Johnny Bright School Policy for Management of Life-Threatening Allergies (2022-2023)

A) Identification of Children at Risk

- It is the **responsibility of the anaphylactic/potentially anaphylactic child's parents to inform the school principal** of their child's allergy.
- **All staff members need to be made aware of these children**.
- Each child should wear a **MedicAlert® bracelet** that states his or her allergy/ies and the location of his / her auto-injector(s) (EpiPen®).
- A photograph and a description of each child's allergy should be kept discretely in the child's classroom, the office, and the teacher's Day Book. Parental permission is required for this. For younger children, it may be appropriate to have the Anaphylaxis Alert Poster in a visible area.

B) Availability and Location of EpiPens:

- Anaphylactic or potentially anaphylactic children who are old enough should **carry at least one EpiPen with them at all times** and have back-ups available in the school. Most children are able to carry their own auto-injector by the age of 6 to 8. For children with insect sting allergy, this would not have to be for the full year but from March to November. As a precaution, the school will keep 2 extra EpiPens® in the office, in case of an emergency.
- Each child should wear a MedicAlert® bracelet that states his or her allergy(ies) and the location of his or her auto-injector.
- **It cannot be presumed that children/adults will self-administer their auto-injector.**
- The individual might not be able to self-administer while having a reaction.)
- Posters describing the signs and symptoms of anaphylaxis and the use of the EpiPen® should be posted in relevant classrooms, the office, and in the staff room.
- Children who are no longer allergic or no longer require an EpiPen® must present a letter of explanation from their allergist.
- Additional EpiPens® should be brought on field trips. If the location is remote, it is recommended that the organizer of the field trip carry a cell phone as well.

C) Treatment Protocol

1. **An individual treatment protocol needs to be established by the child's allergist**. The school cannot assume responsibility for treatment in the absence of such a protocol. A copy of this should be present in the classroom and office along with a photo of the child.
2. To manage an emergency, a routine must be established and practiced. In our training session, we have worked on the following:
   a. One person stays with the injured individual at all times.
   b. One person goes for help.

c. Administer epinephrine at the **first sign** of reaction, however slight (e.g. itching or swelling of the lips/mouth in food allergic children). **There are no contraindications to the use of epinephrine for a potentially life-threatening allergic reaction.**

**Note time of administration.

d. Call 911 and, regardless of the degree of reaction or response to epinephrine, transfer the child to an emergency room. Symptoms may recur up to eight hours after exposure to allergen. One calm and familiar person must stay with the child until a parent or guardian arrives. If the child is being driven to hospital, it is recommended that another individual accompany the driver to provide assistance.
e. Contact the child's parents.
f. Adults must be encouraged to listen to the concerns of the anaphylactic child. The child usually knows when s/he is having a reaction, even before signs are manifest.

D) Training

1. Each year there should be awareness sessions for students and training for all staff, which includes a demonstration on the use of the EpiPen®.
2. As a quick refresher on a periodic basis, teachers could practice use of the EpiPen® during scheduled staff meetings.
3. Substitute teachers will be advised to review the Anaphylaxis Alert posters for children in their class and to review emergency protocol with the designated staff member for their grade level.

E) Allergen Awareness / Allergen Avoidance

The question of banning anything in schools is controversial. We live in a world that is contaminated with potential allergens. Anaphylactic children must learn to avoid specific triggers.
While the key responsibility lies with the anaphylactic individual and his family, in the case of a young anaphylactic child, the school community must also be aware.
In our school, the significant allergies are to peanut and nuts. There are allergies to other foods and insect/wasp stings as well. **We have appealed to the community to keep peanut butter (in particular) and other peanut/nut products out of the school.**
In the classrooms of anaphylactic children, special care is taken to avoid allergens. Parents must consult with the teacher before supplying food or craft materials to these classrooms. There is also a list of packaged "safe food", which has been distributed to the teachers and to the parents of classmates of peanut/nut allergic children. In short, the risk of accidental exposure to a food allergen has been significantly diminished although it can never be completely removed.

Given that anaphylaxis can be triggered by minute amounts of allergen, food anaphylactic children must be encouraged to follow certain guidelines:

- To eat only food which they have brought from home unless it is packaged, clearly labeled and approved by their parents.
- Wash hands before eating.
- Do NOT share food, utensils or containers.
- Place food on a napkin or wax paper, rather than in direct contact with a desk or table.

References

These recommendations are based on the following references:
Anaphylaxis in schools and other child care settings (position paper), The Canadian Society of Allergy and Clinical Immunology, August 1995
Anaphylaxis: A Handbook for School Boards, Health Canada, Canadian School Boards Association, Minister of Supply and Services Canada, 1996 and 2001
Regional School Board Anaphylaxis Protocol, 2000

If you have any questions, or would like a copy of any of the reference materials listed above, please contact the principal/assistant-principal.