State Government Victoria

Department of Education and Early Childhood Development

Anaphylaxis Guidelines

A resource for managing severe allergies in Victorian government schools

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This document is also available on the internet

http://www.education.vic.gov.au/healthwellbeing/health/anaphylaxisschools.htm

Contents

Glossary of Terms

Adrenaline autoinjector	Any autoinjector device that contains adrenaline and is used for anaphylactic reactions, such as EpiPen®, EpiPen®Jr, Anapen® or Anapen®Jr.
Adrenaline autoinjector for general use	A 'backup' or 'unassigned' adrenaline autoinjector that some schools may choose to purchase.
ASCIA Action Plan for Anaphylaxis	This plan is a nationally recognised action plan for anaphylaxis developed by the Australasian Peak Medical Body for Allergy and Immunology (ASCIA), the peak body of immunologists and allergists in Australia. These plans are device specific; that is, they list the student's prescribed autoinjector (EpiPen®/Anapen® or EpiPen®Jr/Anapen®Jr).
Anaphylaxis Management Plan	An individual plan for each student at risk of anaphylaxis, developed in consultation with the student's parents/carers, which must include an ASCIA Action Plan for Anaphylaxis (device specific) signed by their medical practitioner.
School Anaphylaxis Management Policy	A policy containing the matters required by Ministerial Order 90 – Anaphylaxis Management in Schools. A school must have such a policy in place where it has enrolled a student who has been diagnosed as being at risk of anaphylaxis.
Student's Emergency Procedure Plan	ASCIA Action Plan – which must be signed by the student's medical practioner.

1. Introduction

Anaphylaxis is a severe, rapidly progressive allergic reaction that is potentially life threatening. The most common allergens in school-aged children are peanuts, eggs, tree nuts (e.g. cashews), cow's milk, fish and shellfish, wheat, soy, sesame seeds, latex, certain insect stings and medications.

The Department of Education and Early Childhood Development (the Department) is committed to:

- Providing, as far as practicable, a safe and supportive environment in which students at risk of anaphylaxis can participate equally in all aspects of the student's schooling
- Raising awareness about allergies and anaphylaxis in the school community
- Actively involving the parents/carers of each student at risk of anaphylaxis in assessing risks, developing risk minimisation strategies and management strategies for the student
- Ensuring that every staff member has adequate knowledge of allergies, anaphylaxis and emergency procedures
- Effective schools having policies and procedures in place to ensure that the risks associated with severe allergies are minimised, so that all students can feel safe while at school.

This resource has been developed to assist schools in planning for and supporting students with severe allergies. The five sections following this introduction cover the Department's policy; facts about anaphylaxis; the roles and responsibilities of principals, school staff and parents/carers; management strategies; and communicating with staff, students and parents/carers. Appendixes feature a range of supplementary resources, including questions and answers, case studies, community fact sheet and a school checklist.

The key to prevention of anaphylaxis in schools is knowledge, risk minimisation awareness and planning. Schools are required to use these resources to assess and review their current management practices.

2. Department of Education and Early Childhood Development's Policy

Duty of care

All school staff have a duty to take reasonable steps to protect a student under their care from risks of injury that are reasonably foreseeable.

Education and Training Reform Act 2006 (Vic)

Under section 5.10.4 of the Education and Training Reform Act 2006 (Vic) the Minister may make orders, including matters outlined in Schedule 6, which includes the Anaphylaxis Management Policy.

The Victorian Registration and Qualifications Authority (VRQA) must not register a school that has enrolled a student who has been diagnosed as being at risk of anaphylaxis (in circumstances where the school knows or ought reasonably to know) unless it is satisfied that the school has developed an Anaphylaxis Management Policy that includes elements required by *Ministerial Order 90 (section 4.3.1(6) Education and Training Reform Act 2006 (Vic)). Ministerial Order 90* is reproduced on the next page.

Training

Teachers and other school staff who are responsible for the care of students at risk of anaphylaxis should receive training in how to recognise and respond to an anaphylactic reaction, including administration of adrenaline autoinjector devices, e.g. EpiPen® and Anapen® and risk minimisation strategies. Furthermore, all school staff (including volunteers) should have an understanding of the causes, signs and symptoms of anaphylaxis and their role in the school's first aid and emergency response procedures.

Information about current training providers is available from the Department's website, at www.sofweb.vic.edu.au/wellbeing/support/anaphyl.htm

Ministerial Order 90 – Anaphylaxis Management in School

Any school that has a student or students at risk of anaphylaxis must have the following in place:

1 School Anaphylaxis Management Policy (Clause 6).

2. Individual Anaphylaxis Management Plans for students diagnosed by a medical practitioner as being at risk of anaphylaxis (Clause 7).

These plans must:

- be developed in consultation with the student's parents/carers
- be put in place as soon as practicable, preferably before attendance by the student
- set out:
  - information about the diagnosis, including the type of allergy/allergens the student has
  - strategies to minimise the risk of exposure to allergens
  - the name of the person responsible for implementing the strategies
  - information on where the student's medication will be stored
  - the student's emergency contact details
  - an emergency procedures plan provided by the parent, which must be signed by the student's medical practitioner
- require the school to review the plan in consultation with the student's parents/carers annually, if the student's medical condition changes, and immediately after the student has an anaphylactic reaction at school
- state it is the student's parents'/carers' responsibility to provide the emergency procedures plan, inform the school if their child's medical condition changes and provide an up-to-date photo of the student for the plan.

1. Communication Plan (Clause 8)

This plan must:

- ensure that information is provided to all staff, students and parents about anaphylaxis and the school's anaphylaxis management policy
- include information about what steps will be taken to respond to an anaphylactic reaction by a student in a classroom, in the school yard, on school excursions, camps and special event days such as sport days.
- include procedures to inform volunteers and casual relief staff of students at risk and their role of responding to an anaphylactic student in their care
- ensure that school staff are briefed at least twice a year on:
  - the school's anaphylaxis management policy
  - causes, symptoms and treatment of anaphylaxis
  - identities of students diagnosed at risk of anaphylaxis
  - how to use an adrenaline autoinjecting device, including hands-on practice
  - the school's first aid and emergency response procedures.

2. Staff Training and Emergency Response (Clause 9)

- school staff who conduct classes which students at risk of anaphylaxis attend must have up-to-date training in an anaphylaxis management training course
- a sufficient number of staff with up-to-date training are present at other times when students are under the care of the school, such as excursions, yard duty, camps and special event days
- The school's first-aid procedures and the student's emergency procedures plan must be followed in responding to an anaphylactic reaction.

Schools should work in partnership with parents/carers and the student to support students to feel safe at school.

3. Facts about Anaphylaxis

What is anaphylaxis?

Anaphylaxis is a severe, rapidly progressive allergic reaction that is potentially life threatening. Although allergic reactions are common in children, severe life-threatening allergic reactions are uncommon and deaths are rare. However, deaths have occurred and anaphylaxis must therefore be regarded as a medical emergency requiring a rapid response.

What are the main causes?

Certain foods and insect stings are the most common causes of anaphylaxis. Eight foods cause 95 per cent of food allergic reactions in Australia and can be common causes of anaphylaxis:

- peanuts
- tree nuts (i.e. hazelnuts, cashews, almonds, walnuts, pistachios, macadamias, brazil nuts, pecans, chestnuts and pine nuts)
- eggs
- cow's milk
- wheat
- soy
- fish and shellfish (e.g. oysters, lobster, clams, mussel, shrimp, crab and prawns)
- sesame seeds.

Other common allergens include some insect stings, particularly bee stings but also wasp and jumper jack ant stings, tick bites, some medications (e.g. antibiotics and anaesthetic drugs) and latex.

Signs and symptoms

Mild to Moderate Allergic Reaction can include:

- swelling of the lips, face and eyes
- hives or welts
- tingling mouth
- abdominal pain and/or vomiting (these are signs of a severe allergic reaction to insects)

Anaphylaxis (Severe Allergic Reaction) can include:

- difficult/noisy breathing
- swelling of tongue
- swelling/tightness in throat
- difficulty talking and/or hoarse voice
- wheeze or persistent cough
- persistent dizziness or collapse
- pale and floppy (young children)

Note: Symptoms usually develop within 10 minutes to several hours after exposure to an allergen, but can appear within a few minutes.

How can anaphylaxis be prevented?

The key to prevention of anaphylaxis in schools is knowledge of those students who are at risk, awareness of triggers (allergens) and avoidance of exposure to these.

Schools need to work with parents/carers and students to ensure that certain foods or items are kept away from the student while at school.

Appendix 2 provides examples of a range of preventive strategies that schools can implement for in-school and out-of-school settings.

How can anaphylaxis be treated?

Adrenaline given as an injection into the muscle of the outer mid-thigh is the most effective first aid treatment for anaphylaxis.

Children diagnosed as being at risk of anaphylaxis are prescribed adrenaline in an autoinjector for administration in an emergency. The two most common brands of autoinjector available in Australia are EpiPen® and Anapen®. Children under 20 kilograms are prescribed a smaller dosage of adrenaline, through an EpiPen®Jr or Anapen®Jr. These adrenaline autoinjectors are designed so that anyone can use them in an emergency.

Once a child has received the adrenaline, it is important that they remain lying down with feet elevated. If this is not possible due to a difficulty in breathing, the child should remain seated. It is very important for the child to remain where they are and not be made to stand or walk.

4. Roles and Responsibilities

School principals' role and responsibilities

School principals have overall responsibility for implementing strategies and processes for ensuring a safe and supporting environment for students at risk of anaphylaxis. They are required to undertake the following.

1.	Implement a School Anaphylaxis Management Policy.
2.	Actively seek information to identify students with severe life-threatening allergies at enrolment or at the time of diagnosis (whichever is earlier).
3.	Request that parents/carers provide an ASCIA (Australasian Society of Clinical Immunology and Allergy) Action Plan for Anaphylaxis, which has been signed by the student's medical practitioner and that contains an up-to-date photograph of the student (see Appendix 1).
4.	Meet with parents/carers to develop an Anaphylaxis Management Plan for the student. This includes documenting practical strategies for in-school and out-of-school settings to minimise the risk of exposure to allergens, and nominating staff who are responsible for their implementation (see Appendixes 1 and 2). The risk minimisation plan should be customised to the particular student, based on the potential for him or her to be exposed to allergens. This should include strategies for activities within the school (e.g. during cooking and art classes) and at external events (e.g. swimming sports, camps, excursions and interstate/overseas trips).
5.	If using an external canteen provider, schools must ensure that the provider can demonstrate satisfactory training in the area of anaphylaxis and its implications for food-handling practices. This may include careful label reading, and an understanding of the major food allergens that trigger anaphylaxis and cross-contamination issues specific to food allergies.
6.	Ensure that parents/carers provide the student's autoinjector and that it is not out-of-date.
7.	Develop a communication plan to provide information to all staff, students and parents/carers about anaphylaxis and the school's anaphylaxis management policy.
8.	Ensure that there are procedures in place for informing casual relief teachers of the identities of students at risk of anaphylaxis and the steps required for prevention and emergency response. This can include providing copies and/or displaying the student's ASCIA Action Plan for Anaphylaxis in canteens, classrooms and staffrooms (see privacy considerations at the end of Section 6).
9.	Ensure that all school staff are briefed at least twice a year by a staff member who has up-to-date anaphylaxis management training on: • the school's anaphylaxis management policy • the causes, symptoms and treatment of anaphylaxis • the identities of students diagnosed at risk and location of their medication • how to use an adrenaline autoinjecting device, including hands-on practice with a trainer adrenaline autoinjecting device (which does not contain adrenaline) • the school's first aid and emergency procedures.
10.	Allocate time, such as during staff meetings, to discuss, practise and review the school's management strategies for students at risk of anaphylaxis. Practise using the trainer adrenaline autoinjectors as a group.
11.	Encourage ongoing communication between parents/carers and staff about the current status of the student's allergies, the school's policies and their implementation.
12.	Ensure that the student's Anaphylaxis Management Plan is reviewed annually in consultation with parents. However, it should also be reviewed when the student's medical condition changes, and reviewed immediately after a student has an anaphylactic reaction at school.

Role and responsibilities of all school staff

School staff have a duty to take reasonable steps to protect a student under their care from risks of injury that are reasonably foreseeable. This includes administrators, canteen staff, casual relief staff, specialist staff, sessional teachers and volunteers. Staff are required to do the following.

1.	Know and understand the School Anaphylaxis Management Policy.
2.	Know the identity of students who are at risk of anaphylaxis.
3.	Understand the causes, symptoms, and treatment of anaphylaxis.
4.	Obtain regular training in how to recognise and respond to an anaphylactic reaction, including administering an adrenaline autoinjector.
5.	Keep a copy of each student's ASCIA Action Plan for Anaphylaxis, or know where to find one quickly, and follow it in the event of an allergic reaction.
6.	Know the school's first aid emergency procedures and their role in relation to responding to an anaphylactic reaction.
7.	Know where students' adrenaline autoinjectors are kept. (Remember that the adrenaline autoinjector is designed so that anyone can administer it in an emergency.)
8.	Know and follow the prevention and risk minimisation strategies in the student's Anaphylaxis Management Plan.
9.	Plan ahead for special class activities (e.g. cooking, art and science classes), or special occasions (e.g. excursions, incursions, sport days, camp, cultural days, fetes and parties). Work with parents/carers to provide appropriate food for their child if the food the school/class is providing may present a risk for him or her.
10.	Avoid the use of food treats in class or as rewards, as these may contain hidden allergens. Consider the alternative strategies provided in this document (see Appendix 2). Work with parents/carers to provide appropriate treats for anaphylactic students.
11.	Be aware of the possibility of hidden allergens in foods and of traces of allergens when using items such as egg or milk cartons in art or cooking classes.
12.	Be aware of the risk of cross-contamination when preparing, handling and displaying food.
13.	Make sure that tables and surfaces are wiped down regularly and that students wash their hands after handling food.
14.	Raise student awareness about severe allergies and the importance of their role in fostering a school environment that is safe and supportive for their peers.

Role and responsibilities of first aid coordinators/school nurses

First aid coordinators or school nurses should take a lead role in supporting principals and teachers to implement prevention and management strategies for the school. They are required to do the following.

1.	Work with principals to develop, implement and review the school's Anaphylaxis Management Policy and every student's Anaphylaxis Management Plan.
2.	Obtain regular training in how to recognise and respond to an anaphylactic reaction, including administering an adrenaline autoinjector (i.e. EpiPen®/Anapen®).
3.	Provide or arrange regular training to other staff members to recognise and respond to anaphylactic reactions.
4.	Keep an up-to-date register of students at risk of anaphylaxis.
5.	Regularly review the **individual** Anaphylaxis Management Plans to: • Ensure that students' emergency contact details are up-to-date • Ensure that the device-specific Action Plan for Anaphylaxis matches the supplied autoinjector • check that the adrenaline autoinjector is not out-of-date, such as at the beginning or end of each term. For those students with an EpiPen®, check the adrenaline is not cloudy through the EpiPen® window • inform parents/carers in writing a month prior to the expiry date if the adrenaline autoinjector needs to be replaced. Ensure that adrenaline autoinjectors are stored correctly (at room temperature and away from light) in an unlocked, easily accessible place, and that this storage area is appropriately labelled.
6.	Work with staff to conduct regular risk prevention, minimisation, assessment and management strategies.
7.	Work with staff to develop strategies to raise school staff, student and community awareness about severe allergies.
8.	Provide or arrange post-incident support (e.g. counselling) to students and staff, if appropriate.

Role and responsibilities of parents/carers of a student at risk of anaphylaxis

1.	Inform the school, either at enrolment or diagnosis, of the student's allergies, and whether the student has been diagnosed as being at risk of anaphylaxis.
2.	Obtain an ASCIA Action Plan for Anaphylaxis from the student's medical practitioner that details their condition and any medications to be administered and provide this to the school.
3.	Meet with the school to develop the student's Anaphylaxis Management Plan.
4.	Provide the adrenaline autoinjector (EpiPen®/Anapen®) and any other medications to the school.
5.	Replace the adrenaline autoinjector and any other medication before their expiry date.
6.	Assist school staff in planning and preparation for the student prior to school camps, field trips, incursions, excursions or special events (e.g. class parties, cultural days, fetes or sport days). Supply alternative food options for the student when needed.
7.	Inform staff of any changes to the student's emergency contact details.
8.	Participate in reviews of the student's Anaphylaxis Management Plan: • when there is a change to the student's condition • immediately after the student has an anaphylactic reaction at school • at its annual review.

5. Anaphylaxis Management

School Anaphylaxis Management Policy

Section 4.3.1(6) of the *Education and Training Reform Act 2006 (Vic)* requires a school to have Anaphylaxis Management Policy in place when it has enrolled a student in circumstances where the school knows, or ought reasonably to know, that the student has been diagnosed as being at risk of anaphylaxis. This policy must contain the items outlined in *Ministerial Order 90 – Anaphylaxis Management in Schools*.

Anaphylaxis Management Plan

Every student who has been diagnosed as at risk of anaphylaxis must have an individual Anaphylaxis Management Plan, which clearly sets out the following.

1.	Information about the diagnosis, including the student's specific allergy/allergens.
2.	Strategies to minimise the risk of exposure to allergen.
3.	The name of the person responsible for implementing the strategies.
4.	Information on where the student's medication will be stored.
5.	The student's emergency contact details.
6.	An ASCIA Action Plan for Anaphylaxis signed by the student's medical practitioner.
7.	The requirement for the school to review the plan in consultation with the student's parents/carers annually, if the student's medical condition changes, and immediately after the student has an anaphylactic reaction at school.
8.	The responsibility of the student's parents/carers to: • provide a copy of the student's ASCIA Action Plan for Anaphylaxis signed by the student's medical practitioner • inform the school if their child's medical condition changes • provide an up-to-date photo of the student for the plan.

The Anaphylaxis Management Plan should also include the student's ASCIA Action Plan for Anaphylaxis, which sets out the emergency procedures to be taken in the event of an allergic reaction. It is the responsibility of parents/carers to complete an ASCIA Action Plan for Anaphylaxis, in consultation with their child's medical practitioner, and to provide a copy to the school. It must be signed by the student's medical practitioner, and include an up-to-date photograph of the student.

A copy of the student's ASCIA Action Plan for Anaphylaxis should be kept in various locations around the school, including in the student's classroom, the canteen, the sick bay and the school office. It should be visible and/or easily accessible by staff in the event of an incident. (See end of Section 6 in relation to privacy considerations.)

Appendix 1 gives a template for an Anaphylaxis Management Plan, which can be downloaded from the Department's website, at www.sofweb.vic.edu.au/wellbeing/support/anaphyl.htm

Keep information up-to-date

As a student's allergies may change with time, it is important for schools to ensure that the student's Anaphylaxis Management Plan and ASCIA Action Plan for Anaphylaxis are kept current and reviewed with the student's parents/carers annually, when there is a change in the student's medical condition, or immediately after the student has an anaphylactic reaction at school.

Storage and accessibility of adrenaline autoinjectors

Adrenaline given through an autoinjector (EpiPen®/Anapen®) to the outer mid-thigh muscle is the most effective treatment for anaphylaxis. Administering adrenaline can reverse potentially life-threatening symptoms, such as shortness of breath or swelling of the face and throat within minutes.

Children diagnosed as being at risk of anaphylaxis are prescribed adrenaline in an autoinjector, such as EpiPen® and Anapen®. Children under 20 kg are prescribed a smaller dosage of adrenaline, such as the EpiPen®Jr or Anapen®Jr. The adrenaline autoinjectors are designed so that anyone can use them in an emergency. If a student has been prescribed an adrenaline autoinjector, it must be provided by the student's parent/carers to the school.

1.	Adrenaline autoinjectors should be: • stored correctly and be able to be accessed quickly, because, in some cases, exposure to an allergen can lead to an anaphylactic reaction in as little as five minutes • stored in an unlocked, easily accessible place away from direct heat. They should not be stored in the refrigerator or freezer • clearly labelled with the student's name • signed in and out when taken from its usual place, e.g. for camps or excursions.
2.	Each student's adrenaline autoinjector should be distinguishable from other students' adrenaline autoinjectors and medications.
3.	All staff should know where adrenaline autoinjectors are located.
4.	A copy of the student's ASCIA Action Plan for Anaphylaxis should be kept with their adrenaline autoinjector.
5.	Depending on the speed of past reactions, it may be appropriate to have the adrenaline autoinjector in class or in a yard-duty bag.
6.	It is important that trainer adrenaline autoinjectors (which do not contain adrenaline) are kept in a separate location from students' adrenaline autoinjectors.

Schools may consider purchasing an adrenaline autoinjector for general use as a 'backup' to those supplied by parents/carers, particularly if there is no single, central, easily accessible location on the site. The dosage of an adrenaline autoinjector for general use should be 0.3 ml of adrenaline, which can be given to any student who weighs over 20 kg. It should be clearly labelled as the adrenaline autoinjector for general use and must be kept with the appropriate Action Plan for Anaphylaxis for general use (i.e. EpiPen® or Anapen® specific, depending on device stated in the student's plan).

It is also important to ensure that adrenaline autoinjectors are not out-of-date (i.e.past the expiry date printed on them). They should last for at least 12 months. It is the parents'/carers' responsibility to supply their child's adrenaline autoinjector to the school and to replace it before it is out of date. However, a designated staff member, such as the school nurse or first aid coordinator, should regularly check (e.g. at the beginning or end of each term) the expiry date of adrenaline autoinjectors and that the EpiPens® are not cloudy or have substances floating in them. If the designated school staff member identifies a problem they should send a written reminder to the student's parents/carers to replace the adrenaline autoinjector.

EpiClub is a free service that sends a reminder by email, SMS or standard mail prior to the expiry date of an EpiPen®. Schools can register with EpiClub at http://www.epiclub.com.au

The ANAlert Expiry Alert is a free alert service that sends reminders to replace an Anapen® before it expires, helping ensure it is within its 'use by' or 'expiry date'. ANAlert can be accessed at www.analert.com.au

Prevention strategies

The key to prevention of anaphylaxis is the identification of triggers (allergens) and prevention of exposure to these. For students who have been diagnosed with a severe allergy, schools can put in place a range of practical prevention strategies to minimise exposure to known allergens.

When considering appropriate prevention strategies, schools should take into account factors such as the allergen involved, the age of the student and the severity of the allergy (based on information provided by the student's parent/carers from their child's medical practitioner).

Risk assessment

Schools should undertake a risk assessment based on individual student's usual routine (including specialist and elective classes); as well as plan for special circumstances and environments (e.g. class parties, sports days, cultural days, fetes, camps, incursions or excursions). These risk assessments are individual and should be undertaken in all the environments the students is in during the school year/term.

It is useful to discuss and establish emergency procedures for various scenarios (e.g. if an anaphylactic reaction occurs in the classroom, while on yard duty or after school) and have drills to assess the effectiveness these procedures. Also be aware that the research shows that students in the 10–18-year-age group are at a higher risk of suffering a fatal anaphylactic reaction.

Consultation

It may also be necessary to consult with parents/carers and other relevant members of the community, such as teachers, canteen staff and camp/excursion organisers.

Food bans?

Banning of food or other products is not recommended, because it can create complacency among staff and students and does not eliminate the presence of hidden allergens. It is also very difficult to monitor and enforce such a ban. It is better for school communities to become aware of the risks associated with anaphylaxis, and to implement practical, age-appropriate strategies to minimise exposure to known allergens.

A ban on peanut and nut products within a school is not also recommended, but it may be agreed to by a school and its community. If a school does decide to ban peanut or nut products it should not, however, claim to be 'peanut or nut free'. Evidence from experts indicates that this type of claim is not reliable and may lead to a false sense of security about exposure to peanuts and nuts.

Statistics show that peanuts and nuts are the most common trigger for an anaphylactic reaction. To minimise the risk of a first-time reaction to peanuts and nuts, schools should not use peanuts, nuts, peanut butter or other peanut or nut products in curricular or extracurricular activities. Remember, that school activities should never place pressure on any students to try foods, whether they contain a known allergen or not. Furthermore, it is important to note that common allergens in school-age children are not just restricted to peanuts and tree nuts, but also includes eggs, dairy, soy, wheat, sesame seeds, fish and shellfish.

More information about peanut and nut banning can be found in the *ASCIA Guidelines for Prevention of Food Anaphylactic Reactions in Schools*, available from the ASCIA website **(at www.allergy.org.au)**.

Specific strategies

Specific strategies should be put in place for in-school and out-of-school settings, including:

- during classroom activities (including class rotations, specialist and elective classes)
- in canteens or during lunch or snack times
- before and after school, in the yard and during breaks
- for special events, including incursions, sport days, cultural days, fetes or class parties
- for excursions and camps.

A range of practical prevention strategies for in-school and out-of-school settings are set out in Appendix 2. Anaphylaxis Australia Inc. has also published a brochure outlining risk minimisation strategies that could be implemented in common school activities (available at www.allergyfacts.org.au/component/virtuemart/).

Staff training

Teachers and other school staff responsible for the care of students at risk of anaphylaxis should be trained in how to recognise and respond to an anaphylactic reaction, including administering an adrenaline autoinjector (i.e. EpiPen®/Anapen®). This training may include administrators, canteen staff, specialist staff, casual staff and volunteers. In addition, all school staff (including volunteers, casual relief teachers, specialist staff, sessional staff, canteen staff and administrative staff) should have an understanding of the causes, signs and symptoms of anaphylaxis and of their role in the school's first aid and emergency response procedures.

Emergency response

It is important for schools to have in place first aid and emergency response procedures that allow staff to react quickly if an anaphylactic reaction occurs, for both in-school and out-of-school settings. Drills to test the effectiveness of these procedures should be undertaken.

Self-administration of the adrenaline autoinjector (e.g. EpiPen®/Anapen®)

The decision whether a student can carry their own adrenaline autoinjector should be made when developing the student's Anaphylaxis Management Plan, in consultation with the student, the student's parents/carers and the student's medical practitioner.

It is important to note that students have the right to self-administer if they are able to at the time, but even an 18-year-old may not physically be able to self-administer due to the effects of a reaction. Staff still have a duty of care to administer an adrenaline autoinjector for students who carry their own adrenaline autoinjectors.

If a student self-administers an adrenaline autoinjector, another staff member must be alerted and an ambulance called (on emergency number 000/112). It is important that the student does not stand and is not moved unless in further in danger (e.g. the anaphylactic reaction was caused by a bee sting and the bee hive is close by).

If a student carries their own adrenaline autoinjector, a second adrenaline autoinjector (provided by the parent/carer) should be kept on site in an easily accessible, unlocked location that is known to all staff.

Responding to an incident

Where possible, only staff with training in the administration of the adrenaline autoinjector should administer the student's adrenaline autoinjector. However, adrenaline autoinjectors are designed for general use and, in the event of an emergency, one may be administered by any person, following the instruction in the student's ASCIA Action Plan for Anaphylaxis.

How to administer the New Look EpiPen®	
1.	Remove from plastic container.
2.	Check the 'window' to make sure it is clear; and check the expiry date.
3.	Form a fist around EpiPen® and pull off the blue safety cap.
4.	Place orange end against the student's outer mid-thigh (with or without clothing).
5.	Push down hard until a click is heard or felt and hold in place for 10 seconds.
6.	Remove EpiPen®.
7.	Massage injection site for 10 seconds.
8.	Note the time you administered the EpiPen®.
9.	The used autoinjector must be handed to the ambulance paramedics along with the time of administration.

How to administer an Anapen®	
1.	Remove from box container and check the expiry date.
2.	Remove black needle shield.
3.	Form a fist around Anapen® and remember to have your thumb in reach of the red button, then remove grey safety cap.
4.	Place needle end against the student's outer mid-thigh.
5.	Press the red button with your thumb so it clicks and hold it for 10 seconds.
6.	Replace needle shield and note the time you administered the Anapen®.
7.	The used autoinjector must be handed to the ambulance paramedics along with the time of administration.

Always call an ambulance as soon as possible (000)

When using a standard phone call 000 (triple zero) for an ambulance.

If you are using a GSM digital mobile phone which is out of range of your service provider, displays a message indicating emergency calls only, or does not have a SIM card, call 112.

If an adrenaline autoinjector is administered, the school must	
1.	**Immediately** call an ambulance (000/112).
2.	Lay the student flat and elevate their legs. Do not stand or walk. If breathing is difficult for them, allow them to sit but not to stand.
3.	Reassure the student experiencing the reaction as they are likely to be feeling anxious and frightened as a result of the reaction and the side-effects of the adrenaline. Watch the student closely in case of a worsening condition. Ask another staff member to move other students away and reassure them elsewhere.
4.	In the rare situation where there is no marked improvement and **severe symptoms** (as described in the ASCIA Action Plan for Anaphylaxis) are present, a second injection (of the same dosage) may be administered after five minutes, if a second autoinjector is available.
5.	**Then** contact the student's emergency contacts.
6.	**Later**, contact Emergency Services Management, Department of Education and Early Childhood Development to report the incident on 9589 6266 (available 24 hours a day, 7 hours a week).

First-time reactions

If a student has a severe allergic reaction, but has not been previously diagnosed with an allergy or as being at risk of anaphylaxis, an ambulance should be called immediately. Follow any instructions given by emergency services (which may include administering the autoinjector for general use), as well as the school's normal first aid emergency procedures.

Post-incident support and review processes

An anaphylactic reaction can be a very traumatic experience for the student, others witnessing the reaction, and parents/carers. In the event of an anaphylactic reaction, students and staff may benefit from post-incident counselling, provided by the school nurse, guidance officer, student welfare coordinator or school psychologist.

If there has been an anaphylactic reaction, the following procedures should be undertaken.

Review management processes	
1.	The adrenaline autoinjector must be replaced by the parent/carer as soon as possible.
2.	If the adrenaline autoinjector for general use has been used this should also be replaced as soon as possible.
3.	Appropriate steps should be taken to reassure the student and parents/carers. This may include: • closer monitoring of the student by school staff • having the student carry the adrenaline autoinjector at all times (depending on the student's age, maturity and ability) • staff undergoing renewed training.

6. Communicating with Staff, Students and Parents/Carers

It is important to work with the whole-school community to better understand how to provide safe and supporting environments for all students, including students with severe allergies.

Principals should develop a communication plan to provide information about severe allergies and the school's policies to staff, students and parents/carers.

Raising staff awareness

All staff involved in the care of students at risk of anaphylaxis (including class teachers, office staff, volunteers, casual relief teachers, specialist staff, canteen staff, and administrative and other office staff) should know the following.

What all staff need to know	
1.	The school's anaphylaxis management policy.
2.	What steps to take in responding to an anaphylactic reaction by a student in a classroom, in the school yard, on school excursions, camps and special event days (e.g. sport days).
3.	Their role in responding to an anaphylactic student in their care.
4.	The causes, symptoms and treatment of anaphylaxis.
5.	The identity of all students diagnosed at risk of anaphylaxis.
6.	How to use an adrenaline autoinjecting device, through hands-on practice with a trainer adrenaline autoinjecting device (which does not contain adrenaline).
7.	The school's first aid and emergency response procedures.

Some ways to achieve this include allocating time, such as at staff meetings, to discuss, practise and review the school's management strategies for students at risk of anaphylaxis; and by providing and/or displaying copies of the student's ASCIA Action Plan for Anaphylaxis in canteens, classrooms and staffrooms.It is particularly important to ensure that there are procedures in place for informing casual relief teachers of students at risk of anaphylaxis and the steps required for prevention and emergency response.

A designated staff member, such as the daily organiser or school operations manager, should have responsibility for briefing new staff (including administration and office staff, canteen staff, sessional teachers, specialist teachers, volunteers or casual relief staff) about particular students at risk of anaphylaxis, the school's policies and prevention strategies.

Raising student awareness

Peer support is an important element of support for students at risk of anaphylaxis. Staff can raise awareness in school through fact sheets or posters displayed in hallways, canteens and classrooms. Class teachers can discuss the topic with students in class, with a few simple key messages, outlined in the following.

Student messages about anaphylaxis	
8.	Always take food allergies seriously – severe allergies are no joke.
9.	Don't share your food with friends who have food allergies.
10.	Wash your hands after eating.
11.	Know what your friends are allergic to.
12.	If a school friend becomes sick, get help immediately.
13.	Be respectful of a school friend's adrenaline autoinjector.
14.	Don't pressure your friends to eat food that they are allergic to.

Source: *Be a Mate kit*, published by Anaphylaxis Australia Inc.

It is important to be aware that a student at risk of anaphylaxis may not want to be singled out or be seen to be treated differently. Also be aware that bullying of students at risk of anaphylaxis can occur in the form of teasing, tricking a student into eating a particular food or threatening a student with the substance that they are allergic to, such as peanuts. Talk to the students involved so they are aware of the seriousness of an anaphylactic reaction. Any attempt to harm a student diagnosed at risk of anaphylaxis must be treated as a serious and dangerous incident and treated accordingly. *Schools can refer to the Building Respectful and Safe Schools: A resource for school communities*, an anti-bullying resource for ideas and strategies for dealing with bullying situations (available at www.education.vic.gov.au/respect).

Work with parents/carers of students at risk of anaphylaxis

Schools should be aware that parents/carers of a child who is at risk of anaphylaxis may experience considerable anxiety about sending their child to school. It is important to develop an open and cooperative relationship with them so that they can feel confident that appropriate management strategies are in place. Aside from implementing practical prevention strategies in schools, the anxiety that parents/carers and students may feel can be considerably reduced by regular communication and increased education, awareness and support from the school community.

Engage the broader school community

Schools can raise awareness about anaphylaxis in the school community through education campaigns, so that parents/carers of all students have an increased understanding of the condition.

Fact sheets to promote greater awareness of severe allergies in the school community can be downloaded from the Department's Student Wellbeing website at http://www.education.vic.gov.au/healthwellbeing/health/anaphylaxisschools.htm

Privacy considerations

Schools should be aware that the ASCIA Action Plan for Anaphylaxis contains health information of the student, and its use/disclosure should therefore be carefully monitored. The parents/carers and the student should be advised as to how it will be used within the school to enable staff to act quickly and appropriately in the event of an anaphylactic reaction.

Appendix 1: Anaphylaxis Management Plan

COVER SHEET

This plan is to be completed by the principal or nominee on the basis of information from the student's medical practitioner (ASCIA Action Plan for Anaphylaxis) provided by the parent/carer.

Is the parents'/carers' responsibility to provide the school with a copy the student's ASCIA Action Plan for Anaphylaxis containing the emergency procedures plan (signed by the student's medical practitioner) and an up-to-date photo of the student – to be appended to this plan; and to inform the school if their child's medical condition changes.

School			Phone	
Student's name				
Date of birth			Year level	
Severely allergic to				
Other health conditions				
Medication at school				
Emergency contacts – parent/carer	**Parent/carer (1)**		**Parent/carer (2)** *(if available)*	
	Name		Name	
	Relationship		Relationship	
	Home phone		Home phone	
	Work phone		Work phone	
	Mobile		Mobile	
	Address		Address	
Other emergency contacts if parent/carer not available	**Other contact (1)**		**Other contact (2)** *(if available)*	
	Name		Name	
	Relationship		Relationship	
	Home phone		Home phone	
	Work phone		Work phone	
	Mobile		Mobile	
	Address		Address	
Medical practitioner contact	Name			
	Phone			
Emergency care to be provided at school				
Storage for adrenaline autoinjector (device specific) (i.e. EpiPen®/Anapen®)				

ANAPHYLAXIS MANAGEMENT PLAN

(To be completed by principal or nominee and signed by both principal/nominee and parent/carer)

The following Anaphylaxis Management Plan has been developed with my knowledge and input and will be reviewed on (insert date of proposed review).			...../...../.....
Signature of parent/carer	.....	Date	...../...../.....
Signature of principal (or nominee)	.....	Date	...../...../.....
Risk minimisation strategies	**Refer to Appendix 2 – prevention strategies**		

ENVIRONMENT

To be completed by principal or nominee. Please consider each environment/area (on and off school site) the student will be in for the term, e.g. canteen, food tech room, sports oval, excursions and camps etc.

Name of environment/ area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/ area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/ area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/ area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**
Name of environment/ area			
Risk identified	**Actions required to minimise the risk**	**Who is responsible?**	**Completion date?**

ASCIA ACTION PLAN FOR ANAPHYLAXIS

(Attach a copy of this plan here, which parents/carers are to supply (outlining emergency procedures, signed by the student's medical practitioner, with an up-to-date photo of the child).

ascia
australasian society of clinical immunology and allergy
www.allergy.org.au

ACTION PLAN FOR Anaphylaxis

for use with EpiPen® or Epipen® Jr adrenaline autoinjectors (with blue safety release and orange needle end)

Name:

Date of birth:

Photo

Confirmed allergens:

Family/emergency contact name(s):

Work Ph:

Home Ph:

Mobile Ph:

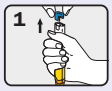
Plan prepared by:

Dr

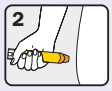
Signed

Date:

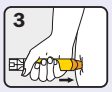
How to give EpiPen® or EpiPen® Jr



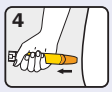
Form fist around EpiPen® and PULL OFF BLUE SAFETY RELEASE.



PLACE ORANGE END against outer mid-thigh (with or without clothing).



PUSH DOWN HARD until a click is heard or felt and hold in place for 10 seconds.



REMOVE EpiPen®. Massage injection site for 10 seconds.

MILD TO MODERATE ALLERGIC REACTION

- swelling of lips, face, eyes
- hives or welts
- tingling mouth
- abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

ACTION

- **For insect allergy, flick out sting if visible. Do not remove ticks**
- Stay with person and call for help
- Give medications (if prescribed) .....
  Dose: .....
- Locate EpiPen® or EpiPen® Jr
- Contact family/emergency contact

Watch for any one of the following signs of Anaphylaxis

ANAPHYLAXIS (SEVERE ALLERGIC REACTION)

- difficult/noisy breathing
- swelling of tongue
- swelling/tightness in throat
- difficulty talking and/or hoarse voice
- wheeze or persistent cough
- persistent dizziness or collapse
- pale and floppy (young children)

ACTION

1. **Lay person flat, do not stand or walk. If breathing is difficult allow to sit**
2. **Give EpiPen® or EpiPen® Jr**
3. **Phone ambulance*- 000 (AU), 111 (NZ), 112 (mobile)**
4. **Contact family/emergency contact**
5. **Further adrenaline doses may be given if no response after 5 minutes (if another adrenaline autoinjector is available)**

If in doubt, give EpiPen® or EpiPen® Jr

EpiPen® Jr is generally prescribed for children aged 1-5 years.
*Medical observation in hospital for at least 4 hours is recommended after anaphylaxis.

Additional information

Appendix 2: Prevention Strategies

In-school settings

Classrooms	
1.	Keep a copy of the student's ASCIA Action Plan for Anaphylaxis in the classroom.
2.	Liaise with parents/carers about food-related activities ahead of time.
3.	Use non-food treats where possible, but if food treats are used in class it is recommended that parents/carers of anaphylactic students provide a treat box with alternative treats. Treat boxes should be clearly labelled and only handled by the student.
4.	Never give food from outside sources to a student who is at risk of anaphylaxis.
5.	Treats for the other students in the class must not contain the substance to which the student is allergic. It is recommended to use non-food treats where possible.
6.	Products labelled 'may contain traces of nuts' should not be served to students allergic to nuts.
7.	Be aware of the possibility of hidden allergens in cooking, food technology, science and art classes (e.g. egg or milk cartons). Note: that year level/specialist teachers must consider the risk-minimisation strategies of the student diagnosed at risk, even if that student is not in their class.
8.	Have regular discussions with students about the importance of washing hands, eating their own food and not sharing food.
9.	A designated staff member should inform casual relief teachers and specialist teachers of students at risk of anaphylaxis, the preventive strategies in place and the school's emergency procedures. Provide casual relief teachers with a procedure sheet and a copy of the student's ASCIA Action Plan for Anaphylaxis and a copy of the student's Anaphylaxis Management Plan.

Canteens	
1.	If using an external canteen provider, the provider should be able to demonstrate satisfactory training in the food allergen management and its implications on food-handling practices, including knowledge of the major food allergens triggering anaphylaxis, cross-contamination issues specific to food allergy, label reading, etc.
2.	Refer to http://www.allergyfacts.org.au/component/virtuemart/
3.	Canteen staff, including volunteers, should be briefed about students at risk of anaphylaxis, preventative strategies in place and the information in their ASCIA Action Plan for Anaphylaxis. See http://www.health.vic.gov.au/foodsafety/downloads/allergen_intolerance_biz.pdf
4.	Some schools have the student's name and photo displayed in the canteen as a reminder to staff.
5.	Liaise with parents/carers about food for the student. Parents/carers are the best resource available to the school and should be used as such.
6.	Food banning is not generally recommended. Instead, a 'no-sharing' approach is recommended for food, utensils and food containers. However, school communities can agree to not stock peanut and tree nut products (e.g. hazelnuts, cashews, almonds, etc.), including chocolate/hazelnut spreads.
7.	Products labelled 'may contain traces of nuts' should not be served to students allergic to nuts.

8.	Canteens should provide a range of healthy meals/ products that are designed to exclude any traces of peanut or other nut products.
9.	Physical isolation of students at risk of anaphylaxis is not recommended. Nut-free tables or nut-free zones may be appropriate for younger children.
10.	Be wary of contamination of other foods when preparing, handling or displaying food. For example, a tiny amount of butter or peanut butter left on a knife and used elsewhere may be enough to cause a severe reaction in someone who is at risk of anaphylaxis from cow's milk products or peanuts.
11.	Make sure that tables and surfaces are wiped down regularly.
12.	Refer to 'Safe Food Handling' in the School Policy and Advisory Guide, available at http://www.education.vic.gov.au/management/governance/spag/governance/safetymgt/foodhandling.htm

Yard	
1.	If a school has a student who is at risk of anaphylaxis, sufficient staff on yard duty must be trained in the administration of the adrenaline autoinjector (i.e. EpiPen®/ Anapen®) to be able to respond quickly to an anaphylactic reaction if needed.
2.	The adrenaline autoinjector should be easily accessible from the yard, and staff should be aware of its exact location. **(Remember that an anaphylactic reaction can occur in as little as five minutes.)**
3.	Schools must have a Communication Plan in place so the student's medical information and medication can be retrieved quickly if a reaction occurs in the yard. This may include options of all yard duty staff carrying emergency cards in yard-duty bags, walkie talkies or yard-duty mobile phones. All staff on yard duty must be aware of the emergency management plan and how to notify the general office/ first aid team of an anaphylactic reaction in the yard.
4.	Yard duty staff must also be able to identify those students at risk of anaphylaxis.
5.	The teacher must direct another person to bring the adrenaline autoinjector to them and should never leave a student who is experiencing an anaphylactic reaction unattended.
6.	A student experiencing an anaphylactic reaction should not be moved.
7.	Students with anaphylactic responses to insects should be encouraged to stay away from water or flowering plants. Schools should liaise with parents/carers to encourage students to wear light or dark rather than bright colours, as well as closed shoes and long-sleeved garments when outdoors.
8.	Consideration should be given to the placement plants and sources of water in the playground so that students at risk of anaphylaxis from insect stings can avoid these areas without being unfairly restricted in their movement. Keep lawns and clover mowed and outdoor bins covered.
9.	The student should keep drinks and food covered while outdoors.

Special events (e.g. sporting events, incursions, class parties, etc.)	
1.	Staff must know where the adrenaline autoinjector is located and how to access it if required.
2.	Staff should avoid using food in activities or games, including as rewards.
3.	For special occasions, class teachers should consult parents/carers in advance to either develop an alternative food menu or request the parents/carers to send a meal for the student. In all situations, the child at risk of anaphylaxis should not be placed in a position in which they are discriminated against.
4.	Parents/carers of other students should be informed in advance about foods that may cause allergic reactions in students at risk of anaphylaxis and requested that they avoid them in treats brought from home.
5.	Party balloons should not be used if any student is allergic to latex.
6.	Swimming caps should not be used for a student who is allergic to latex.

Out of school settings

Travel to and from school by bus
Schools should involve parents/carers in discussions with the bus company on safety strategies and emergency medication and response prior to the students travelling on the school bus.

Field trips/excursions, sporting events	
1.	The student's adrenaline autoinjector, ASCIA Action Plan and a mobile phone must be taken on all field trips/excursions.
2.	A staff member or team of staff trained in the recognition of anaphylaxis and the administration of the adrenaline autoinjector must accompany the student on field trips or excursions. The number of staff attending should be determined by a risk assessment. All staff members present during the field trip or excursion need to be aware of the identity of any student at risk of anaphylaxis attending.
3.	Staff must develop first aid procedures plan that sets out clear roles and responsibilities in the event of an anaphylactic reaction. These first aid procedure plans will vary according to the number of anaphylactic students attending, the nature of excursion/sporting event, size of venue, distance from medical assistance, the structure of excursion and corresponding staff–student ratio.
4.	The school should consult parents/carers of anaphylactic students in advance to discuss issues that may arise; to develop an alternative food menu; or request the parent/carer send a meal (if required).
5.	Parents/carers may wish to accompany their child on field trips and/or excursions. This should be discussed with parents/carers as another strategy for supporting the anaphylactic student.
6.	Consider the potential exposure to allergens when consuming food on buses. If this risk is assessed as too high it may well be deemed necessary for students to refrain from eating on the school bus.

Camps and Remote Settings	
1.	Schools must have a risk minimisation strategy in place for students at risk of anaphylaxis for school camps, developed in consultation with their parents/carers, and the students' medical practitioner and camp owners prior to the camp dates.
2.	The camp provider should be able to demonstrate satisfactory training in the management of food allergens and its implications for food handling practices; namely: • knowledge of the major food allergens that cause anaphylaxis • how to avoid cross-contamination • the consequences of cross-contamination of allergens for the food allergic individual. For further information, visit http://www.health.vic.gov.au/foodsafety/downloads/allergen_intolerance_biz.pdf
3.	Camps must be advised in advance of any students with food allergies.
4.	Schools should not sign any written disclaimer or statement from a camp owner/operator that indicates that the owner/operator is unable to provide food which is safe for students at risk of anaphylaxis. Schools have a duty of care to protect students in their care from reasonably foreseeable injury and this duty cannot be delegated to any third party.
5.	If a camp owner/operator cannot confirm with the school that it is able to provide food that is safe for anaphylactic students, then the school should consider using an alternative camp provider.
6.	If the school has concerns about the whether the food provided on a camp will be safe for students at risk of anaphylaxis, it should also consider alternative means for providing food for those students.
7.	Staff should liaise with parents/carers to develop alternative menus or allow students to bring their own meals.
8.	Camps should avoid stocking peanut or tree nut products, including nut spreads. Products that 'may contain' traces of nuts may be served, but not to students who are known to be allergic to nuts (unless it is specifically approved in their individual Anaphylaxis Management Plan).
9.	Use of other substances containing allergens should be avoided where possible.
10.	The student's adrenaline autoinjector, individual Anaphylaxis Management Plan, ASCIA Action Plan for Anaphylaxis and a mobile phone must be taken on camp. If mobile phone access is not available, an alternative method of communication in an emergency must be considered, e.g. a satellite phone.
11.	A team of staff who have been trained in the recognition of anaphylaxis and the administration of the adrenaline autoinjector must accompany the student on camp. However, all staff present need to be aware if there is a student at risk of anaphylaxis.
12.	Staff must develop first aid procedures that sets out clear roles and responsibilities in the event of an anaphylactic reaction.
13.	Know local emergency services, how to contact them and the time it will take to do so. Liaise with them before the camp.

14.	The adrenaline autoinjector should remain close to the student and staff must be aware of its location at all times.
15.	The adrenaline autoinjector should be carried in the school first aid kit; however, schools can consider allowing students, particularly adolescents, to carry their adrenaline autoinjector on camp. Remember that all staff members still have a duty of care towards the student even if they do carry their own adrenaline autoinjector. Schools should consider purchasing a backup adrenaline autoinjector to be kept in the first aid kit.
16.	Students with anaphylactic responses to insects should always wear closed shoes and long-sleeved garments when outdoors and should be encouraged to stay away from water or flowering plants.
17.	Cooking and art and craft games should not involve the use of known allergens.
18.	Consider the potential exposure to allergens when consuming food on buses and in cabins.
19.	Refer to 'Safe Food Handling' in the *School Policy and Advisory Guide*, available at http://www.education.vic.gov.au/management/governance/spag/governance/safetymgt/foodhandling.htm

Overseas travel	
1.	Where an excursion or camp is occurring overseas, schools should involve parents/carers in discussions regarding risk management well in advance.
2.	Investigate the potential risks and minimisation strategies for a student with anaphylaxis (e.g. airline travel regulations for passengers diagnosed at risk of anaphylaxis, the sourcing of safe foods, and the accessing of emergency medical assistance in the overseas destination). **Be aware this can involve a lengthy process of translation of names of allergens, emergency information and explanations about allergies and anaphylaxis, including students' ASCIA Action Plan.**

Work experience
Schools should involve parents, student and the employer in discussions regarding risk management prior to an anaphylactic student undertaking work experience.

Appendix 3: Anaphylaxis Management Plan

Q1.	**What is the difference between an allergy and anaphylaxis?**
	Not everyone with allergies will have anaphylaxis. In fact, it is estimated that anaphylaxis only affects a very small percentage of the population. During an anaphylactic reaction, a person may have breathing difficulties, swelling of the tongue, tightness in the throat, difficulty talking, a wheeze or persistent cough, and may even lose consciousness or collapse. Hives, welts, vomiting, diarrhoea and swelling by themselves are not symptoms of anaphylaxis, but they can be early warning signs.
Q2.	**How do I know if the anaphylactic student's adverse reaction is anaphylaxis and not asthma?**
	Unlike asthma, anaphylaxis can affect more than one system in the body. This means that, during a reaction, you may see one or more of the following symptoms: swelling or welts on the skin, stomach pain, vomiting or diarrhoea, in addition to breathing difficulties and increased heart rate or altered consciousness. If you mistakenly treat asthma as anaphylaxis and give the adrenaline autoinjector according to the student's ASCIA Action plan for Anaphylaxis, no harm will be done. If in doubt, it is better to give the adrenaline autoinjector.
Q3.	**What if I think the anaphylactic student's adverse reaction is anaphylaxis, so administer the adrenaline autoinjector and it turns out to be something else?**
	The adrenaline autoinjector contains adrenaline, which is a natural hormone. If it is given to a student who does not have anaphylaxis, the student will have a raised heart rate and become pale and sweaty. They will feel anxious and shaky. These are common side-effects of adrenaline and the student should be fine. You must call an ambulance immediately to treat the other medical symptoms. Make sure you advise the ambulance service that you have administered the adrenaline autoinjector and also give them the time of the dose.
Q4	**What are my legal rights if I make a mistake?**
	In the unlikely situation where a staff member administers an adrenaline autoinjector and is then sued for negligence, the Department of Education and Early Childhood Development will defend the action at no expense to the staff member, except in the most exceptional circumstances, and payment of any damages will be made by the State of Victoria. Please refer to Personal Liability of School Employees in the School Policy and Advisory Guide, available at http://www.education.vic.gov.au/management/governance/spag/governance/legalpos/
Q5	**Can I give an adrenaline autoinjector if it has expired?**
	The adrenaline autoinjector may only be given if the fluid inside is clear. If the fluid is a rust colour or cloudy, do not give it. Instead, call an ambulance immediately. If your school has an adrenaline autoinjector for general use, be prepared to administer it. Remember, the key to effective management is preparation – do not allow yourself to be in a situation where you have a student with anaphylaxis in your care and the adrenaline autoinjector has expired. If the only autoinjector you have is out of date, but if it is an EpiPen® and the fluid is clear, you may use it. However, no school in the Victorian government school system should be holding an expired adrenaline autoinjector.

Q6	**What happens to the student once I give them the adrenaline autoinjector?**
	You should immediately see a reversal of the more serious symptoms of the student's reactions. They will breathe more easily as the swelling and tightness in their throat will recede. However, they may feel very anxious and shaky. This is a side-effect of adrenaline. Reassure the student and closely watch them in case of a repeat reaction.
Q7	**Can I give a second dose of the adrenaline autoinjector?**
	Watch the student closely in case of a repeat reaction. In the rare situation where there is no marked improvement and **severe symptoms** (as described in the ASCIA Action Plan for Anaphylaxis) are present, a second injection (of the same dosage) may be administered after five minutes.
Q8	**What happens if I accidentally inject myself?**
	Call the ambulance immediately, as you will need to go to hospital. If a student is having a reaction, ask another staff member to take over. If the school has an adrenaline autoinjector for general use, ask someone to retrieve it to give to the student.
Q9	**If a student does not have an adrenaline autoinjector and appears to be having a reaction, can I administer another student's adrenaline autoinjector to them?**
	No – the trigger that set off the first student's reaction could be the same allergen that causes a reaction in another student. Instead, call an ambulance. Ask someone else to remove the student diagnosed with anaphylaxis to another area and to closely observe them in case they react to the same trigger. If your school has an adrenaline autoinjector for general use, this can be administered for students weighing more than 20 kg.
Q10	**What is the difference between an EpiPen® and Anapen®?**
	Both the EpiPen® and Anapen® (and EpiPen®Jnr and Anapen®Jnr) contain the same dosage of adrenaline and can be administered for children and young people at risk of an anaphylactic reaction. The difference between EpiPen® and Anapen® is in the delivery mechanism of the adrenaline; namely, the Anapen® requires users to press a button on the top to administer the adrenaline but the EpiPen® does not. Delivery information for each adrenaline autoinjector is provided on the ASCIA action plan for Anaphylaxs.
Q11	**A student has provided one type of adrenaline autoinjector, but the adrenaline autoinjector for general use is not the same brand. Does this matter?**
	No, as long as the dosage of both adrenaline autoinjectors is the same, the brand of the second adrenaline autoinjector does not matter. However, because the delivery mechanism varies between adrenaline autoinjectors, 'the instructions administration on device (adrenaline autoinjector for general use) should be followed.'
Q12	**What should I do if the parents/carers haven't replaced their child's adrenaline autoinjector after it has expired?**
	Contact the parents/carers immediately and request them to replace the adrenaline autoinjector. If the school has an adrenaline autoinjector for general use, be prepared to use it. Make sure that all staff members know where it is stored and that is labelled 'adrenaline autoinjector for general use'.

Q13	**What if the parents/carers haven't told us about their child's condition, but the child mentions it in class?**
	Contact the student's parents/carers immediately to verify if their student has anaphylaxis. If they do, ask the parents/carers to obtain an adrenaline autoinjector and ASCIA Action Plan forAnaphylaxis (device specific) for the school as soon as possible. Immediately begin the process of developing an Anaphylaxis Management Plan with the parents/carers, the student's doctor (through the parents/carers) and the student (where appropriate).
Q14	**Can we ask parents/carers to not send nut products to school? What happens if they refuse?**
	Before you make this request of parents/carers, ask yourself why you are doing this and if there are other actions that you could take instead. It may be more appropriate, for example, to provide better education and awareness to the classmates of the student with anaphylaxis about minimising risks during certain times, such as lunch. You can request parents/carers not to send nut products to school, but it is important to realise that this does not mean that your school is 'nut free'. While most parents/carers will be happy to comply, there may be a small group who refuse. In those situations it is best to work with them. Educate them about how severe anaphylaxis can be by using the fact sheet provided in Appendix 5, and accessing the recommended online resources. Help parents/carers to develop alternative nutritious food options for their children.
Q15	**What can I do to keep a student with anaphylaxis safe in my class?**
	Be well prepared. Minimise their exposure to the allergen by planning ahead and thinking about alternatives for certain activities when necessary. Consult with the student and their parents/carers when any food is to be consumed in class and keep a separate labelled treats jar that only that student can handle. Be familiar with the student's ASCIA Action Plan for Anaphylaxis and know where the adrenaline autoinjector is and how to administer it. Consult with the student's parents/carers about potential hidden allergens in foods or other substances (e.g. soaps or lotions). • Ensure you have completed all risk minimisation strategies for the different areas the child may be in while in your care. • Ensure that all staff are regularly provided with education in relation to the identification of anaphylactic reactions and how to respond. • Ensure staff awareness of the school's anaphylaxis management policy, emergency management plan and each student's Anaphylaxis Management Plan.
Q16	**If we follow all the policies and recommendations will we prevent anaphylactic reactions in our school'?**
	You will certainly minimise the risk of a reaction and be well equipped to manage one should it occur. However there is no guarantee that you will prevent one. Remember that advance planning and good preparation and risk minimisation for all school settings is the best way to minimise risk and effectively manage anaphylaxis.

Appendix 4: Case Studies

These case studies are included to illustrate examples of management strategies in schools.

Case study 1: Primary school in the south-western suburbs of Melbourne

There are six students (three girls and three boys 6–12 years old) at risk of anaphylaxis in a student population of 585.

Allergens	Tree nuts, peanuts, eggs
Reactions to date at school	None
Adrenaline autoinjector storage and expiry	There are six adrenaline autoinjectors in the school. The adrenaline autoinjectors are located in the sick bay cupboard. Each student has an individual bag with their photo, name, grade and other relevant details. The bag includes the student's ASCIA Action Plan for Anaphylaxis, their adrenaline autoinjectors (also labelled), and a felt pen to record time and dose. The bags are visually distinctive and spaced on two shelves. All staff members have access to the sick bay, which is kept unlocked. A designated first aid teacher checks and records the expiry dates of the adrenaline autoinjectors at the start of every year. The expiry dates are re-checked at the start and end of every term. Parents/carers are contacted a month in advance of the expiry date and advised to replace the adrenaline autoinjectors.
Training	The school has received training from St John Ambulance Australia (Vic) Inc.
Action plan	Each student's device-specific ASCIA Action Plan for Anaphylaxis is updated annually by the student's medical practitioner. The plan is distributed to specialist teachers and classroom teachers, and is also located in the general office, sick bay, class rolls and in specialist classrooms.
School community awareness	All staff are briefed at least twice per year at staff meetings (as per *Ministerial Order 90*). A welfare committee has been established and meets fortnightly to discuss management of students with any medical conditions. The canteen has been briefed and a letter has been sent home to classmates' parents. New parents/carers are informed about anaphylaxis at information sessions.
Managing anaphylaxis in various school settings	The photographs of students at risk of anaphylaxis are at every phone point in the school. Also located there are forms to be used when an ambulance is called. These forms are used for all medical emergencies, but were initially developed for anaphylaxis. The 'dos and don'ts' of adrenaline autoinjector administration and the five rights of medication – right person, right drug, right route, right dose and right date – are also listed near the phones.

Case Study 2: Primary school in western Victoria

There are two students (a girl aged 10 and a boy aged 11) at risk of anaphylaxis in a student population of 235.

Allergens	Peanuts and dairy
Reactions to date at school	None
Adrenaline autoinjector storage and expiry	Adrenaline autoinjectors hang in a blue pencil case on the staffroom noticeboard next to the each child's ASCIA Action Plan for Anaphylaxis. The staffroom is unlocked and easily accessible. It is the first aid coordinator's responsibility to check the expiry date of the autoinjectors and notify parents/carers when to replace them.
Training	The school has received training from St John Ambulance Australia (Vic) Inc.
Action plan	Each anaphylactic student has an ASCIA Action Plan for Anaphylaxis. Copies of the plan are located in the staffroom and the sick bay, and kept with relevant classroom teachers.
School community awareness	Staff members are briefed at least twice yearly (as per *Ministerial Order 90*). When a student moves a grade, a special folder is passed onto the new class teacher and special mention is made of the student's condition. All casual relief teachers (CRTs) know of the student's condition, as it is a small community and they tend to use the same CRTs. The classroom teacher has talked to the class about the student's condition; and the student even brought in a video on anaphylaxis from home.
Managing anaphylaxis in various school settings	All medical emergencies during yard duty designated a Code Blue. When this occurs, staff may use their own mobile phones to call the office or send a student to the office. The office then issues a Code Blue over the PA system and designated first aid staff in the school report to the yard. Students with severe food allergies bring food prepared at home for special occasions/treats, although some students do bring non-allergic products to the class for them. The class teacher also does advance planning with the students and parents/carers and requests lists of appropriate foods. The adrenaline autoinjector is taken on camps and field trips. Often a parent/carer also accompanies the class. On camp, the adrenaline autoinjector is stored with the designated first aid teacher, the teacher in charge or the parent, depending on the activities being undertaken and who has responsibility for the student. The students also carry separate food on camp, although the camp also provides a special menu for them.

Case Study 3: P–12 school in south-east Melbourne

There are two students (a girl aged 9 and a boy aged 11) at risk of anaphylaxis in a student population of 850.

Allergens	Nuts
Reactions to date at school	None
Adrenaline autoinjector storage and expiry	There are four adrenaline autoinjectors in the school. Two are kept in a medicine bag that also contains the students' ASCIA Action Plan for Anaphylaxis. The medicine bags are kept in an unlocked cupboard in a locked first aid room, which all staff members can access. Another medicine bag is also stored in the student's school bag, which is distinguished from other bags by a ribbon. These school bags are stored separately from classmates' bags. The first aid coordinator checks the 'window' and expiry dates on the adrenaline autoinjectors at the start of the year and regularly during it, and returns all medications to the student's parents/carers at the end of the year. It is the parent's responsibility to return it the following year with up-to-date medication and information.
Training	The school has received training from Ambulance Victoria First Aid.
Action plan	Each student's ASCIA Action Plan for Anaphylaxis (device specific) is displayed in appropriate locations; namely, first aid room, office, staffroom, student's classrooms and in each student's class role. Details of students' ASCIA Action Plan for Anaphylaxis are also entered into the school database.
School community awareness	Class teachers, adjacent room class teachers, year level coordinators and specialist teachers are made aware by the first aid coordinator. They are provided with class listings and relevant information on children with medical conditions.
Managing anaphylaxis in various school settings	Students are required to wash their hands before and after handling food. No food swapping is allowed and only the student who is at risk of anaphylaxis can touch their own lunch. On special events/occasions, food from home is sent for these students. Special care is taken during art and cooking classes to ensure supplies are nut free. The canteen only sells products that are pre-approved by parents/carers and a cautionary note is attached to the lunch order bag when an at risk student buys food from the canteen. Teachers perform yard duty in pairs. In case of an emergency, basic first aid is to be performed while another teacher/aide goes to the general office or the child's school bag (whichever is closer) to bring the medicine bag. A comprehensive risk minimisation strategy has been put in place and all identified risks managed as much as possible for all the environments these two children are in for 2011.

Appendix 5: Managing Anaphylaxis in Victorian Government Schools – Fact sheet*

What are allergies?

Allergies occur when the immune system produces antibodies against substances in the environment (allergens) that are usually harmless. Once allergy has developed, exposure to the particular allergen can result in symptoms varying from mild to life threatening (anaphylaxis).

What is anaphylaxis?

Anaphylaxis is a severe, rapidly progressive allergic reaction that is potentially life threatening. Although allergic reactions are common in children, severe life threatening reactions are uncommon and deaths are rare. However, deaths have occurred and anaphylaxis must therefore be regarded as a medical emergency.

What are the main causes?

Food allergies are the most common triggers for an anaphylactic reaction. Eight foods cause 90 per cent of food allergic reactions in Australia and can be common causes of anaphylaxis:

- peanuts
- tree nuts (e.g. hazelnuts, cashews, almonds)
- eggs
- cow's milk
- wheat
- soy
- fish and shellfish
- sesame seeds.

Other triggers include insect stings (particularly bee stings, wasps and jumper jack ants), ticks, medications (particularly antibiotics and anaesthetics), latex, anaesthetic drugs and exercise.

What are the signs and symptoms of anaphylaxis?

Mild to Moderate Allergic Reaction can include:

- swelling of lips, face, eyes
- hives or welts
- tingling mouth
- abdominal pain, vomiting (these are signs of a severe allergic reaction to insects)

Anaphylaxis (Severe Allergic Reaction) can include:

- difficult/noisy breathing
- swelling of tongue
- swelling/tightness in throat
- difficulty talking and/or hoarse voice
- wheeze or persistent cough
- persistent dizziness or collapse
- pale and floppy (young children)

Why is it important to know about anaphylaxis?

The most important aspect of the management of children with anaphylaxis is avoidance of any known triggers. Schools need to work with parents/carers and students to ensure that certain foods or items are kept away from the student to prevent exposure to known triggers while at school. Knowledge of severe allergies will assist staff to better understand how to help students who have this problem.

How can anaphylaxis be treated?

Adrenaline given as an injection into the muscle of the outer mid-thigh is the most effective first aid treatment for anaphylaxis. Children at risk of recurrent anaphylaxis are advised by their medical practitioners to carry adrenaline in an autoinjector (e.g. EpiPen® or Anapen®) for administration in an emergency. Children under 20 kg are prescribed an EpiPen®Jr or Anapen®Jr, which have a smaller dosage of adrenaline. Parents/carers should provide schools with the child's adrenaline autoinjector, which should be kept in an accessible, unlocked location. If a student is treated with adrenaline (an adrenaline autoinjector) for anaphylaxis, an ambulance must be called and the student should be taken immediately to a hospital

How can anaphylaxis be prevented?

The key to prevention of anaphylaxis in schools is knowledge of those students who are at risk; awareness of triggers (allergens); and prevention strategies, such as risk minimisation of exposure to these triggers. Some children wear a medical warning bracelet to indicate allergies.

What are my responsibilities as a parent/carer if my child is at risk of anaphylaxis?

When a child is at school and is at risk of anaphylaxis, parents/carers must:

- inform school staff of the diagnosis and its cause
- discuss prevention strategies with the school, including risk minimisation
- work with school staff to develop an Anaphylaxis Management Plan in consultation with the child's medical practitioner
- provide a copy of your child's ASCIA Action Plan for Anaphylaxis, with an up-to-date photograph
- supply the student's adrenaline autoinjector and ensure it has not expired
- attend the school's training session, where possible.

What are the responsibilities of school staff regarding students at risk of anaphylaxis?

Staff involved should:

- know the identity of students who are at risk of anaphylaxis
- liaise regularly with parents
- follow information contained in the student's Anaphylaxis Management Plan (inclusive of their ASCIA Plan for Anaphylaxis)
- obtain training in how to recognise and respond to an anaphylactic reaction, including administering an adrenaline autoinjector
- ensure the adrenaline autoinjector is stored correctly (at room temperature and away from light) in an unlocked, easily accessible place
- know where the adrenaline autoinjector is located
- in the event of a reaction, follow the procedures in the student's ASCIA Action Plan for Anaphylaxis.

Summary of important points for anaphylaxis at school

Anaphylaxis is a medical emergency that requires a rapid response. Certain foods and insect stings are the most common causes of anaphylaxis. The key to prevention of anaphylaxis is identification of allergen triggers and prevention of exposure to these triggers. Schools need to develop prevention strategies in consultation with the student (if appropriate) and their parents.

Adrenaline given through an adrenaline autoinjector is the best treatment for anaphylaxis. The adrenaline autoinjector is designed so anyone can use it in an emergency. School staff responsible for the care of students at risk of anaphylaxis should be trained in how to recognise and respond to an anaphylactic reaction, including administering an adrenaline autoinjector.

Where can I find further information?

- Anaphylaxis Advisory Support Line: 1300 725 911 or 9345 4235
- Anaphylaxis Australia Inc.: www.allergyfacts.org.au
- Royal Children's Hospital, Allergy and Immunology Department: www.rch.org.au/allergy/index.cfm?doc_id=7219
- Australasian Society of Clinical Immunology and Allergy: www.allergy.org.au offers online training. It is useful resource, but does not replace face-to-face training.

* Adapted from the *NSW Health Factsheet – Anaphylaxis*, available at www.health.nsw.gov.au/pubs/factsheet/pdf/anaphylaxis_allergic_fs.pdf

Appendix 6: Anaphylaxis Management Checklist for Schools

No.	Item	(✓)
1.	Proactively seek information about severe allergies from parents/carers.	
2.	If a student has been diagnosed as being at risk of anaphylaxis, meet with parents/carers to obtain information about student's allergies and prevention strategies.	
3.	Conduct risk assessment assessments for the student's environments. Develop individual Anaphylaxis Management Plans.	
4.	Parents/carers to provide copies of device specific ASCIA Action Plan for Anaphylaxis with up-to-date photo.	
5.	Parents/carers to provide the student's adrenaline autoinjector or other medication.	
6.	Develop communication plan for staff, students and parents/ carers to raise awareness about severe allergies and the school's policies.	
7.	Implement preventative and risk minimisation strategies in the individual Anaphylaxis Management Plans.	
8.	Arrange staff training about: • the school's Anaphylaxis Management Policy • the causes, symptoms and treatment of anaphylaxis • the identity of students diagnosed at risk of anaphylaxis • how to use an adrenaline autoinjecting device including hands-on practice • the school's first aid and emergency response procedures.	
9.	Make sure adrenaline autoinjectors are correctly stored, and that staff know where they are and can access them quickly (less than five minutes from the time of signs and symptoms appearing).	
10.	Regularly check all adrenaline autoinjectors to make sure they are not out-of-date.	
11.	Regularly check EpiPens® to make sure they are not cloudy.	
12.	Ensure the student's adrenaline autoinjector and ASCIA Action Plan for Anaphylaxis are taken whenever the student participates in off-site activities (e.g. camps, excursions, field trips, sport days and work experience).	
13.	Regularly review school management strategies and practise scenarios for responding to an emergency.	
14.	**Review each student's Anaphylaxis Management Plan annually or if the student's situation changes.**	