Rocky Mountain
SCHOOL DISTRICT NO. 6

POLICY 5150

ALLERGIC REACTION / ANAPHYLAXIS

POLICY

> *"Anaphylaxis -- sometimes called "allergic shock" or "generalized allergic reaction" -- is a severe allergic reaction that can lead to rapid death, if untreated." Common causes are food, latex, insect stings, medication and exercise.*

Ensuring the safety of the anaphylactic children in a school setting depends on the cooperation of the entire school community.

This policy summarizes the responsibilities of all members of the school community in minimizing the risk of exposure and ensuring immediate response to an emergency.

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REGULATIONS:

1. It is suggested that the following principles serve as a foundation for individual school plans for dealing with life threatening allergies:

   - Parental involvement in all phases of planning.
   - Cooperation rather than enforcement.
   - Open communication.
   - Flexibility in implementation.
   - Proactive planning.
   - Doing what is reasonable and prudent.

2. Information and Awareness

   Parents/guardians have the primary responsibility for informing school personnel regarding their child's severe allergy. The physician must diagnose the child with anaphylaxis and prescribe the specific treatment protocol.

   Safety measures a school can reasonably expect to implement are:

   2.1 "Medical Alert Card" (including photograph of child, allergen to avoid, and management plan) and "Request for Administration of Medication at School" form will be completed and signed by the physician and parents should be obtained.

   2.2 A meeting with the child's parents to establish individual care plans should be held at the beginning of the school year.

   2.3 In consultation with the parents, medical alert posters should be posted in the office, classroom, medical room and any other room which is used on a regular basis by the child.

   2.4 All staff (teaching and non-teaching) must be made aware of and be able to visually identify students who have potentially life-threatening allergies. This may include: custodians, supervisors, bus drivers, substitute teachers, first aid attendants, parent volunteers, coaches, and food services personnel.

   2.5 An annual training session for all staff regarding the administration of medication and epinephrine auto-injectors (in consultation with the public health nurse and parent) must be held and reviewed mid-year. Training must reflect current clinical guidelines as outlined in the Anaphylaxis Framework (BC Ministry of Education website) regarding the use of auto-injectors, including the requirement to administer the second dose 5-15 minutes after the first one if symptoms have not improved. Auto-injectors may include brand names such as EpiPen, Twinjet, Allerject, etc.

2.6 There needs to be recognition by all concerned of the increased danger when changes to the routine occur, especially field trips, sports days, extracurricular outings, and on treat days and festive occasions.

2.7 There needs to be recognition by all concerned of the increased danger in cafeterias, home economics classes and in other food services areas.

2.8 The child's teacher(s) should receive additional information about the child from the parent. The teacher(s), parent(s) and family doctor must maintain open lines of communication.

2.9 The Administrator early in the school year should, through the school newsletter, inform the school community of the presence of an anaphylactic child and of the allergen. The Administrator should ask for the school community's cooperation in reducing the presence of the allergen in the school. An explanation of what an anaphylactic reaction is should be given.

3. Avoidance of the Allergen

The parent and the child have primary responsibility for avoiding the allergen. For a primary child there is a need for the school to assume a greater responsibility than it would be an older child. It is not possible to achieve a completely allergen-free school, as there can be hidden or accidentally introduced sources. Appropriate to the age of the child, the school should attempt to reduce the child's exposure to allergic foods within the school setting.

3.1 There should be no trading and sharing of foods, food utensils and food containers in the allergic child's classroom.

3.2 All food allergic children should only eat lunches and snacks that have been prepared at home.

3.3 A hand washing routine, both before and after eating, for all children in the classroom of an anaphylactic child should be implemented.

3.4 Surfaces such as tables in the areas where students eat and that the child frequents should be washed clean using a disinfectant.

3.5 The use of foods in crafts, cooking classes and special celebrations may need to be restricted depending on the allergies of the students.

3.6 The allergic child's classroom should be checked for other sources of the allergen, e.g. playdough, bean bags, stuffed toys -- peanut shells are sometimes used.

3.7 An allergen restricted eating area should be provided using a cooperative approach with fellow students and their parents.

3.8 Some allergies require more stringent management plans such as the following:

(a) Peanut allergies are one of the most common food allergies and the leading cause of food induced anaphylaxis. Where there is a peanut allergic child in a school an allergy free classroom needs to be instituted.
   (i) In an elementary school where children eat in their classroom the allergic child's classroom needs to be peanut-free.
   (ii) In a school where children eat in a common area, either that common area needs to be peanut-free or a second eating area needs to be established which is peanut-free.

(b) Foods served by the school should omit peanuts and other nuts if peanut allergic individuals are present.

(c) If there is to be cooking or food preparation in the child's class, the parent of the allergic child should be notified ahead of time so that issues, such as cross contamination of bulk food, can be discussed.

(d) It should be recognized that this will reduce but not eliminate the risk of accidental exposure.

3.9 If the allergic child is to take part in a field trip by school bus, the bus should receive a visual inspection by the driver prior to the trip in order that any obvious allergen can be removed. The allergic child should sit in the front seat.

3.10 The use of an allergy causing substance to bully or threaten an allergic child should be treated by the school as if the child had been threatened with a weapon.

4. Emergency Response Procedures

4.1 Since it is impossible to reduce the risk of accidental exposure to zero, an anaphylactic child may require emergency lifesaving measures while at school.

4.2 Each school must develop and practice an emergency response plan (including such topics as: how to access the auto-injector, who will administer it, what to say when calling an ambulance, contacting parents, and safeguards for field trips and other special events).

4.3 An up-to-date supply of auto-injectors provided by the parent(s) must be stored in a covered, secure, unlocked area for quick access. Students should be encouraged to carry an auto-injector on their person wherever possible.

4.4 Regardless of 4.3 above every school should have its own auto-injectors.

4.5 When in doubt use the auto-injector and obtain immediate professional medical assistance.