SECTION 1000: STUDENTS AND SCHOOLS

POLICY 1055: ANAPHYLAXIS

- *Date Adopted: June 12, 2013*

POLICY STATEMENT

The Board recognizes the importance of identification of anaphylactic students by parents/guardians to school authorities and the need to establish policies and procedures in accordance with provincial legislation.

LEGISLATION/REGULATIONS

- Anaphylaxis Protection Order, Ministerial Order 232/07 (M232/07)
- *British Columbia Anaphylactic and Child Safety Framework, 2007*
- *Anaphylaxis: A Handbook for School Boards, 2001*
- *Life Threatening Food Allergies in School and Child Care Settings: A Practical Resource for Parents, Care Providers and Staff, 1999*

POLICY

In accordance with Ministry requirements, the Board provides this policy and the following procedures relating to the response to anaphylaxis in school settings.

PROCEDURES

Definition of Anaphylaxis - pronounced [anna-fill-axis]: Anaphylaxis is a sudden and severe allergic reaction which can be fatal, requiring immediate medical emergency measures be taken.

1. Signs and Symptoms of Anaphylaxis

a. Signs and symptoms of a severe allergic reaction can occur within minutes of exposure to an offending substance. Reactions usually occur within two hours of exposure, but in rarer cases can develop hours later. Specific warning signs as well as the severity and intensity of symptoms can vary from person to person and sometimes from attack to attack in the same person.

1. Signs and Symptoms of Anaphylaxis *(continued)*

b. An anaphylactic reaction can involve any of the following symptoms, which may appear alone or in any combination, regardless of the triggering allergen:

i. Skin: hives, swelling, itching, warmth, redness, rash;

ii. Respiratory (breathing): wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain/tightness, nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing), trouble swallowing;

iii. Gastrointestinal (stomach): nausea, pain/cramps, vomiting, diarrhea;

iv. Cardiovascular (heart): pale/blue colour, weak pulse, passing out, dizzy/lightheaded, shock;

v. Other: anxiety, feeling of "impending doom", headache, uterine cramps in females ;

vi. It is important to note that anaphylaxis can occur without hives.

c. The most dangerous symptoms of an allergic reaction involve:

i. breathing difficulties caused by swelling of the airways, and

ii. a drop in blood pressure indicated by dizziness, light-headedness or feeling faint/weak.

- Both of these symptoms may lead to death if untreated.

d. Because of the unpredictability of reactions, early symptoms should never be ignored, especially if the person has suffered an anaphylactic reaction in the past. If an allergic student expresses any concern that a reaction might be starting, the student should always be taken seriously. When a reaction begins, it is important to respond immediately, following instructions in the student's Anaphylaxis Emergency Plan. The cause of the reaction can be investigated later.

2. Identifying Students at Risk

a. It is the responsibility of the parents/guardians with anaphylactic children to notify the school principal when a child is diagnosed as being at risk of anaphylaxis and provide the school with updated medical information annually.

The parents/guardians must further provide the school with updated medical information whenever there is a significant change related to their child/children.

2. Identifying Students at Risk *(continued)*

Current information should include but not be limited to:

i. inhalants and other known factors that trigger anaphylactic reaction;

ii. symptoms of the anaphylactic reaction;

iii. precautions necessary;

iv. a treatment protocol signed by the child's physician.

b. A uniform standard of identification should be put in place for students with complex medical conditions such as Anaphylaxis e.g., Medic-Alert®11.

This should include the opportunity for parents and students to be made aware of medical identifying information.

c. Because of the unpredictability of reactions, early symptoms should never be ignored.

Since it is not always possible to identify a child at-risk of anaphylaxis in advance, and because there is recognition that anaphylaxis, asthma, and severe allergies are intertwined, it is prudent for school communities to recognize and be prepared to respond to an anaphylactic event, should it occur.

3. Record Keeping, Monitoring and Reporting

a. The school principal is responsible for keeping accurate records for each student at-risk of life-threatening allergies.

i. A record with information relating to the specific allergies for each identified anaphylactic student will form part of the student's Permanent Student Record, as defined in the Permanent Student Record Order. That record shall include the student's emergency response plan.

b. School principals must monitor and report information about anaphylactic incidents to the Superintendent of Schools in aggregate form, to include number of at-risk anaphylactic students and number of anaphylactic incidents.

c. All staff members, including support staff, teachers on call and when necessary, volunteers, must be made aware of anaphylactic students and appropriate procedures.

3. Record Keeping, Monitoring and Reporting *(continued)*

d. A plan to communicate the identity and medical information should be developed jointly by the parent and school. This would include consideration of:

i. an allergy alert form with photograph, description of the allergy, treatment and action plan. This information should be placed in key locations and wherever the child's epinephrine auto-injector is stored;

ii. a strategy to inform parents of the presence of a student with life-threatening allergies in the school and the measures being taken to minimize the risk for the identified student;

iii. an emergency response protocol, for example, for field trips, special celebrations, lunch hour practices, etc.

e. In order to minimize risks the following points should be implemented:

i. require the classroom teacher to keep information about the anaphylactic student's allergies and emergency procedures in a visible location;

ii. ensure that procedures are in place for informing teachers on call and volunteers about anaphylactic students;

iii. involve teachers on call and volunteers in regular in-service programs, or provide separate in-service for them.

4. Student Level Emergency Procedure Plan

a. The plan should be developed in conjunction with the student's parents and the student (where age appropriate), and the plan must be approved by a qualified physician or allergist.

b. The student emergency response plan must be signed by the student's parents, the student (where age appropriate) and the physician, and must be kept on file at readily accessible locations.

c. The student emergency response plan shall include at minimum:

i. the diagnosis;

ii. the current treatment regimen;

iii. who within the school community is to be informed about the plan (e.g., teachers, volunteers, classmates); and

iv. current emergency contact information for the student's parents/guardian.

4. Student Level Emergency Procedure Plan *(continued)*

d. The student's emergency response plan shall also explicitly address:

i. the parent's responsibility for advising the school about any change/s in the student's condition; and

ii. the school's responsibility for updating records.

e. Those exposed to individual student emergency response plans have a duty to maintain the confidentiality of all student personal health information.

5. School Level Emergency Procedure Plan

a. All schools must have an emergency protocol in place to ensure responders know what to do in an emergency. The emergency protocol shall include:

i. administering an auto-injector;

ii. calling emergency medical care (911 where available);

iii. calling student's parents;

iv. administering second dose (within 10 to 15 minutes if symptoms have not improved).

6. Training and In-service

a. *Anaphylaxis training is a critical component of managing risk associated with anaphylaxis. An effective response to Anaphylaxis depends on the cooperation of all members of the school community including students, parents, public health nurses, school personnel and volunteers.*

b. Training is provided by individuals trained to teach anaphylaxis management. The Public Health nurse or other medical expert should be consulted in the development of training policies and the implementation of training.

c. Training is provided at least once a year; best practice suggests training twice a year is advised for secondary schools because of increased student mobility.

d. Direct training is provided to all those reasonably expected to have supervisory responsibility of school-age and pre-school students (e.g., school personnel, teachers on call, foodservice staff and volunteers); best practice suggests training should include student peers, depending on age and maturity. Teacher on call orientation each year shall include a review of policy and training to deal with anaphylactic reactions.

6. Training and In-service *(continued)*

e. Distinction is made between needs of younger and older anaphylactic students; older students may be more likely to engage in risk behaviours.

f. School principals should communicate to all school community members (students, parents, teachers, volunteers, etc.) the school's anaphylaxis policies and procedures.

g. Training should include how to recognize anaphylactic reactions and use of the epinephrine (auto-injector).

h. Training encompasses information relating to:

i. signs and symptoms of anaphylaxis;

ii. common allergens;

iii. avoidance strategies;

iv. emergency protocols;

v. use of the epinephrine auto-injector;

vi. identification of at-risk students as outlined in the individual student emergency response plan;

vii. emergency plans;

viii. method of communication with and strategies to educate and raise awareness of parents, students, employees and volunteers about anaphylaxis.

7. Provision and Storage of Medication

a. Epinephrine auto-injectors are life-saving medication. Access to auto-injectors is critical, therefore all Anaphylactic medications are to be properly stored in a safe central unlocked location where they can be accessed in an emergency.

b. School personnel, teachers on call, food service staff, and volunteers working with an anaphylactic child should be made aware of this location.

c. Parents/guardians should be informed that it is their responsibility:

i. to provide appropriate medication (e.g., epinephrine auto-injector) for their anaphylactic child;

ii. to inform the school where the anaphylactic child's medication will be kept (i.e., with the student, in the student's classroom, and/or other locations);

iii. to inform the school when they deem the child competent to carry their own medication/s, and it is their duty to ensure their child understands they must carry their medication on their person at all times;

7. Provision and Storage of Medication *(continued)*

iv. to provide a second auto-injector to be stored in a central, safe but unlocked location;

v. to ensure anaphylaxis medications have not expired; and

vi. to ensure that they replace expired medications.

8. Allergy Awareness, Prevention, and Avoidance Strategies

a. "*Avoidance is the cornerstone of preventing an allergic reaction. Much can be done to reduce the risk when avoidance strategies are developed*".

b. While it is impossible to eliminate all potential allergens from the school environment, all schools where students at risk of anaphylaxis have been identified should create an allergy-aware environment in response to the most common triggers for anaphylaxis, food allergens and insect stings, and for managing risk associated with rarer allergies to other substances, for example when a child is identified with allergies to medications, exercise, latex.

9. Incident Debriefing

a. All schools where students at risk of anaphylaxis have been identified should create a process to provide a debriefing session to review anaphylactic incidents with regard to exposure, response and lessons learned. Debriefing sessions should include participation by, but not be limited to:

i. the student's parents/guardians;

ii. the student (where age appropriate);

iii. relevant school personnel; and

iv. the public health nurse.