AP 4XXX Anaphylaxis

Legislative References: Nil
Policy Reference: Nil
Collective Agreement References: Nil
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1. Description of Anaphylaxis

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 reaction to reaction in the same persons.

While the exact prevalence is unknown, it has been estimated that more than 600,000 or 1% to 2% of Canadians are at risk of anaphylaxis (from food and insect allergy), and that up to 6% of young children less than three years of age are at risk[1]. In the school age population, it is estimated that between 2-4% of children are at risk of anaphylactic reactions to foods.

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

- **Skin:** hives, swelling, itching, warmth, redness, rash
- **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
- **Gastrointestinal (stomach):** nausea, pain/cramps, vomiting, diarrhoea
- **Cardiovascular (heart):** pale/blue colour, weak pulse, passing out, dizzy/light-headed, shock
- **Other:** anxiety, feeling of “impending doom”, headache, uterine cramps in females

Because of the unpredictability of reactions, early symptoms should never be ignored[2], especially if the person has suffered an anaphylactic reaction in the past.

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

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,

[1] Canadian Society of Allergy and Clinical Immunology. Anaphylaxis in Schools and Other Settings. 2005.
[2] Training strategies need to address the need for a rapid emergency response when symptoms of an anaphylactic reaction appear. Students may be in denial, or unaware, that they are experiencing an anaphylactic reaction.

following instructions in the student's *Student Emergency Procedure Plan*. The cause of the reaction can be investigated later.

The following symptoms may lead to death if untreated:

- breathing difficulties caused by swelling of the airways; and/or
- a drop in blood pressure indicated by dizziness, light-headedness or feeling faint/weak.

2. Identifying Individuals at Risk

At the time of registration, using the district registration form parents are asked to report on their child's medical conditions, including whether their child has a medical diagnosis of anaphylaxis. Information on a student's life threatening conditions will be recorded and updated on the student's Permanent Student Record annually.

It is the responsibility of the parent/guardian to:

- Inform the school principal when their child is diagnosed as being at risk for anaphylaxis.
- In a timely manner, complete medical forms and the Student Emergency Procedure Plan which includes a photograph, description of the child's allergy, emergency procedures, contact information, and consent to administer medication. The Student Emergency Procedure Plan should be posted in key areas such as in the child's classroom, the office, the teacher's daybook, and food consumption areas (e.g. lunch rooms, cafeterias). Parental permission is required to post or distribute the plan.[3]
- Provide the school with updated medical information at the beginning of each school year, and whenever there is a significant change related to their child.
- Inform service providers of programs delivered on school property by non-school personnel of their child's anaphylaxis and care plan, as these programs are not the responsibility of the school.

The school will contact anaphylactic students and their parents to encourage the use of medical identifying information (e.g. MedicAlert® bracelet). The identifying information could alert others to the student's allergies and indicate that the student carries an epinephrine auto-injector. Information accessed through a special number on the identifying information can also assist first responders, such as paramedics, to access important information quickly.

3. Record Keeping – Monitoring and Reporting

For each identified student, the school principal will keep a Student Emergency Procedure Plan on file. These plans will contain the following information:

- Student-Level Information
  - Name
  - Contact information
  - Diagnosis

[3] A section for parental consent is included on the Student Emergency Procedure Plan.

  - Symptoms
  - Emergency Response Plan
- School-Level Information
  - Emergency procedures/treatment
- Physician section including the student's diagnosis, medication and physician's signature.

It is the school principal's responsibility for collecting and managing the information on students' life threatening health conditions and reviewing that information annually to form part of the students' Permanent Student Records.

The school principal will also monitor and report information about anaphylactic incidents to the board of education in aggregate form (to include number of at-risk anaphylactic students and number of anaphylactic incidents) at a frequency and in a form as directed by the superintendent.

4. Emergency Procedure Plans

a) Student Level Emergency Procedure Plan

The school principal must ensure that the parents and student (where appropriate), are provided with an opportunity to meet with designated staff, prior to the beginning of each school year or as soon as possible to develop/update an individual Student Emergency Procedure Plan. The Student Emergency Procedure Plan must be signed by the student's parents and the student's physician. A copy of the plan will be placed in readily accessible, designated areas such as the classroom and office.

The Student Emergency Procedure Plan will include at minimum:

- the diagnosis;
- the current treatment regimen;
- who within the school community is to be informed about the plan – e.g. teachers, volunteers, classmates;
- current emergency contact information for the student's parents/guardian;
- a requirement for those exposed to the plan to maintain the confidentiality of the student's personal health information[4];
- information regarding the parent's responsibility for advising the school about any change/s in the student's condition; and
- information regarding the school's responsibility for updating records.

b) School Level Emergency Procedure Plan

Each school must develop a School Level Emergency Procedure Plan, which must include the following elements:

[4] To be in compliance with the Freedom of Information and Protection of Privacy Act (FOIPPA);

1. Administer the student's auto-injector (single dose, single-use) at the first sign of a reaction. The use of epinephrine for a potentially life-threatening allergic reaction will not harm a normally healthy child, if epinephrine was not required. Note time of administration.
2. Call emergency medical care (911 – where available)
3. Contact the child's parent/guardian
4. A second auto-injector may be administered within 10 to 15 minutes or sooner, after the first dose is given IF symptoms have not improved (i.e. the reaction is continuing, getting worse, or has recurred).
5. If an auto-injector has been administered, the student must be transported to a hospital (the effects of the auto-injector may not last, and the student may have another anaphylactic reaction).
6. One person stays with the child at all times.
7. One person goes for help or calls for help.

The school principal, or designated staff, must ensure that emergency plan measures are in place for scenarios where students are off-site (e.g. bringing additional single dose, single-use auto-injectors on field trips).

5. Provision and Storage of Medication

Children at risk of anaphylaxis who have demonstrated maturity[5] should carry one auto-injector with them at all times and have a back-up auto-injector stored at the school in a central, easily accessible, unlocked location. For children who have not demonstrated maturity, their auto-injector(s) will be stored in a designated school location(s).

The location(s) of student auto-injectors must be known to all staff members and caregivers.

Parents will be informed that it is the parents' responsibility:

- to provide the appropriate medication (e.g. single dose, single-use epinephrine auto-injectors) for their anaphylactic child;
- 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);
- to inform the school when they deem the child competent to carry their own medication/s (children who have demonstrated maturity, usually Grade 1 or Grade 2, should carry their own auto-injector), and it is their duty to ensure their child understands they must carry their medication on their person at all times;
- to provide a second auto-injector to be stored in a central, accessible, safe but unlocked location;
- to ensure anaphylaxis medications have not expired; and
- to ensure that they replace expired medications.

[5] As determined by the child's parents.

6. Allergy Awareness, Prevention and Avoidance Strategies

a) Awareness

The school principal should ensure:

- That all school staff and persons reasonably expected to have supervisory responsibility of school-age students and preschool age children participating in early learning programs (e.g. food service staff, volunteers, bus drivers, custodians) receive training annually or biannually, in the recognition of a severe allergic reaction and the use of single dose, single-use auto-injectors and standard emergency procedure plans.
- That all members of the school community including substitute employees, employees on call, student teachers and volunteers have appropriate information about severe allergies including background information on allergies, anaphylaxis and safety procedures.
- With the consent of the parent, the principal and the classroom teacher must ensure that the student's classmates are provided with information on severe allergies in a manner that is appropriate for the age and maturity level of the students, and that strategies to reduce teasing and bullying are incorporated into this information.

Posters which describe signs and symptoms of anaphylaxis and how to administer a single dose, single-use auto-injector should be placed in relevant areas. These areas may include classrooms, office, staff room, lunch room and/or the cafeteria.

b) Avoidance/Prevention

Individuals at risk of anaphylaxis must learn to avoid specific triggers. While the key responsibility lies with the students at risk and their families, the school community must participate in creating an "allergy-aware" environment. Special care is taken to avoid exposure to allergy-causing substances. Parents are asked to consult with the teacher before sending in food to classrooms where there are food-allergic children. The risk of accidental exposure to a food allergen can be significantly diminished by means of such measures.

Given that anaphylaxis can be triggered by minute amounts of an allergen when ingested, students with food allergies must be encouraged to follow certain guidelines:

- Eat only food which they have brought from home unless it is packaged, clearly labelled and approved by their parents (*Elementary schools)*.
- If eating in a cafeteria, ensure food service staff understands the life-threatening nature of their allergy. When in doubt, avoid the food item in question.
- Wash hands before and after eating.
- Not share food, utensils or containers.
- Place food on a napkin or wax paper rather than in direct contact with a desk or table.

Non-food allergens (e.g. medications, latex) will be identified and restricted from classrooms and common areas where a child with a related allergy may encounter that substance.

7. Training Strategy

At the beginning of each school year, a training session on anaphylaxis and anaphylactic shock will be held for all school staff and persons reasonably expected to have supervisory responsibility of school-age students and preschool age children participating in early learning programs (e.g. food service staff, volunteers, bus drivers, custodians).

Efforts shall be made to include the parents, and students (where appropriate), in the training. Experts (e.g. public health nurses, trained occupational health & safety staff) will be consulted in the development of training policies and the implementation of training. Training will be provided by individuals trained to teach anaphylaxis management.

The training sessions will include:

- signs and symptoms of anaphylaxis;
- common allergens;
- avoidance strategies;
- emergency protocols;
- use of single dose, single-use epinephrine auto-injectors;
- identification of at-risk students (as outlined in the individual Student Emergency Procedure Plan);
- emergency plans; and
- method of communication with and strategies to educate and raise awareness of parents, students, employees and volunteers about anaphylaxis.

Additional Best Practice:

- distinction between the needs of younger and older anaphylactic students.

Participants will have an opportunity to practice using an auto-injector trainer (i.e. device used for training purposes) and are encouraged to practice with the auto-injector trainers throughout the year, especially if they have a student at risk in their care.

Students will learn about anaphylaxis in a general assembly or special class presentations