Food allergy in school.

Why is this important?

Food allergies are a growing food safety and public health concern across the western world. In Ireland 4% of children now have a food allergy. Thus, almost every average-sized school class in Ireland is likely to have a food allergic child enrolled. Keeping food allergic children safe, while ensuring that they experience a full and inclusive childhood, should be the goal of all involved in their care.

What is food allergy?

A food allergy occurs when the immune system forms antibodies against food proteins similar to the way it does to fight bacteria and viruses. These food proteins are called allergens. This usually happens very early in life, as early as 3 to 6 months of age. Every time after that when the body is re-exposed to those food proteins an immune reaction is triggered.

What foods cause allergy?

The most common food allergy is to egg. Many children outgrow their egg allergy before school age but increasing numbers will enter school still allergic to egg. Similarly cow's milk allergic children are attending school.

Peanut, Tree nuts (e.g. cashew, hazelnut, almond, brazil, pine, walnut etc.) are the next most common food allergens (coconut is not nut). Other common food allergens include fish, seeds, shellfish, beans, peas, fruit (especially kiwi), wheat and soya.

The majority of egg and milk allergic children can tolerate some form of egg or milk by the time they enter primary school.

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What are the symptoms (what the patient feels) and the signs (what you, the observer can see) of an allergic reaction?

Symptoms and signs can be mild, moderate, severe/life threatening known as anaphylaxis (pronounced anna-fill-axis).

Mild symptoms include an itchy tongue or roof of mouth. Small children will often report that their mouth feels "funny" or "fizzy". Children may have mildly itchy eyes, nose or skin. They may describe abdominal pain or nausea.

Mild signs include small crops of hives or rash appearing on the skin, mild sneezing fits, localised swelling (e.g. slight eye lid swelling),

Moderate signs include swelling of one or the eyes, lips, itchy watery red eyes, large areas of rash/ hives.

Severe symptoms include fear-children appear panicked, distressed. They may have difficulty talking and /or swallowing. They may feel weak, confused.

Severe signs: difficult/noisy breathing, drooling, protruding tongue (sticking out of mouth) hoarse voice, wheeze or persistent cough persistent dizziness or collapse, pale and floppy (young children).

*It is also important to consider, as very severe, a collection of moderate symptoms, all present together: such as swelling of numerous parts of the body, abdominal pain/vomiting, severe itch and large areas of hives/rash. This is also an indication to administer adrenaline

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What is anaphylaxis?

Anaphylaxis is the presence of severe symptoms and signs. It is essential that immediate action is taken if an allergic child has symptoms and signs of anaphylaxis

How is anaphylaxis be treated?

Adrenaline is the only effective first aid treatment for anaphylaxis. It is given as an injection using an adrenaline autoinjector "pen" into the outer mid thigh muscle.

Adrenaline autoinjectors are designed so that anyone can use them in an emergency. They are most effective when they are used early in the reaction.

Adrenaline in an autoinjector pen device is NOT harmful.

IF IN DOUBT ALWAYS GIVE ADRENALINE. Don't waste time by calling parents to ask what to do - they have already provided a medically approved action plan.

Access a sample action plan by clicking here

What determines how bad a reaction is going to be?

A few key principles:

- Food allergic reactions rarely occur unless a child is in direct contact with that food.
- Skin contact reactions are always milder than reactions after ingestion (eating). *For example:*
  - *If a milk allergic child contacts with milk on their hand they are likely to develop rash (hives) at the point of contact.*
  - *If that child rubs cow's milk on their face they may develop facial rash, swollen eyes, sneezing, swollen lips.*
  - *If the same child accidentally ingests milk then they experience any number of symptoms including life threatening anaphylaxis.*
- Not all allergic children will have the same allergy threshold (i.e. they can react differently to the same amount of food).
- Most food allergic children will experience no symptoms or only develop mild symptoms if they contact with trace amounts of allergens. However there are some allergic children who develop severe reactions after exposure to tiny amounts of food.

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- Some allergic reactions will depend on how the food is prepared. *Most children with egg allergy can tolerate egg baked in cakes, muffins, scones but will react if they eat whole egg (boiled, scrambled etc.) or egg that is hidden but only pasturised (mayonnaise, ice cream). Similarly most children with milk allergy can tolerate milk in a biscuit but will react if they ingest yogurt, chocolate or whole cow's milk.*

Is peanut allergy the most dangerous allergy?

No! It is a misconception that children with peanut allergy are at greater risk than children with other food allergies. Any food allergy can potentially trigger a life threatening allergic reaction. Any school policy for allergy should apply to all food allergies, not just nut allergy.

Should schools ban food that children are allergic to?

This is a controversial issue. There are 14 legally declarable food allergens. Banning a potential 14 food allergens from a school is impractical and impossible to police 100% of the time.

Evidence shows that nut children have had allergic reactions in schools where nuts were banned. A school allergy policy that only involves the banning of a food is incomplete and can be received poorly by the school population as a whole. It sends a negative message about allergy and allergic children. It is much more important to have good food allergy safety measures in place and effective emergency preparedness.

These measures are discussed below – "**How to keep food allergic children safe in school".** In conjunction with these measures it may be appropriate to ban a food from a class, rather than the whole school.

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How to keep food allergic children safe in school.

A. General considerations

- Consider developing a policy for the care of allergic children in your school.
- Get input from all stakeholders: Parents of allergic children, school board, and teachers.
- Include all aspects of care:
    a. Day to day management of food allergy/safety measures
    b. Emergency response plan
    c. Peer and staff allergy awareness training

- Develop safety practices that include rather than exclude allergic children:

1. Promote the concept of never sharing food "Sharing is caring but never share food".
2. Ensure that all eating is supervised and orderly. Advise children to put away all books and pencils before eating. Children should sit at their desks while eating, rather than walk around, as this increases the risk of exposure.
3. Encourage all children to wash their hands after before and after eating. If this means trips to bathrooms then consider having children bringing soapy wipes to school.
4. Discourage all teachers from using food as a reward or treat (e.g. sweets, jellies, lollipops etc.) These top shelf food pyramid items do not promote a healthy eating message. Consider using non-food rewards and treats instead (e.g. pencils/erasers/stickers etc.).
5. Identify specific events that may increase the risk of allergic reaction. Consider how to manage these events without excluding the allergic child.

- Children being moved to another classroom.
- Birthday parties, cultural events and celebrations-involve the child's parent, ensure there is alternative food available.
- Bake sales are a very high-risk event for food allergic children. Some allergic children have created their own stalls with food prepared in their homes but must not be allowed shop at other stands.

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- Cooking activities: raw egg and whole milk are high-risk products for egg and milk allergic children. Tiny amounts will be distributed long distances if egg/milk are whisked. Baking that involves raw egg/whole milk should be discouraged in classes with egg and or milk allergic children.
- For classes with nut allergic children, attention is needed if/when making bird feeders and nature tables both of which commonly contain nuts. Nut allergic children can still be involved as long as both activities are free from nut.
- Arts and crafts - egg boxes may have raw egg on them. Children with food allergy often have atopic dermatitis and their skin is very sensitive to many products independent of their food allergy. They may not tolerate face paints etc.
- Nature walks/trips to parks can present risks. Make sure to talk to parents of allergic children before planning these trips (even a simple walk to the local park). Children may need extra medication on the day of the trip. Children with severe pollen allergy may experience sudden eye and nose symptoms. Nut allergic children should not collect any nuts.

B. Child specific considerations:

- Before creating a management plan specific for an allergic child it is recommended that a school representative (teacher) meet with the child's parents.
- Explain to them the schools general approach to allergy management (as above). Be aware that parents of food allergic children starting school are particularly anxious. Their child may never have spent time out of their presence before. Their child may have already experienced an anaphylactic reaction.
- Identify the foods that their child needs to avoid.
- Ask about the child's understanding of their own allergies (this is particularly relevant in secondary school)
- Get information regarding the emergency plan that has been advised by the child's doctor.
- Establish if a doctor has advised that the child carry adrenaline autoinjectors.

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- Parents/guardians should provide schools with
    - liquid anti histamine
    - (if prescribed) 2 in date adrenaline autoinjectors
    - an action plan for the student.

All these items should be stored unlocked and easily accessible to all staff.

- Both adrenaline autoinjectors must be kept together, not 1 in classroom, 1 in office. Both should be taken on outings from school.
- Identify all school staff members that need to be aware of the child's allergies .
- Identify how all the gathered information will be communicated: written plan displayed in staff room etc.

Are there other issues to consider?

Yes. Remember that when dealing with food allergic children, keeping them safe at all costs is not the correct approach. Food allergic children are known to experience considerable anxiety due to their condition. They suffer limitations, isolation and exclusion every day. They also suffer teasing and bullying.

It is advised that schools create a policy for the care of food allergic children that aims not only to ensure their safety but also

- To give allergic children a positive psychosocial environment by ensuring inclusion and acceptance.
- To create an age appropriate awareness, understanding of food allergy amongst peers.

How does school staff access adrenaline autoinjector training?

At the current time, there is neither a legal nor formal requirement for adrenaline autoinjector training in Irish childcare, education or work environments.

There's no reason why an adult, who has been trained in the use of an adrenaline autoinjector that's been prescribed by a doctor, cannot act as the trainer for work or school staff.

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There is a link from our website site to all 4 adrenaline autoinjectors that are available in Ireland, to their training pens and educational video clips.

http://ifan.ie/adrenalineautoinjectorsandtrainerdevices/

Indemnity

An Irish school was fined heavily in 2014, on the basis of discrimination against a food allergic child, for enforcement of unreasonable arrangements.

We are aware that many schools have documents in place. It is our understanding that they are not a reflection of individual teachers' reluctance to come to the help of a child in need, but a legal requirement of their institution, for which there is no formal or policy based/national requirement.

We do not advise on whether or not to sign.

Existing legislation already covers any person from liability if they offer to assist a person in a life-threatening medical emergency. Signed parental waivers do not improve this cover.

Emerging legislation will allow schools go further and keep generic adrenaline autoinjectors, rather than relying on individual families to provide multiple kits. Staff will need prescribed training. This will improve safety at school significantly as the generic autoinjectors can be used by trained staff for children who develop a severe reaction for the first time and do not have their own AAIs.

We strongly recommend a meeting between parent and teacher to ensure that all elements of the child's emergency plan are in place: adrenaline pen, trainer device, management plan etc.

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IRISH FOODALLERGY NETWORK

Special needs assistant (SNA) applications

The SNA scheme was put in place to provide for Children and Young People with Special Educational Needs to cater for a minority of students who have significant need for care support and who would not be able to attend school without such additional support.

There is no indication that a child with food allergy requires an SNA in order to be able to attend school and to take part in education.

However, where a child has significant care needs arising from a disability or medical condition, plus a food allergy, they may qualifiy for SNA based on their disability or medical condition.

Domicilary Care Allowance (DCA) applications

The DCA scheme is intended for a child with a severe disability who requires ongoing care and attention, substantially over and above the care and attention usually required by a child of the same age.

There is no indication that a child with food allergy requires a DCA in order to deal with activities of daily living.

However, where a child has a disability so severe that it requires them needing care, attention and supervision substantially in excess of another child of the same age, plus a food allergy, they may qualify for a DCA.

Eligibility for DCA is not based primarily on the medical or psychological condition, but on the resulting lack of function of body or mind necessitating the degree of extra care and attention required. As such it is not possible to say if a particular child or any particular condition/disability will qualify for a payment under the scheme. Each application is assessed on an individual basis taking account of the evidence submitted.

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