consider the costs of implementation?

Appendix B: Sample Letter for Classmates and Parents¹

- 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.

¹ Adopted from Managing Life-Threatening Food Allergies in Schools, Massachusetts Department of Education, 2002

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:

Appendix C: Sample Letter for Substitute Teachers, Volunteers, etc.²

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

² Adopted from Managing Life-Threatening Food Allergies in Schools, Massachusetts Department of Education, 2002

Appendix D: Sample Outline of Training Program for Unlicensed School Personnel to Administer Epinephrine by Auto Injector in Life-Threatening Allergic Conditions³

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

OUTLINE OF TRAINING PROGRAM FOR UNLICENSED SCHOOL PERSONNEL TO ADMINISTER EPINEPHRINE BY AUTOINJECTOR 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.

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.

³ Adopted from Managing Life-Threatening Food Allergies in Schools, Massachusetts Department of Education, 2002

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:
Epi-Pen 0.3mg (1: 1000) and Epi-Pen 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.

Appendix E: Sample Development of a Partnership between the Trained Unlicensed School Personnel and the Student with an Allergic Reaction⁴

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

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.)

⁴ Adopted from Managing Life-Threatening Food Allergies in Schools, Massachusetts Department of Education, 2002

- 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.

Epi-Pen Trainers, Epi-Pen 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

Appendix F: Sample Epinephrine Competency Skill Checklist⁵

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: _____

⁵ Adopted from Managing Life-Threatening Food Allergies in Schools, Massachusetts Department of Education, 2002

Appendix G: Sample Food Allergy and Anaphylaxis Emergency Care Plan

FARE
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No

**PLACE
PICTURE
HERE**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING:
SEVERE SYMPTOMS

 LUNG Short of breath, wheezing, repetitive cough	 HEART Pale, blue, faint, weak pulse, dizzy	 THROAT Tight, hoarse, trouble breathing/swallowing	 MOUTH Significant swelling of the tongue and/or lips
 SKIN Many hives over body, widespread redness	 GUT Repetitive vomiting, severe diarrhea	 OTHER Feeling something bad is about to happen, anxiety, confusion	OR A COMBINATION of symptoms from different body areas.

↓ ↓ ↓

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.
 - Consider giving additional medications following epinephrine:
 - » Antihistamine
 - » Inhaler (bronchodilator) if wheezing
 - Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
 - If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
 - Alert emergency contacts.
 - Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

 NOSE Itchy/runny nose, sneezing	 MOUTH Itchy mouth	 SKIN A few hives, mild itch	 GUT Mild nausea/discomfort
---	---------------------------------	---	--

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: 0.15 mg IM 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE

DATE

PHYSICIAN/HCP AUTHORIZATION SIGNATURE

DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

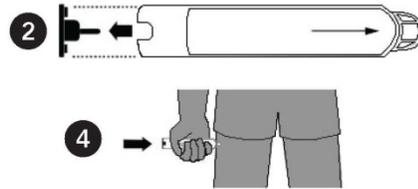


FARE
Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

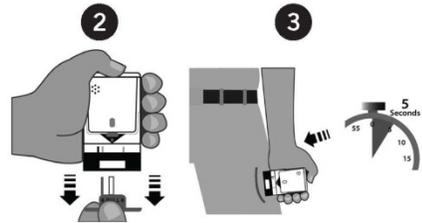
EPIPEN® (EPINEPHRINE) AUTO-INJECTOR DIRECTIONS

1. Remove the EpiPen Auto-Injector from the plastic carrying case.
2. Pull off the blue safety release cap.
3. Swing and firmly push orange tip against mid-outer thigh.
4. Hold for approximately 10 seconds.
5. Remove and massage the area for 10 seconds.



AUVI-Q™ (EPINEPHRINE INJECTION, USP) DIRECTIONS

1. Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.
2. Pull off red safety guard.
3. Place black end against mid-outer thigh.
4. Press firmly and hold for 5 seconds.
5. Remove from thigh.



ADRENACLICK®/ADRENACLICK® GENERIC DIRECTIONS

1. Remove the outer case.
2. Remove grey caps labeled "1" and "2".
3. Place red rounded tip against mid-outer thigh.
4. Press down hard until needle penetrates.
5. Hold for 10 seconds. Remove from thigh.



OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can get worse quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: _____

DOCTOR: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: _____

PHONE: _____

NAME/RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE _____

DATE _____

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (WWW.FOODALLERGY.ORG) 5/2014

Appendix H: Sample Food Allergy Assessment Form⁶

Food Allergy Assessment Form

Student Name: _____ Date of Birth: _____ Date: _____

Parent/Guardian: _____ Phone: _____ Cell/work: _____

Health Care Provider (name) treating food allergy: _____ Phone: _____

Do you think your child's food allergy may be life-threatening? No Yes
 (If YES, please see the school nurse as soon as possible).

Did your student's health care provider tell you the food allergy may be life-threatening? No Yes
 (If YES, please see the school nurse as soon as possible.)

History and Current Status

Check the foods that have caused an allergic reaction:

- | | | |
|---|---|-------------------------------|
| <input type="checkbox"/> Peanuts | <input type="checkbox"/> Fish/shellfish | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Peanut or nut butter | <input type="checkbox"/> Soy products | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Peanut or nut oils | <input type="checkbox"/> Tree nuts (walnuts, almonds, pecans, etc.) | |

Please list any others: _____

How many times has your student had a reaction? Never Once More than once, explain: _____

When was the last reaction? _____

Are the food allergy reactions: staying the same getting worse getting better

Triggers and Symptoms

What has to happen for your student to react to the problem food(s)? *(Check all that apply)*

- Eating foods Touching foods Smelling foods Other, please explain: _____

What are the signs and symptoms of your student's allergic reaction? *(Be specific; include things the student might say.)*

How quickly do the signs and symptoms appear after exposure to the food(s)?

_____ Seconds _____ Minutes _____ Hours _____ Days

Treatment

Has your student ever needed treatment at a clinic or the hospital for an allergic reaction?

- No Yes, explain: _____

Does your student understand how to avoid foods that cause allergic reactions? Yes No

What treatment or medication has your health care provider recommended for use in an allergic reaction?

Have you used the treatment? No Yes

Adapted with permission from ESD 171 SNC
 Guidelines for Anaphylaxis

⁶ Adopted from Guidelines for Care of Students with Anaphylaxis, Washington Department of Education, 2009

Does your student know how to use the treatment? No Yes

Please describe any side effects or problems your child had in using the suggested treatment: _____

If you intend for your child to eat school provided meals, have you filled out a diet order form for school?

Yes.

No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is to be available at school, have you filled out a medication form for school?

Yes.

No, I need to get the form, have it completed by our health care provider, and return it to school.

If medication is needed at school, have you brought the medication/treatment supplies to school?

Yes.

No, I need to get the medication/treatment and bring it to school.

What do you want us to do at school to help your student avoid problem foods? _____

I give consent to share, with the classroom, that my child has a life-threatening food allergy.

Yes.

No.

Parent/Guardian Signature: _____ Date: _____

Reviewed by R.N.: _____ Date: _____

Adapted with permission from ESD 171 SNC Program

Endnotes

¹ K. Jackson et al., “Trends in Allergic Conditions among Children: United States, 1997–2011,” *National Center for Health Statistics Data Brief* (2013). Retrieved from <http://www.cdc.gov/nchs/data/databriefs/db121.pdf>

² Food Allergy Facts and Statistics for the U.S., 2013, “Food Allergy Research and Education,” <http://www.foodallergy.org/document.doc?id=194>.

³ R.S. Gupta et al., “Geographic Variability of Childhood Food Allergy in the United States,” *Pediatrics* 51, no. 9 (2012): 856–61.

⁴ A.M. Branum and S.L. Lukacs, “Food allergy among U.S. children: trends in prevalence and hospitalizations,” *National Center for Health Statistics Data Brief*, no. 10 (2008):1–8; H.A. Sampson, A. Munoz-Furlong, R.L. Campbell et al., “Second symposium on the definition and management of anaphylaxis: summary report—Second National Institute of Allergy and Infectious Disease/Food Allergy and Anaphylaxis Network Symposium,” *Annals of Emergency Medicine* 47, no. 4 (2006): 373–80.

⁵ A.M. Branum and S.L. Lukacs, “Food allergy among children in the United States,” *Pediatrics* 124, no. 6 (2009): 1549.

⁶ A.L. Neugut, A.T. Ghatak, and R.L. Miller, “Anaphylaxis in the United States: An Investigation into Its Epidemiology,” *Archives of Internal Medicine* 161, no. 1 (2001): 15.

⁷ American Academy of Allergy, Asthma, and Immunology, and American College of Allergy, Asthma, and Immunology, Joint Task Force on Practice Parameters, Joint Council of Allergy, Asthma, and Immunology, *Journal of Allergy and Clinical Immunology* 115 (2005): S483–523.

⁸ T.P. O’Toole et al., “Nutrition services and foods and beverages available at school: results from the School Health Policies and Programs Study, 2006,” *Journal of School Health* 77 (2007): 500–21.

⁹ A. Nowak-Wegzyn, M.K. Conover-Walke, and R.A. Wood, “Food-Allergic Reactions in Schools and Preschools,” *Archives of Pediatric Adolescent Medicine* 155, no. 7 (2001): 790–95.

¹⁰ C.L. McIntyre et al., “Administration of Epinephrine for Life-Threatening Allergic Reactions in School Settings,” *Pediatrics* 116, no. 5 (2005): 1138.

¹¹ Food Allergy Research and Education, “Statewide Guidelines for Schools,” <http://www.foodallergy.org/laws-and-regulations/statewide-guidelines-for-schools>.

¹² O’Toole et al., “Nutrition services and foods and beverages,”; H.L. Leo and N.M. Clark, “Managing children with food allergies in childcare and school,” *Curr Allergy Asthma Rep.* 7, no. 3 (2007): 187–91; A. Muñoz-Furlong, “Food allergy in schools: concerns for allergists, pediatricians, parents, and school staff,” *Annals of Allergy, Asthma, and Immunology* 93, no. 5, suppl 3 (2004): S47–S50.

¹³ Virginia Guidelines for Recognition and Treatment of Anaphylaxis in the School Setting, 2013.

¹⁴ G.S. Rhim and M.S. McMorris, “School Readiness for Children with Food Allergies,” *Annals of Allergy, Asthma, and Immunology* 86, no. 2 (2001): 172–76.

¹⁵ S.H. Sicherer et al., “The U.S. Peanut and Tree Nut Allergy Registry: Characteristics of Reactions in Schools and Day Care,” *Journal of Pediatrics* 138, no. 4 (2001): 560–65.

¹⁶ McIntyre et al., “Administration of Epinephrine.”

¹⁷ Sicherer et al., “The U.S. Peanut and Tree Nut Allergy Registry.”

¹⁸ M. Dahl, “After Texas Boy Dies from Ant Bites, Debate Rages over Epipens in Schools,” *NBC News-Health*, September 18, 2013, www.nbcnews.com/health/texas-boys-deathreignites-debate-over-epipens-schools-4B11194403.

¹⁹ Rhim and McMorris, “School Readiness for Children with Food Allergies.”

²⁰ State Honor Roll 2014. Asthma and Allergy Foundation of America. <http://www.aafa.org/display.cfm?id=5&sub=105&cont=649>

²¹ Model states were selected based on information collected from Food Allergy Research and Education and Asthma and Allergy Foundation of America