Students

Anaphylaxis Prevention, Response, and Management Program [1]

School attendance may increase a student's risk of exposure to allergens that could trigger anaphylaxis. Students at risk for anaphylaxis benefit from a School Board policy that coordinates a planned response in the event of an anaphylactic emergency. Anaphylaxis is a severe systemic allergic reaction from exposure to allergens that is rapid in onset and can cause death. Common allergens include animal dander, fish, latex, milk, shellfish, tree nuts, eggs, insect venom, medications, peanuts, soy, and wheat. A severe allergic reaction usually occurs quickly; death has been reported to occur within minutes. An anaphylactic reaction can also occur up to one to two hours after exposure to the allergen.

While it is not possible for the District to completely eliminate the risks of an anaphylactic emergency[2] when a student is at school, an Anaphylaxis Prevention, Response, and Management Program using a cooperative effort among students' families, staff members, students, health care providers, emergency medical services, and the community helps the District reduce these risks and provide accommodations and proper treatment for anaphylactic reactions. [3]

The footnotes are not intended to be part of the adopted policy; they should be removed before the policy is adopted.

[1] 105 ILCS 5/2-3.182(d), added by P.A. 102-413, requires school boards to update or implement an anaphylactic policy by 8-17-22 (six months after the Ill. State Board of Education (ISBE) distributed its model on 2-17-22) in accordance with the model policy developed by ISBE, titled *Anaphylaxis Response Policy for Illinois Schools*, (*ISBE Model*), available at: www.isbe.net/Documents/Anaphylactic-policy.pdf. Administrative procedures referencing the *ISBE Model* must support this policy in order to comply with the law. See the discussion in f/n 4 below and 7:285-AP, *Implementing an Anaphylaxis Prevention, Response, and Management Program* for a sample implementation procedure.

The law requires the *ISBE Model*, and in turn a district's policy based on the *ISBE Model*, to include: (a) a procedure and treatment plan, including emergency protocols and responsibilities for school nurses and other appropriate school personnel, for responding to anaphylaxis, (b) requirements for a training course for appropriate school personnel on prevention and responding to anaphylaxis, (c) a procedure and appropriate guidelines for the development of an individualized emergency health care plan for children with a food or other allergy that could result in anaphylaxis, (d) a communication plan for intake and dissemination of information provided by Illinois regarding children with a food or other allergy that could result in anaphylaxis, including a discussion of methods, treatments, and therapies to reduce the risk of allergic reactions, including anaphylaxis, (e) strategies for reducing the risk of exposure to anaphylactic causative agents, including food and other allergens, and (f) a communication plan for discussion with children who have developed adequate verbal communication and comprehension skills and with the parents or guardians of all children about foods that are safe and unsafe and about strategies to avoid exposure to unsafe food. 105 ILCS 5/2-3.182(b).

The *ISBE Model* is primarily focused on item (a). Little to no guidance for schools regarding items (b) – (f) exists in it other than to generally cite to voluminous resources made available by the Centers for Disease Control and Prevention (CDC) and National Association of School Nurses (NASN). See f/n 3, below. This policy and its implementing procedures are designed to supplement the *ISBE Model* and further lead school officials to resources regarding items (b) – (f). 105 ILCS 5/2-3.182(b)(1-6).

[2] The *ISBE Model* does not provide a specific definition for *anaphylactic emergency,* but it appears to use that term and *anaphylaxis* interchangeably.

[3] This ends statement requires board work and should be discussed (what effect or impact will this district statement have on the students and the community?) and altered accordingly before board adoption. The *ISBE Model* provides that students at risk for anaphylaxis benefit from a policy that coordinates a planned response in the event of an anaphylactic emergency, and it emphasizes that an emergency plan should include all stakeholders. For more information on ends statements and governance, see IASB's *Foundational Principles of Effective Governance* at: www.iasb.com/principles_popup.cfm.

The Superintendent or designee shall develop and implement an Anaphylaxis Prevention, Response, and Management Program for the prevention and treatment of anaphylaxis that: [4]

1. Fully implements the Ill. State Board of Education (ISBE)'s model policy required by the School Code that: (a) relates to the care and response to a person having an anaphylaxis reaction, (b) addresses the use of epinephrine in a school setting, (c) provides a full food allergy and prevention of allergen exposure plan, and (d) aligns with 105 ILCS 5/22-30 and 23 Ill.Admin.Code §1.540. [5]

2. Ensures staff members receive appropriate training, including: (a) an in-service training program for staff who work with students that is conducted by a person with expertise in anaphylactic reactions and management, and (b) training required by law for those staff members acting as *trained personnel*, as provided in 105 ILCS 5/22-30 and 23 Ill.Admin.Code §1.540. [6]

3. Implements and maintains a supply of undesignated epinephrine in the name of the District, in accordance with policy 7:270, *Administering Medicines to Students*. [7]

4. Follows and references the applicable best practices specific to the District's needs in the Centers for Disease Control and Prevention's *Voluntary Guidelines for Managing Food*

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The clause "using a cooperative effort among students' families, staff members, students, health care providers and emergency medical services, and the community" is optional and can be removed. The purpose of the clause is to share responsibility for management among all stakeholders.

[4] 105 ILCS 5/10-20. To balance the requirement to implement a policy based upon the *ISBE Model* (105 ILCS 5/2-3.182(d)) with the practicalities of managing a district, this paragraph delegates the board's implementation duty to the superintendent.

[5] Number one outlines the goals that the legislature directed ISBE to include in the topics covered by the *ISBE Model*. 105 ILCS 5/2-3.149(a)-(c). The *ISBE Model* is based on the *Virginia Dept. of Education Anaphylaxis Policy*, available at: www.doe.virginia.gov/support/health_medical/anaphylaxis_epinephrine/, and it incorporates NASN recommendations for a comprehensive anaphylaxis school policy. See the *NASN Sample Anaphylaxis Policy*, at: www.nasn.org/nasn-resources/resources-by-topic/allergies-anaphylaxis. Boards may add further expectations and include additional goals that reflect those expectations here. Ensure that any additional expectations or goals align with policy 7:270, *Administering Medicines to Students*.

[6] Number two includes the biennial in-service training program required by 105 ILCS 5/10-22.39(e) and training required by 105 ILCS 5/22-30(g) for those staff members who will be *trained personnel*, authorized by 105 ILCS 5/22-30(b-10), to provide or administer undesignated epinephrine in specific situations. The law authorizes *school nurses* and *trained personnel* to administer undesignated epinephrine. See sample policy 5:100, *Staff Development Program* (at f/n 5 if the board does not list all training in the policy), and 7:270-AP2, *Checklist for District Supply of Undesignated Asthma Medication, Epinephrine Injectors, Opioid Antagonists, and/or Glucagon*. 105 ILCS 5/22-30(b-5) does not specifically state that staff members authorized to administer (student-specific) epinephrine under a student's specific individual plan must also complete the more rigorous training required for *trained personnel*. However, the *ISBE Model* is clear that "[o]nly trained personnel should administer epinephrine to a student believed to be having an anaphylactic reaction," and it requires each building-level administrator to identify at least two employees, in addition to the school nurse (if any), to be *trained personnel*. The more in-depth training for staff members who may administer epinephrine (whether student-specific or undesignated) is also a best practice emphasized in the *CDC Guidelines*, which is referenced in the *ISBE Model* (see f/n 8, below).

[7] Optional. Delete number three if a board has not adopted the **School District Supply of Undesignated Epinephrine Injectors** subhead in policy 7:270, *Administering Medicine to Students*.

Allergies in Schools and Early Care and Education Programs and the *National Association of School Nurses Allergies and Anaphylaxis Resources/Checklists*. [8]

5. Provides annual notice to the parents/guardians of all students to make them aware of this policy. [9]
6. Complies with State and federal law and is in alignment with Board policies.

Monitoring [10]

Pursuant to State law and policy 2:240, *Board Policy Development*, the Board monitors this policy at least once every three years by conducting a review and reevaluation of this policy to make any necessary and appropriate revisions. The Superintendent or designee shall assist the Board with its reevaluation and assessment of this policy's outcomes and effectiveness. Any updates will reflect any necessary and appropriate revisions.

LEGAL REF.: 105 ILCS 5/2-3.182, 5/10-22.39(e), and 5/22-30.
23 Ill.Admin.Code §1.540.
Anaphylaxis Response Policy for Illinois Schools, published by ISBE.

CROSS REF.: 4:110 (Transportation), 4:120 (Food Services), 4:170 (Safety), 5:100 (Staff Development Program), 6:120 (Education of Children with Disabilities), 6:240 (Field Trips), 7:180 (Prevention of and Response to Bullying, Intimidation and Harassment), 7:250 (Student Support Services), 7:270 (Administering Medicines to Students), 8:100 (Relations with Other Organizations and Agencies)

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[8] Number four refers to the CDC's *Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs*, at: www.cdc.gov/healthyschools/foodallergies/pdf/20_316712-A_FA_guide_508tag.pdf (*CDC Guidelines*), which is cited in the *ISBE Model* as a resource for a "full food allergy and prevention of allergen exposure plan." Adopting the entire, voluminous *CDC Guidelines* document as policy is not practical. The *CDC Guidelines* also state that not every recommendation will be appropriate or feasible for every district's needs. The *National Association of School Nurses Allergies and Anaphylaxis Resources/Checklists*, at: http://www.nasn.org/nasn-resources/resources-by-topic/allergies-anaphylaxis, are also linked as a resource in the *ISBE Model*. The *ISBE Model* acknowledges that not all schools have access to school nurses or other health staff on a regular basis, and it encourages districts to take this into consideration when developing building-level plans.

[9] Number five is required by 105 ILCS 5/2-3.182(c), added by P.A. 102-413. The notification must include contact information for parents/guardians to engage further with the district to learn more about individualized aspects of the policy. For ease of administration, districts may want to include this notification in student handbook(s). The Ill. Principal's Association (IPA) maintains a handbook service that coordinates with **PRESS** material, *Online Model Student Handbook* (MSH), at: www.ilprincipals.org/resources/model-student-handbook.

[10] 105 ILCS 5/2-3.182(e) provides that ISBE shall review and update its model policy at least once every three years. Although this section does not expressly state that boards must also conduct a review within this time frame, that is the logical conclusion based on a board's duty in 105 ILCS 5/10-16.7 to direct the superintendent through policy.