

# Food Allergy Management in Schools (FAMS)

Expert Recommendations for K-12



---

*This resource was supported by Cooperative Agreement Number NU380T000282, funded by the Centers for Disease Control and Prevention, in partnership with the American Academy of Pediatrics. Its contents are solely the responsibility of Food Allergy Research and Education and do not necessarily represent the official views of the American Academy of Pediatrics or the Centers for Disease Control and Prevention of the Department of Health and Human Services.*

---

# Acknowledgements & Endorsements

These expert recommendations were prepared by Food Allergy Research and Education (FARE) in close collaboration with representatives from multiple organizations who were part of the Food Allergy Management in Schools Advisory Council, listed below. FARE acknowledges Christine Creter and Joanna Ribisl of the Creter Group for their role in managing and coordinating this project, along with Jessica Martin, PhD, for her role as lead writer and researcher.

## FAMS Advisory Council

**Michael Pistiner, MD, MMSc (Chairperson)**  
*Mass General for Children*

**Brooke Balchan, DO, FAAP**  
*American Academy of Pediatrics (AAP),  
Council on School Health*

**Andrea Boudreaux, PsyD, MPH, MHA, FACH**  
*American School Health Association (ASHA)*

**Kelly Cleary, MD, FAAP**  
*Food Allergy Research and Education (FARE)*

**Liz Dixon, MS**  
*Institute for Child Nutrition (ICN)*

**Eleanor Garrow-Holding  
Amelia G. Smith, JD**  
*Food Allergy & Anaphylaxis Connection Team (FAACT)*

**Kayla Jackson**  
*AASA, The School Superintendents Association*

**Susan Maffe, MS, RD, SNS**  
*School Nutrition Association (SNA)*

**Lynda Mitchell, MA, CAE**  
*Allergy & Asthma Network*

**Linda Neumann, RN**  
*National Association of School Nurses (NASN)*

**Jenna Riemenschneider, MSc**  
*Asthma and Allergy Foundation of America (AAFA)*

**Thomas Silvera, MSHS-PH**  
*Elijah-Alavi Foundation*

**Mary Vargas, JD**  
*Stein & Vargas LLP*

**Julie Wang, MD**  
*American Academy of Pediatrics (AAP),  
Icahn School of Medicine at Mount Sinai*

## Endorsing Organizations

The following organizations have reviewed the Food Allergy Management in Schools: Expert Recommendations and have agreed to fully endorse this publication and its recommendations:



# Table of Contents

<b>GLOSSARY</b> .....	<b>5</b>
<b>INTRODUCTION</b> .....	<b>6</b>
<i>Box 1. FAMS Expert Recommendations Summary</i> .....	8
<b>1. PERSONNEL TRAINING AND EDUCATION</b> .....	<b>10</b>
OVERVIEW .....	10
WHAT INFORMATION SHOULD SCHOOLS INCLUDE IN FOOD ALLERGY TRAINING? .....	10
<i>Table 1. Recommended Content for All-Staff Food Allergy Training</i> .....	10
<i>Box 2. Types of Food Allergies</i> .....	11
HOW SHOULD SCHOOLS IMPLEMENT FOOD ALLERGY TRAINING? .....	13
<b>2. PREVENTING ALLERGEN EXPOSURE</b> .....	<b>14</b>
OVERVIEW .....	14
<i>Box 3. Food Allergy Self-Management in Students</i> .....	14
HOW SHOULD SCHOOLS IDENTIFY AND DOCUMENT FOOD ALLERGIES? .....	14
<i>Table 2. Food Allergy Documents in Schools</i> .....	15
HOW SHOULD SCHOOL NUTRITION PROGRAMS MANAGE FOOD ALLERGIES?.....	16
HOW CAN SCHOOLS PREVENT FOOD ALLERGEN EXPOSURE? .....	17
<i>Box 4. Best Practices for Settings Where Meals or Snacks Are Eaten in Classrooms</i> .....	18
<i>Box 5. Should Schools Consider Food Allergen Restrictions?</i> .....	20
<b>3. PREPARING FOR EMERGENCIES</b> .....	<b>21</b>
OVERVIEW .....	21
WHAT PROTOCOLS AND PROCEDURES ARE NEEDED TO PREPARE FOR FOOD ALLERGY REACTIONS?.....	21
WHAT ARE THE BEST PRACTICES FOR EPINEPHRINE IN SCHOOLS? .....	21
<b>4. COMMUNICATION AND COLLABORATION</b> .....	<b>23</b>
OVERVIEW .....	23
WHAT IS THE BEST APPROACH TO A COMPREHENSIVE FOOD ALLERGY MANAGEMENT PROGRAM?.....	23
<i>Table 3. Examples of Team Roles and Responsibilities</i> .....	24
<b>CONCLUSIONS</b> .....	<b>26</b>
<b>REFERENCES</b> .....	<b>27</b>
<b>APPENDIX</b> .....	<b>30</b>
A1. FAMS ADVISORY COUNCIL MEMBERS .....	30
A2. STAFF TRAINING AND EDUCATIONAL RESOURCES .....	31
A3. ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN (AAEP) TEMPLATE.....	32

# Glossary

## 504 plans

plans developed by 504 coordinators, school staff, caregivers, and students that document legally binding accommodations to safely and fully include students with disabilities, including those with food allergies, in all school programs and activities

## allergens

substances that cause allergic reactions in people who have allergies to those specific substances

## Allergy and Anaphylaxis Emergency Plan (AAEP)

plan developed by health care providers in collaboration with students and caregivers that explains, in simple language, how school staff should respond to an allergic reaction in an individual student

## American Academy of Pediatrics (AAP)

organization of pediatricians with the mission of ensuring optimal physical, mental, and social health of infants, children, adolescents, and young adults

## Americans with Disabilities Act (ADA)

federal law that prohibits discrimination on the basis of disability, including food allergies

## anaphylaxis

severe, life-threatening allergic reaction that can be associated with blood pressure drops, trouble breathing, rash, swelling, and vomiting; requires urgent treatment with epinephrine

## celiac disease

disease caused by an immune reaction to eating foods containing gluten, which is found in wheat, barley, and rye

## cross-contact

accidental transfer of a food allergen from one food to a food that is meant to be allergen-free; may occur through direct contact between foods or through the use of shared utensils, cooking equipment, or prep surfaces

## Centers for Disease Control and Prevention (CDC)

U.S. federal agency that promotes public health

## Child Nutrition Programs

federally funded nutrition programs run by the USDA that help ensure children, including school students, receive nutritious meals and snacks

## eosinophilic esophagitis (EoE)

non-IgE-mediated food allergy in which allergen exposure leads to the buildup of immune cells in the throat, leading to inflammation and trouble swallowing, among other symptoms

## epinephrine

first-line treatment for severe allergic reactions and life-threatening anaphylaxis

## Food & Drug Administration (FDA)

U.S. federal agency that regulates most foods, medical products, medical devices, and certain other products

## food allergy

immune reaction to a food that can cause serious and potentially life-threatening reactions

## food intolerance

condition caused by the inability to digest certain foods

## Food Protein-Induced Enterocolitis Syndrome (FPIES)

non-IgE-mediated food allergy in which allergen exposure leads to vomiting, diarrhea, and dehydration

## IgE antibody

immune protein that causes some food allergies

## Individualized Education Plans (IEPs)

plans developed to ensure a student with a qualifying learning disability receives necessary specialized education and services

## Individualized Health Care Plans (IHPs)

nursing care plans developed by school nurses that ensure students' physical and mental health medical needs are being met

## Section 504

federal law that prevents institutions that receive federal funding, including schools, from discriminating based on disabilities, including food allergies

## self-administer

treat oneself with epinephrine during an allergic reaction

## self-carry

when the student carries their own epinephrine device

## site-wide food restrictions

policies that ban a certain food from the environment to protect students with food allergies

## unassigned epinephrine

epinephrine device prescribed by a health care provider in the name of a school or school district that can be used for any person having a suspected allergic reaction

## U.S. Department of Agriculture (USDA)

federal department responsible for regulating farming, forestry, rural development, and certain foods

# Introduction

**Food allergy** is a common medical condition. An estimated 5.8% of children,<sup>13</sup> which is about 4 million K–12 students, have a diagnosed food allergy. This is an average of 2 students in every classroom that may have food allergies.<sup>14</sup>

Not all people with food allergies have formal diagnoses though. The actual rate of food allergies among children may be as high as 7.6%.<sup>15</sup>

People can have allergies to any food, but the nine most common food **allergens** in the United States are:<sup>15</sup>

- Peanuts
- Tree nuts (such as cashews, walnuts, and pecans)
- Shellfish (such as shrimp and crab)
- Milk
- Wheat
- Egg
- Fish
- Sesame
- Soy

Serious food allergy reactions, including life-threatening **anaphylaxis**, can occur in school settings. In a 2-year period, about 2 out of every 5 students with food allergies have at least one allergic reaction while attending school or school-related activities.<sup>1</sup> Allergic reactions are on the rise in children and can lead to emergency department visits, hospitalization, and, in some cases, death.<sup>17–20</sup> Importantly, these events are almost always avoidable.<sup>18</sup>

Food allergies can also negatively affect the school experiences of students. Children with food allergies are at risk for:<sup>21,22</sup>

- Social isolation and bullying
- Peer pressure and risk-taking behaviors
- Anxiety and fear of accidental exposure to their allergen(s)

Due to these factors, food allergies may affect mental health, school attendance, or participation in academic activities, potentially resulting in learning loss. However, studies are still needed on this topic.

Schools are responsible for the safety of all students, including those with food allergies. To keep students with food allergies safe, schools should have food allergy management plans and rules. Because food allergy reactions can happen in people who don't know they have an allergy, these plans should include how to prevent, recognize, and treat allergic reactions in the entire student body.<sup>8,23,24</sup>

To assist K–12 schools in developing best practices for food allergy management, Food Allergy Research and Education (FARE) assembled an advisory council of people from different professional backgrounds to create expert recommendations. Members of the advisory council are listed in [Appendix A1](#). This effort was funded by the **CDC** and the **AAP** and is intended to complement the existing CDC [Voluntary Guidelines for Managing Food Allergies In Schools and Early Care and Education Programs](#) published in 2013.<sup>25</sup>



**1 in 4**  
life-threatening food allergy reactions in the school setting happen in people **without** diagnosed food allergies (including faculty and staff).<sup>8</sup>

The FAMS advisory council developed 34 recommendations ([Box 1](#)) with the following goals in mind:

- Reduce accidental exposure to food allergens among students with known food allergies
- Improve recognition and treatment of food allergic reactions
- Ensure that students with food allergies can participate fully and safely in all school activities

Although these recommendations are intended for school administrators and district leaders, we anticipate that this document will also be used by anyone who is interested in food allergy management in schools, including caregivers of students with food allergies, teachers, school nurses, and other school and district staff.

Because these recommendations may not be appropriate or feasible for every school, districts should first determine what must be implemented based on federal and state law and local policies, and implement those recommendations. Because these recommendations are voluntary, schools may consider them in determining what actions may be appropriate for an individual student. However, any actions that school districts take for individual students must be implemented consistent with applicable federal, state, and local laws, including regulations. And while these recommendations provide information related to certain applicable laws, they should not be construed as giving legal advice. Schools should consult local legal professionals for such advice.

## Box 1. FAMS Expert Recommendations Summary

The FAMS advisory council developed recommendations to assist K–12 schools in developing best practices for IgE-mediated food allergy management. The 34 recommendations are summarized below. Additional details and training resources for each recommendation are available in the body of this document and in [Appendix A2](#).

### 1. Personnel Training and Education

#### What Information Should Schools Include in Food Allergy Training?

- 1.1. Train all staff on the prevalence and burden of food allergy, common food allergens, food allergen exposure prevention, and food allergy reaction recognition and management.
- 1.2. Train all school nutrition professionals and cafeteria monitors on food allergen exposure prevention.
- 1.3. Train district- and building-level administrative staff, school business officials, and school leadership on the legal requirements for food allergy management in schools.
- 1.4. Provide volunteers with written education on food allergy reaction prevention, recognition, and management.
- 1.5. Ensure school-contracted workers have received adequate food allergy training.

#### How Should Schools Implement Food Allergy Training?

- 1.6. Conduct audience-appropriate food allergy training at least once per year for all staff.
- 1.7. Ensure training programs are evidence-based and tailored to the audience.
- 1.8. Designate staff members to ensure completion and documentation of food allergy training for all staff.

### 2. Preventing Allergen Exposure

#### How Should Schools Identify and Document Food Allergies?

- 2.1. Establish standardized procedures for identifying known food allergies in students.
- 2.2. Standardize documentation and communication of all known food allergies.

#### How Should School Nutrition Programs Manage Food Allergies?

- 2.3. Maintain medical statements from state-licensed health care professionals to document appropriate meal modifications for students with food allergies.
- 2.4. Ensure that students with food allergies, as determined by a state-licensed health care professional, have full and equal access to foods offered by the school nutrition program.
- 2.5. Publish weekly or monthly school menus.
- 2.6. Maintain a current food label library.
- 2.7. Designate staff members to assist children with food allergies who may not be able to safely avoid allergens on their own.
- 2.8. Set up procedures to separately receive, store, prepare, cook, transport, hold, serve, and reheat allergy-safe foods and meals.



## Box 1. FAMS Expert Recommendations Summary (Continued)

### How Can Schools Prevent Food Allergen Exposure?

- 2.9. When possible, discourage eating in classrooms; if eating in classrooms is necessary, designate an area for eating that is separate from learning spaces, especially for younger children.
- 2.10. Wash hands before and after preparing, serving, or eating meals or snacks to avoid food allergen cross-contact.
- 2.11. Clean surfaces before and after meals or snacks to avoid food allergen cross-contact.
- 2.12. During meal and snack times, ensure students have adequate space to sit and eat.
- 2.13. Discourage sharing of food items among students.
- 2.14. Encourage the use of non-food student incentives/rewards and classroom celebrations.
- 2.15. Ensure students with food allergies can fully participate by evaluating school materials, activities, and projects for potential food allergens and adjusting accordingly.
- 2.16. Apply protocols and procedures for preventing food allergen reactions to school-sponsored events and activities, including bus rides, field trips, clubs, sports, and extracurricular activities.
- 2.17. Ensure food allergy protocols and procedures do not exclude students with food allergies.

### Should We Consider Site-Wide or Room Food Allergen Restrictions?

Consider the factors outlined in [Box 5](#) before deciding.

## 3. Preparing for Emergencies

### What Protocols and Procedures Are Needed to Prepare for Food Allergy Reactions?

- 3.1. Maintain Allergy and Anaphylaxis Emergency Plans (AAEPs) and medication authorization forms as part of Individualized Healthcare Plans (IHPs) and/or 504 plans for students with known food allergies.
- 3.2. Implement protocols and procedures for staff response to a suspected allergic or anaphylactic reaction in people without known food allergies or without AAEPs.

### What Are the Best Practices for Epinephrine in Schools?

- 3.3. Maintain a constant supply of unassigned epinephrine.
- 3.4. Allow students who are approved by their caregivers and health care providers to self-carry and/or self-administer epinephrine.
- 3.5. Store unassigned and assigned epinephrine in secure areas that are unlocked and easily accessible by staff.

## 4. Communication and Collaboration

### What Is the Best Approach to a Comprehensive Food Allergy Management Program?

- 4.1. Implement and document a food allergy management approach that considers the individual needs of students with food allergies.
- 4.2. Ensure consistent communication and enforcement of food allergy management policies and procedures.
- 4.3. Ensure all staff are aware of their individual roles in food allergy management.
- 4.4. Align food allergy management plans with the needs of the school community.

# 1. Personnel Training and Education

## Overview

Food allergy reactions can happen suddenly and need fast treatment. Quickly recognizing and treating food allergy reactions can be lifesaving.<sup>26</sup> But students having an allergic reaction may not be aware of what’s happening or may not be able to communicate their symptoms with others.

During a food allergy reaction, the closest staff member must know how to respond, regardless of their usual roles and responsibilities. Although school nurses can be an excellent resource for food allergy management, unfortunately, many U.S. schools do not employ school nurses. Even in schools with nurses, it is unlikely that the closest staff member during an allergic reaction will be a nurse. This is why all adults in school settings should have a basic understanding of what food allergy reactions look like, how to manage these reactions, and staff roles and responsibilities in case of emergencies.

Approximately  
**8 in 10**  
food allergy reactions in  
schools happen in the  
classroom.<sup>1</sup>

## What Information Should Schools Include in Food Allergy Training?

### 1.1. Train all staff on the prevalence and burden of food allergy, common food allergens, food allergen exposure prevention, and food allergy reaction management.

We recommend food allergy training for all school staff, including but not limited to teachers, curriculum advisors, cafeteria monitors, and janitors. The goal of this training is to improve food allergy awareness, reduce the risk of accidental allergen exposure, and improve responses to food allergy reactions. All-staff food allergy training should, at minimum, include the content shown in **Table 1**.

**Table 1. Recommended Content for All-Staff Food Allergy Training**

Prevalence and Burden of Food Allergies	Food Allergen Exposure Prevention	Food Allergy Reaction Management
<ul style="list-style-type: none"> <li>Types of food allergies (<a href="#">Box 2</a>)</li> <li>Prevalence of diagnosed and undiagnosed food allergies</li> <li>Mental, emotional, and physical health effects of food allergies</li> <li>Most common causes of food allergy reactions</li> </ul>	<ul style="list-style-type: none"> <li>Eating or accidentally ingesting is the most common cause of food allergy reactions</li> <li>Potential areas of allergen exposure in the school setting</li> <li><b>Cross-contact</b> avoidance</li> <li>Cleaning and handwashing protocols</li> <li>Reading food labels</li> <li>Hidden sources of food allergens (such as art, science supplies, or soap)</li> <li>School- and/or district-level rules for allergen exposure prevention</li> </ul>	<ul style="list-style-type: none"> <li>Mild food allergy reaction signs and symptoms (including age-specific identifiers)</li> <li>Anaphylaxis signs and symptoms, including potential variations by race/ethnicity (for example, hives may be red or pink on lighter skin tones but may be the same color as the skin on darker skin tones)<sup>27</sup></li> <li>Importance of quick treatment</li> <li>School and/or district policies for <b>epinephrine</b> storage and use</li> <li>Use and administration of epinephrine autoinjectors for designated staff</li> </ul>

Free or low-cost school staff training resources, including the [FARE Food Allergies: Keeping Students Safe and Included](#) training, are listed in [Appendix A2](#).

## Box 2. Types of Food Allergies

Not all food allergies are the same. Food allergies can be IgE-mediated or non-IgE-mediated.

- IgE-mediated food allergies are caused by an immune protein called an **IgE antibody**, and reactions usually happen within minutes of eating an allergen, though can occur up to 2 hours after exposure. This type of allergy can lead to a severe reaction, known as anaphylaxis.
- Non-IgE-mediated food allergies are also caused by reactions to foods, but these reactions don't involve IgE antibodies and don't cause anaphylaxis. However, non-IgE-mediated food allergies can lead to illness, which may happen hours or even days after eating an allergen. Examples of non-IgE-mediated food allergies include **eosinophilic esophagitis (EoE)** and **food protein-induced enterocolitis (FPIES)**.

**Both types of food allergies can be severe, and schools should implement policies and procedures for students with IgE- and non-IgE-mediated allergies.**

Some students may have other types of food reactions that are not the same as allergies. This includes **celiac disease**, an autoimmune disease in which the person must avoid gluten, or **food intolerance**, like lactose intolerance in which the body can't digest milk sugar. Although some of the FAMS recommendations may be applicable to these conditions, FAMS discussions were specifically focused on IgE-mediated food allergies.

### 1.2. Train all school nutrition professionals and cafeteria monitors on food allergen exposure prevention.

All school nutrition professionals and cafeteria monitors should receive additional food allergy training in addition to the training recommended for all staff. This recommendation aligns with the **2022 FDA Food Code**, which recommends food allergy training as part of basic food safety training for food service workers.<sup>28</sup> Basic food allergy training for school nutrition programs should include:

- School and/or district rules for identifying and documenting food allergies in students
- Proper techniques for washing, rinsing, and sanitizing surfaces
- Strategies for separating and preparing food allergy-safe meals and ingredients
- Reading food labels and disclosing ingredients
- Requirements for allergen substitutions
- Methods for keeping students safe without causing embarrassment or isolation
- Current **USDA** guidance and **FDA Food Code** used by districts or states

**One resource for school nutrition staff training is the **FARECheck** program, which is an enhanced American National Accrediting Board (ANAB)-accredited training and review program in food handling and safety practices to help keep individuals with food allergies safe. For additional resources, see **Appendix A2**.**

### 1.3. Train district- and building-level administrative staff, school business officials, and school leadership on the legal requirements for food allergy management in schools.

Under the [Americans with Disabilities Act \(ADA\)](#) and [Section 504](#), a student with a food allergy has a disability that restricts their diet and can interfere with breathing.<sup>29,30</sup> Therefore, training on the legal requirements for food allergy management in schools should be provided to administrators, leaders, and business officials. These include (but are not limited to) special education directors, school nutrition program directors, athletic directors, 504 coordinators, directors of transportation, directors of school health services, and before- and after-care administrators.

Training topics should, at minimum, include:

- ADA classification of disabilities
- Section 504 protections for students with disabilities, including those with food allergies
- [504 plans](#), [Individualized Health Care Plans \(IHPs\)](#), and [Individualized Education Plans \(IEPs\)](#)
- Legal requirements for accommodating prescription diets
- USDA meal substitution policies and requirements
- Federal and state laws related to food allergies, including [HR2468 \(School-Based Allergies and Asthma Management Program Act\)](#)
- District policies related to food allergies
- Legal requirements and responsibilities when contracting with outside companies (such as transportation services or catering services, among others)

Refer to the free administrator-specific version of [FARE's Food Allergies: Keeping Students Safe and Included](#) training, listed in [Appendix A2](#).

### 1.4. Provide volunteers with written education on food allergy reaction prevention, recognition, and management.

We recognize that requiring food allergy training for all school volunteers is not possible in most cases. However, volunteers may be responsible for supervising students with food allergies. To ensure basic food allergy awareness among volunteers, we recommend providing all volunteers with written information on the symptoms of food allergy reactions and what to do in case of a reaction. Schools should consider providing food allergy training for volunteers who have more contact with students.

Volunteers without food allergy training should never be the only caretakers of students; staff who have received food allergy training should always be present. Regardless of the amount of volunteer training, schools are responsible for the safety of students.



Refer to the educational handbook for school volunteers listed in [Appendix A2](#).

### 1.5. Ensure school-contracted workers have received adequate food allergy training.

Outside companies are often contracted for transportation, school nutrition programs, substitute teaching, security, and before- and after-care, among other services. Schools are responsible for ensuring all contractors who are in school settings at the same times as students and provide programs for or interact with students have received food allergy training and are complying with ADA and Section 504 laws for students with food allergies.<sup>31</sup>

When schools contract with these companies, they should:

- Assess the company's food allergy training requirements before signing or renewing contracts
- Make sure that company training content aligns with school requirements for companies that require food allergy training for their staff
- Require training as part of the agreement for companies that do not have food allergy training for their staff
- Provide companies and their contractors with school- and building-specific procedures for food allergy management

## How Should Schools Implement Food Allergy Training?

### **1.6. Conduct audience-appropriate food allergy training at least once per year for all staff.**

We recommend annual all-staff training on food allergies. This may be offered as a component of standard annual training requirements. When staff are hired mid-year, make sure that they receive food allergy training before beginning their job duties.

In addition to annual training, any changes to district or school food allergy policies and procedures should be communicated to staff immediately. Schools should identify a specific staff member to be responsible for communicating changes.

### **1.7. Ensure training programs are evidence-based and tailored to the audience.**

Food allergy training should be tailored to the needs of the audience. For example, elementary school staff benefit from different training than high school staff due to the different developmental stages of the students. The educational background of the trainees and their roles and responsibilities within the school should also be considered.

For a list of evidence-based training programs and resources, see [Appendix A2](#).

### **1.8. Designate staff members to ensure completion and documentation of food allergy training for all staff.**

Food allergy training is only helpful if it is being completed. To ensure staff are attending training, we recommend assigning staff members to document training completion. These staff members may also track or distribute professional development credits for attendance.

The best method for checking training completion depends on the type of training offered. For example, if food allergy training takes place at a live seminar, use attendance sheets. If training is provided through an on-demand or live online program, staff can submit certificates of completion.

When possible, we suggest testing staff after they have attended training to confirm that they have the needed knowledge and skills to safely manage food allergies in schools.

## 2. Preventing Allergen Exposure

### Overview

There is no cure for food allergies, and strict avoidance of the food is the primary management option.<sup>32,33</sup> Even trace amounts of food allergens can cause severe allergic reactions, and there is no way to predict how severe a reaction will be before the student is exposed to the allergen, even if they have had only mild reactions in the past.<sup>34</sup>

About 3 in every 4 students with food allergies accidentally ingest their food allergens at some point.<sup>35</sup> In school settings, most food allergy reactions happen in the classroom (83%) or cafeteria (15%).<sup>1</sup>

When considering FAMS recommendations for preventing food allergen exposure, schools should consider the ability of their students to self-manage their food allergies. As outlined in **Box 3**, self-management skills differ by age, grade level, and developmental abilities.



Most allergic reactions among students happen after **ingesting** food allergens.

Some students may also have allergic reactions after **touching** allergens (such as wheat pasta in art class or spilt milk on a table) or **inhaling** allergens (such as powdered milk or steam from fish during a cooking class).<sup>7,11,12</sup>

### Box 3. Food Allergy Self-Management for Students in Schools

Students have different abilities to manage and cope with food allergies depending on their:

- Ages
- Grade levels
- Developmental stages and abilities
- Social skills
- Coping abilities

Schools should consider these factors when developing food allergy policies and procedures. Below, we provide general guidance for basic expectations for students by grade level. Keep in mind that not all students within a single school or grade level will have the same self-management capabilities. For more information about management by grade level, see the [AAAAI Food Allergy Stages Handouts](#), [FAACT Food Allergy Curricula Program for Schools](#), or the [FARE Resources for Every Age](#).

Elementary (K–5)	Middle (6–8)	High (9–12)
<p><b>Most students with food allergies can...</b></p> <ul style="list-style-type: none"> <li>• Tell people what they are allergic to</li> <li>• Follow simple safety rules (such as handwashing)</li> </ul>	<p><b>Most students with food allergies can...</b></p> <ul style="list-style-type: none"> <li>• Follow safety rules and understand dietary restrictions</li> <li>• Check food labels</li> <li>• Recognize symptoms of allergic reactions</li> </ul>	<p><b>Most students with food allergies can...</b></p> <ul style="list-style-type: none"> <li>• Be involved in the development of their food allergy management plan</li> </ul>

## How Should Schools Identify and Document Food Allergies?

### 2.1. Establish standardized procedures for identifying known food allergies in students.

We recommend that all schools formalize their processes for identifying known food allergies in students. Depending on the school, these processes may include caregiver surveys or other screening tools.

Schools should assign the task of identifying students with known food allergies to specific staff members. Although school nurses are the obvious choice for this responsibility, schools without nurses can consider assigning this task to administrators or school counselors. Responsibilities of the designated staff members include obtaining food allergy information from caregivers, following up with caregivers to complete or clarify responses, and regularly updating information according to school rules.

## 2.2. Standardize documentation and communication of all known food allergies.

Known food allergies and corresponding management plans can be formally documented using several different types of plans, all of which have different purposes (**Table 2**). At minimum, **Allergy and Anaphylaxis Emergency Plans (AAEPs)** should be maintained on file for all students with known food allergies. AAEPs may also be referred to as Anaphylaxis Emergency Care Plans (AECPs), Anaphylaxis Emergency Plans (AEPs), or Food Allergy Action Plans (FAAPs). Please refer to **Appendix 3** for an example of the AAEP by the AAP.

**Table 2. Food Allergy Documents in Schools**

Plan	Purpose	Process	School responsibilities
<b>AAEP</b>	To explain in simple language how school staff should respond to an allergic reaction in an individual student, as recommended by their health care provider	<ul style="list-style-type: none"> <li>Developed by health care providers in collaboration with students and caregivers</li> <li>Provided to school by caregivers</li> </ul>	<ul style="list-style-type: none"> <li>Obtain an AAEP signed by the student’s health care provider each year</li> <li>File the plan in the student’s records or as part of the student’s 504 plan or IHP</li> </ul>
<b>IHP</b>	To direct a school nurse in meeting student’s medical needs	<ul style="list-style-type: none"> <li>Developed and maintained on file in the student’s health record by the school</li> </ul>	<ul style="list-style-type: none"> <li>Develop the IHP, led by the school nurse, in collaboration with the caregiver, the student, and their healthcare provider</li> <li>File the plan as part of the student’s health record</li> <li>Review and update the plan at least annually</li> </ul>
<b>504 plan</b>	To document legally binding accommodations to safely and fully include students with disabilities, including those with food allergies, in all school programs and activities	<ul style="list-style-type: none"> <li>Upon request, a determination meeting is conducted with the 504 coordinator and team</li> <li>For eligible students, the plan is developed collaboratively by students, caregivers, and school staff</li> </ul>	<ul style="list-style-type: none"> <li>Inform caregivers of students with food allergies about their legal right to request a 504 eligibility determination meeting</li> <li>Refer students with food allergies to 504 coordinators</li> <li>Work with caregivers, students, and 504 coordinators to review and update the plan annually</li> <li>File the plan in students’ educational records</li> <li>Make sure all school staff are implementing the plan</li> </ul>
<b>IEP</b>	To document the special education needs, including special education instruction, supports, and services, of a student with specific learning disabilities	<ul style="list-style-type: none"> <li>Upon request, a determination meeting is conducted with the IEP coordinator and team</li> <li>For eligible students, the plan is developed collaboratively by students, caregivers, and school staff</li> </ul>	<ul style="list-style-type: none"> <li>Note: IEPs are usually used for students with food allergies if they also have a separate qualifying disability</li> </ul>

AAEP, Allergy and Anaphylaxis Emergency Plan; IEP, Individualized Education Plan; IHP, Individualized Health Care Plan.

Unless specifically stated in a student's 504 plan, all food allergy documentation and accommodations should be treated as confidential.

If food allergies are identified in students without 504 plans, schools are responsible for informing students and caregivers about their eligibility for a meeting with a 504 team.<sup>36</sup> This is especially important if current school policies, resources, or staffing are unable to meet the individual needs of students with food allergies. Although not all students with food allergies require 504 plans, schools are legally required to inform students and caregivers of their rights under Section 504.

A flow chart for creating a 504 plan is available from [St. Louis Children's Hospital Food Allergy Management & Education \(FAME\)](#).

Schools should have procedures for communicating known food allergies and associated AAEPs and 504 plan accommodations with trained staff, including school nurses, teachers, paraprofessionals, school nutrition professionals, cafeteria monitors, substitute teachers, and other staff who interact with students. Remember, schools must get approval from the caregiver and student to communicate information regarding their allergies and accommodations.

Staff with different roles and responsibilities may benefit from different forms of communication. For example, documenting food allergies in educational records is useful for classroom staff, while documenting food allergies in point-of-sale systems is useful for cafeteria staff.

## How Should School Nutrition Programs Manage Food Allergies?

### 2.3. Maintain medical statements from state-licensed health care professionals to document appropriate meal modifications for students with food allergies.

Medical statements are documents required by the USDA Food and Nutrition Service for [Child Nutrition Programs](#) to support the need for food substitutions for medical reasons.<sup>37</sup> Medical statements are simple forms that include:

- The type of disability and how the disability affects the student's diet (for example, "Student has a peanut allergy and cannot eat peanuts")
- The diet prescribed by the health care provider (for example, "All food must be free of peanuts, including trace amounts of peanut")
- The foods that should be omitted and the suggested substitutions (for example, "No peanut-containing foods; suggested substitutions include almond or sunflower butters and other peanut-free foods")
- Other food modifications needed for the student due to a qualifying disability, such as texture changes or special equipment to eat

These forms must be signed by state-licensed health care professionals, which include physicians, physician assistants, nurse practitioners, and registered dietitians. USDA permits registered dietitians, regardless of whether they have a state license, to write medical statements to request meal modifications on behalf of students with disabilities in the school meal programs.<sup>38</sup> Because access to health care providers can be a barrier for many families, schools should have procedures in place to help caregivers obtain the necessary signatures.

The [USDA requirements](#) for medical statement forms are published online. Many states have their own templates for Medical Statement forms.



## **2.4. Ensure that students with food allergies, as determined by a state-licensed health care professional, have full and equal access to foods offered by the school nutrition program.**

When planning meal and snack modifications for students with food allergies, school nutrition programs must make sure that food substitutions have similar:

- Nutritional value
- Dietary variety
- Quality
- Convenience

When possible, school nutrition professionals should work with registered dietitians or nutritionists to design meal modifications for students with food allergies.

This recommendation applies to all foods provided by the school, including breakfast, lunch, snacks, alternative meals for students whose accounts have unpaid balances, and shelf-stable foods stored for emergency situations.

## **2.5. Publish weekly or monthly school menus.**

Publishing school menus allows caregivers and students to review upcoming meals and plan ahead. These published menus should include, at a minimum, labeling for the top-9 allergens. They may also include clear labeling for gluten or list all ingredients for those with allergies outside of the top 9.

Importantly, caregivers and students should be told that school menus are subject to change, such as in the case of supplier delays or substitutions. When a meal changes, or if a planned allergen-free meal has been modified to include an allergen, schools should quickly communicate these changes to caregivers and students.

While menus are meant to help caregivers and students plan their meals, school staff are still responsible for proper labeling and communication of potential food allergens during meal and snack times.

## **2.6. Maintain a current food label library.**

School nutrition professionals should be able to share complete ingredient lists for meals and snacks served or planned within a 24-hour window. To make sure ingredient lists are accurate, a food label library should be maintained by school nutrition program staff.

Food label libraries can be maintained using digital photographs or binders. Food labels should be maintained for at least 24 hours after foods are served in case of a delayed allergic reaction.

## **2.7. Designate staff members to assist children with food allergies who may not be able to safely avoid allergens on their own.**

During meal and snack selection, a school nutrition professional, cafeteria monitor, or other school staff member should be assigned to help students with food allergies select safe foods. These staff members should have completed food allergy training that includes detailed information about how to read and understand food labels.

## **2.8. Set up procedures to separately receive, store, prepare, cook, transport, hold, serve, and reheat allergy-safe foods and meals.**

Schools should standardize procedures for separating allergen-safe foods from foods that may contain allergens during every step of food handling.

# **How Can Schools Prevent Food Allergen Exposure?**

## **2.9. When possible, discourage eating in classrooms; if eating in classrooms is necessary, designate an area for eating that is separate from learning spaces, especially for younger children.**

Schools should discourage eating in the classroom whenever possible. Students with food allergies often feel anxious about meals and snacks, and eating in classrooms can distract these students from learning.<sup>39,40</sup>

There are times when schools may not have alternatives to eating in classrooms, and we have listed recommendations for managing food in classrooms in [Box 4](#).

## Box 4. Best Practices for Settings Where Meals or Snacks Are Eaten in Classrooms

- Designate times for meals and snacks; do not allow snacking during lessons (unless required by another student's accommodation plan; for example, a student with diabetes may need to eat at certain times)
- Make learning areas food-free zones; designate separate areas for eating
- Require students to wash hands with soap and water or disposable, fragrance-free wipes
- Clean eating surfaces with soap, water, and disposable cloths or towels after snacks and meals
- If there is no separate classroom area that can be used for eating, increase supervision for younger children

### 2.10. Wash hands before and after preparing, serving, or eating meals or snacks to avoid food allergen cross-contact.

Hands must be properly washed with soap and water to remove allergens. Schools should make sure that sinks are easy to access before and after meal and snack times. For schools or classrooms without sinks, rules should be put in place for bathroom access before and after eating, both to prevent allergen cross-contact and to encourage basic hygiene practices.

If handwashing before and after meals is not feasible for all students, schools may consider providing fragrance-free disposable wipes as a substitute for soap and water. If providing wipes is not possible, we suggest prioritizing handwashing before eating for students with food allergies and before and after eating for students without food allergies.



Hand sanitizer does **not** remove food allergens and is not an alternative to handwashing.<sup>2</sup>

### 2.11. Clean surfaces before and after meals or snacks to avoid food allergen cross-contact.

FDA *Food Code* recommends cleaning surfaces with soap and water, rinsing with water, sanitizing, and air drying before and after eating; all school nutrition programs should follow these procedures.<sup>28</sup> We recognize that this process is not possible in most classroom and extracurricular settings. Therefore, we recommend cleaning surfaces with soap, water, and disposable towels before and after eating. In cases where this is not possible, fragrance-free wet wipes may be used.

Eating surfaces should never be cleaned with shared cloths or towels or reused water from a cleaning bucket.

Sanitizing sprays, gels, or bleach do not remove allergens from surfaces.<sup>2</sup>

### 2.12. During meal and snack times, ensure students have adequate space to sit and eat.

Students should not be crowded around lunch tables or other areas during meal and snack times.

### 2.13. Discourage sharing of food items among students.

Food sharing can lead to accidental food allergen exposure, and schools should discourage this practice, especially for younger students. Schools should explain the reason for the policy in age-appropriate ways and regularly remind students about this rule without blaming or singling out the student with food allergies. Cafeteria monitors and other school staff who monitor meal and snack times should discourage food sharing.

### 2.14. Encourage the use of non-food student incentives/rewards and classroom celebrations.

Schools should strongly discourage the use of food as student incentives or as part of classroom celebrations. There are many non-food alternatives for prizes, gifts, and awards, such as:

- Books
- Bookmarks
- Stickers
- Extra recess time
- Extra art time

Many more examples of free or low-cost non-food incentives are available from [Kids With Food Allergies](#).

## 2.15. Ensure students with food allergies can fully participate by evaluating school materials, activities, and projects for potential food allergens and adjusting accordingly.

Students with food allergies should be able to fully participate in all class activities and projects. In some cases, lesson plans or curricula may require adjustments to accommodate students with food allergies. Examples of class activities and projects that contain food allergens include:

- Play dough containing wheat
- Egg drop, egg flotation, and vinegar egg immersion in a science class
- Crafts using milk or egg cartons, birdseed, or dried pasta
- Candle-making using soy
- Mosaic arts using crushed egg shells
- Egg and spoon race in gym
- Carrying bags of flour as baby simulations in health class



Some common class materials have hidden allergens. For example, finger paints can contain milk, and some crayons contain soy. A list of allergens in craft supplies is available from [\*\*Kids With Food Allergies.\*\*](#)

Students with food allergies should never be required to participate in activities that expose them to their food allergens.

## 2.16. Apply protocols and procedures for preventing food allergen reactions to school-sponsored events and activities, including bus rides, field trips, clubs, sports, and extracurricular activities.

Students with food allergies should be able to fully participate in field trips, sports, extracurricular activities, before-and after-care activities, and all other school-related activities. Schools are responsible for making sure that these activities are safe for all students, including those with food allergies. This recommendation applies to any school-related activities conducted by third-party contractors.

For activities where food is involved, such as snacks during sporting events or meals during field days, schools should provide equivalent, allergen-safe alternatives. We suggest the use of packaged foods with clear labeling for snacks. In cases where foods are catered (for example, pizza delivery or food trucks), schools should ensure that the businesses provide allergen-safe alternatives and that all foods are labeled.

## 2.17. Ensure food allergy protocols and procedures do not exclude students with food allergies.

Schools should consider inclusivity and fairness when developing food allergy management protocols. Some well-intended food allergy rules exclude or discriminate against students. Examples include isolating students at allergen-free lunch tables, requiring students to eat with staff, or stopping children from participating in events with food. These and other similar food allergy management rules should be avoided (unless they are included as part of students' accommodation plans).

Bullying is a challenge for many students with food allergies.<sup>10,41,42</sup> Examples of bullying, teasing, and harassment in schools include teasing students about their allergy, pressuring students to eat foods that they are allergic to, and threatening or assaulting students with their allergen(s). This type of bullying can make students feel unsafe or put them in life-threatening situations.

To reduce bullying, schools should include food allergy education in their programming. We suggest [\*\*FARE's Protect a Life \(PAL\)<sup>®</sup> program.\*\*](#)

As part of an inclusive food allergy management program, schools should have policies with zero tolerance for bullying. Schools should also proactively prevent bullying through student and staff education on food allergies.<sup>42</sup>



**About 1 in 3** children have been bullied, teased, or harassed about their food allergies; of these, 1 in 5 reported that teachers and/or school staff were the perpetrators.<sup>9,10</sup>

## Box 5. Should Schools Consider Food Allergen Restrictions?

Some schools have used **site-wide food restrictions** (also called site-wide bans) to try to reduce the risk of accidental allergen exposure. However, these bans are controversial, and no high-quality evidence supports the benefit of site-wide bans for preventing allergic reactions.<sup>43</sup> Schools with food allergen bans have the same amounts of allergic reactions as schools without these restrictions.<sup>44</sup>

As with other recommendations, the individual needs of students with food allergies must be considered, and a 504 accommodation may require a food restriction.

Site-wide restrictions are difficult to enforce. Studies have found that banned foods are still found in schools with site-wide restrictions, indicating that these policies may be ineffective at keeping allergens out of schools. Caregivers and staff should not assume that a restriction of a specific allergen is keeping all students with food allergies safe.<sup>45-47</sup>

### Aside from preventing food allergen exposure, for what reasons might a school consider food restrictions?

Although studies do not show that site-wide restrictions reduce accidental allergen exposure,<sup>39</sup> there may be instances when specific allergen restrictions should be considered. In settings when cross-contact cannot be prevented, especially with young children, these strategies might be helpful. No studies have been conducted on the psychosocial impact of food restrictions in schools, and expert opinions vary widely on this topic.

In general, we suggest that schools consider the following factors before enacting a site-wide food restriction:

- Alternatives to site-wide restrictions, such as room-specific restrictions, food-free zones, enhanced supervision at mealtimes, or student buddy systems
- Individual student accommodation requirements, as recommended in a 504 plan by a licensed professional
- Methods of communicating and enforcing site-wide restrictions
- Potential psychosocial effects of site-wide restrictions
- Plans for routinely re-evaluating the relevance of restrictions or when a restriction may be removed

## 3. Preparing for Emergencies

### Overview

Immediate treatment with epinephrine can be lifesaving for a person experiencing a severe allergic reaction. Epinephrine is a safe and effective drug that is recommended for the treatment of confirmed or suspected severe allergic reactions.<sup>48-50</sup>

During an allergic reaction, quickly giving epinephrine is critical. When epinephrine is administered within minutes of an allergic reaction, people are less likely to be hospitalized or admitted to the intensive care unit (ICU).<sup>51,52</sup>

Therefore, all schools should have policies and procedures in place for treating severe allergic reactions.

### What Protocols and Procedures Are Needed to Prepare for Food Allergy Reactions?

#### 3.1. Maintain AAEPs and medication authorization forms as part of IHPs and/or 504 plans for students with known food allergies.

AAEPs and medication authorization forms should be maintained as part of IHPs and/or 504 plans for all students with known food allergies. Templates for AAEPs can be found in [Appendix A3](#). These plans should be easily accessible for all staff members with regular student contact.

Some families or caregivers may not have access to a health care provider who can fill out these forms; therefore, schools should have measures in place for assisting these families with accessing a health care provider.

#### 3.2. Implement protocols and procedures for staff response to a suspected allergic or anaphylactic reaction in people without known food allergies or without AAEPs.

Up to 1 in 4 severe allergic reactions in schools happen in students without known allergies.<sup>8</sup> Therefore, schools should have protocols and procedures in place for the treatment of suspected allergic reactions in students without known food allergies and for students with food allergies who do not have AAEPs on file. These policies should be documented, including protocols for:

- Recognizing symptoms
- Staff responsibilities (for example, who is able to administer epinephrine? Who should call 911/contact emergency medical services? Who should accompany the student in the ambulance?)
- 911 procedures and when to involve emergency medical services

### What Are the Best Practices for Epinephrine in Schools?

#### 3.3. Maintain a constant supply of unassigned epinephrine.

All schools should maintain an uninterrupted supply of **unassigned epinephrine** (also called stock epinephrine, non-patient-specific epinephrine, or undesignated epinephrine) that is prescribed for general emergency use. According to the [2013 School Access to Emergency Epinephrine Act](#), all schools are legally allowed to have unassigned epinephrine for use in any person experiencing an allergic reaction.

We suggest that schools designate staff members who are responsible for maintaining the school's unassigned epinephrine supply. Different states have different requirements for unassigned epinephrine in schools, but responsibilities may include:<sup>3-7</sup>

- Obtaining a prescription for unassigned epinephrine from a health care provider or the district medical officer
- Obtaining a standing order for administration (if needed, depending on the state and district)
- Ordering the epinephrine
- Reviewing the expiration dates regularly
- Replacing expired devices

Epinephrine can be expensive when purchased from pharmacies.<sup>53</sup> In some cases, supply-chain issues can also impact pricing. Several resources are available to help schools access epinephrine at no or low cost, including manufacturer programs that provide free or discounted epinephrine to schools. These opportunities help make maintaining a supply of unassigned epinephrine more affordable for schools.

Maintaining unassigned epinephrine is also a health equity issue due to the challenges some families face in accessing health care. Racially and ethnically minoritized populations and lower-income people with food allergies are less likely to have epinephrine prescriptions.<sup>52,54,55</sup> Given that these same populations are at higher risk for developing food allergies, difficulty accessing epinephrine further compounds disparities.<sup>56</sup> Therefore, maintaining unassigned epinephrine is especially important in schools which may have more students with food allergies who do not have their own epinephrine.



Expired epinephrine should be replaced as soon as possible. However, expired epinephrine should not be thrown away until a replacement is on site.<sup>4-8</sup>

**Different states regulate the administration of epinephrine in schools in different ways. Schools should ensure that a trained staff member who is legally able to administer epinephrine is present in every building whenever students are present.**

### **3.4. Allow students who are deemed ready by their caregivers and health care providers to self-carry and/or self-administer epinephrine.**

Once students are developmentally ready, they can begin to **self-carry** their epinephrine, which ensures easy access to it in case of an emergency. Schools should have a standardized process for allowing students to self-carry epinephrine.

We recommend allowing caregivers and health care providers to decide whether a student is ready to self-carry. School nurses may also be able to assess whether a student can self-carry.<sup>57</sup>

Even if a student is self-carrying their epinephrine, they may not be able to **self-administer**. In that case, eligible school staff may need to administer a student's self-carried epinephrine. We suggest that schools educate caregivers and students about safe self-carry practices, including communicating with others about where their epinephrine is and what to do if they have symptoms of an allergic reaction.

### **3.5. Store unassigned and assigned epinephrine in secure areas that are unlocked and easily accessible by staff.**

Epinephrine should be securely stored, ideally in an unlocked area that is not easily accessible by students. At all times, multiple staff members should have access to epinephrine storage. If epinephrine is in a locked area, all trained personnel who can legally administer epinephrine should have access with keys or lock codes.

The ideal storage location for epinephrine varies by school. For example, large schools should have more than one storage location for easy access from any building or floor. Or, in schools where only nurses can legally administer epinephrine, the nurse's office may be the best storage location.

Consider how epinephrine will be carried and be readily accessible on field trips, field days, assemblies, or in other atypical school settings. Staff with proper epinephrine training must be available.

All manufacturer instructions for epinephrine should be followed, including temperature requirements.

## 4. Communication and Collaboration

### Overview

Food allergy management in schools requires a team-based approach. Collaboration among staff, caregivers, and students is the best way to make sure that students with food allergies are learning in safe and inclusive environments. A comprehensive food allergy management plan embraces this collaborative approach and ensures that staff have clear roles and responsibilities based on their skills and expertise.

### What Is the Best Approach to a Comprehensive Food Allergy Management Program?

#### 4.1. Implement and document a food allergy management approach that considers the individual needs of students with food allergies.

Ideally, food allergy management policies are developed at the district level and implemented by schools. However, if districts do not have food allergy management plans—or if district plans do not adequately protect students—schools should develop their own comprehensive food allergy management plans.

Examples of food allergy management plans that do not adequately protect students include those that:

- Don't have policies for epinephrine administration
- Encourage the use of discriminatory practices (for example, separating students with food allergies from other students)
- Don't meet the needs of the school's population (for example, not including guidance for school breakfasts or summer lunch programs)



A school's comprehensive food allergy management plan does **not** replace the need for individualized student accommodation plans.

The CDC's [Voluntary Guidelines for Managing Food Allergies In Schools and Early Care and Education Programs](#) includes examples of the different parts of a comprehensive food allergy management plan.<sup>25</sup>

#### 4.2. Ensure consistent communication and enforcement of food allergy management policies and procedures.

Food allergy management plans should be documented and made accessible to all staff, caregivers, and students. Schools should ensure that all staff members are aware of food allergy management protocols and procedures.

#### 4.3. Ensure all staff are aware of their individual roles in food allergy management.

School food allergy management plans should identify the staff members who are responsible for key tasks, including managing personnel training, identifying and documenting food allergies, and managing unassigned epinephrine. Different staff members may have different responsibilities depending on the school.

[Table 3](#) outlines examples of roles and responsibilities for the different food allergy management team members.

#### 4.4. Align food allergy management plans with the needs of the school community.

When developing a comprehensive food allergy management plan, schools should consider the needs of their student body, including factors such as:

- |   |  |
|---|--|
| <ul style="list-style-type: none"><li>• Grade levels</li><li>• Level of staff supervision</li><li>• Student developmental abilities</li><li>• Cultural representation</li></ul> | <ul style="list-style-type: none"><li>• Socioeconomics</li><li>• Language and literacy levels</li><li>• Health care access</li></ul> |
|---|--|

**Table 3. Examples of Team Roles and Responsibilities**

Topic	Team Member							
	Administrators	School nurse or healthcare staff	School nutrition program staff	Classroom staff (teachers, paraprofessionals)	Social workers, counselors, and behavioral staff	Support staff (janitors, cafeteria monitors, security guards, chaperones)	Caregivers	Students
<b>Training and Education</b>	<ul style="list-style-type: none"> <li>• Development of training requirements</li> <li>• Identification of training method(s)</li> <li>• Designation of staff member to document training</li> </ul>	<ul style="list-style-type: none"> <li>• Development of training requirements</li> <li>• Delivery of training for staff</li> <li>• Maintenance of professional development with continuing education that includes food allergies</li> </ul>	<ul style="list-style-type: none"> <li>• Participation in food allergy training as required by 2022 FDA Food Code</li> </ul>	<ul style="list-style-type: none"> <li>• Participation in food allergy training, including administration of epinephrine</li> <li>• Participation in bullying prevention training</li> </ul>	<ul style="list-style-type: none"> <li>• Participation in food allergy training, including administration of epinephrine</li> <li>• Participation in bullying prevention training</li> </ul>	<ul style="list-style-type: none"> <li>• Participation in food allergy training, including administration of epinephrine</li> </ul>	<ul style="list-style-type: none"> <li>• Participation in food allergy educational activities</li> </ul>	<ul style="list-style-type: none"> <li>• Engagement in food allergy lessons</li> <li>• Engagement in bullying prevention lessons and initiatives</li> </ul>
<b>Prevention</b>	<ul style="list-style-type: none"> <li>• Determination and communication of applicable district policies and state and federal regulations</li> <li>• Designation of staff member to identify and document food allergies in students</li> <li>• Development of protocols and procedures for identification and documentation of students with food allergies</li> <li>• Development of protocols and procedures for prevention of food allergen cross-contact</li> <li>• Incorporation of food allergy content into student learning</li> <li>• Regular review of effectiveness of policies</li> <li>• Oversight and enforcement of policies</li> </ul>	<ul style="list-style-type: none"> <li>• Identification and documentation of food allergies in students</li> <li>• Maintenance of all IHPs, AAEPs, and 504 plans</li> <li>• Regular review of effectiveness of policies</li> </ul>	<ul style="list-style-type: none"> <li>• Identification and documentation of food allergies in collaboration with nurse, dietitian, or other designated school staff</li> <li>• Maintenance of private and confidential system to identify students with food allergies</li> <li>• Development and communication of equal and nutritious allergen-safe meals, snacks, and emergency food supplies</li> <li>• Designation of staff to assist students in selecting allergen-free meals</li> <li>• Creating an environment where students with food allergies will be safe</li> <li>• Reading food labels</li> <li>• Prevention of cross-contact</li> <li>• Following the school's food allergy management plan</li> <li>• Meal modifications for students with food allergies</li> </ul>	<ul style="list-style-type: none"> <li>• Adherence to handwashing and cleaning protocols before and after all meals and snacks</li> <li>• Use of non-food incentives, rewards, and celebrations</li> <li>• Monitoring of student interactions to prevent food sharing or bullying</li> <li>• Incorporation of food allergy content into lesson plans</li> </ul>	<ul style="list-style-type: none"> <li>• Adherence to handwashing and cleaning protocols before and after all meals and snacks</li> <li>• Use of non-food incentives, rewards, and celebrations</li> <li>• Monitoring of student interactions to prevent food sharing or bullying</li> </ul>	<ul style="list-style-type: none"> <li>• Adherence to handwashing and cleaning protocols for food surfaces and high-touch areas</li> <li>• Monitoring of student interactions during meals</li> </ul>	<ul style="list-style-type: none"> <li>• Provision of IHP and 504 plan</li> <li>• Consideration and assessment of student ability to self-manage food allergies</li> </ul>	<ul style="list-style-type: none"> <li>• Avoidance of food sharing</li> <li>• Handwashing</li> </ul>



**Table 3. Examples of Team Roles and Responsibilities (Continued)**

Topic	Team Member							
	Administrators	School nurse or healthcare staff	School nutrition program staff	Classroom staff (teachers, paraprofessionals)	Social workers, counselors, and behavioral staff	Support staff (janitors, cafeteria monitors, security guards, chaperones)	Caregivers	Students
<b>Emergency Preparedness</b>	<ul style="list-style-type: none"> <li>Determination and communication of applicable district policies and state and federal regulations, including indemnity and liability</li> <li>Advocacy for unassigned epinephrine stocking</li> <li>Funding of unassigned epinephrine stocking</li> <li>Designation of staff member to maintain epinephrine in school</li> <li>Review of all cases of epinephrine use and adjustment of policies as needed</li> </ul>	<ul style="list-style-type: none"> <li>Documentation of all AAEPs</li> <li>Provision of epinephrine administration training for staff</li> <li>Maintenance of unassigned epinephrine, including obtaining standing orders and prescriptions, ordering, and reviewing expiration dates</li> <li>Assessment of student readiness for self-carry</li> <li>Advocacy for unassigned epinephrine stocking</li> <li>Review of all cases of epinephrine use and adjustment of policies as needed</li> </ul>	<ul style="list-style-type: none"> <li>Monitoring and identification of signs or symptoms of food allergy reactions</li> </ul>	<ul style="list-style-type: none"> <li>Monitoring and identification of signs or symptoms of food allergy reactions</li> <li>Regular review of AAEPs for all rostered students</li> </ul>	<ul style="list-style-type: none"> <li>Monitoring and identification of signs or symptoms of food allergy reactions</li> </ul>	<ul style="list-style-type: none"> <li>Monitoring and identification of signs or symptoms of food allergy reactions</li> </ul>	<ul style="list-style-type: none"> <li>Provision of assigned epinephrine to school at diagnosis and prior to start of school year</li> <li>Provision of AAEP</li> <li>Consideration and assessment of student ability to self-carry and self-administer</li> <li>Education of child regarding food allergy reaction management</li> </ul>	<ul style="list-style-type: none"> <li>Self-carry and self-administration of epinephrine, when developmentally ready</li> <li>Verbal or nonverbal communication with peers and adults in the event of anaphylaxis</li> </ul>
<b>Communication</b>	<ul style="list-style-type: none"> <li>Regular review of policies to ensure school needs are being met</li> <li>Communication of protocols and procedures to staff, parents, and students</li> <li>Advocacy and collaboration on district-level food allergy policies</li> </ul>	<ul style="list-style-type: none"> <li>Provision of educational resources for caregivers and students</li> <li>Communication with caregivers encouraging obtaining epinephrine prescriptions and ongoing health care professional evaluations for students</li> <li>Support for caregivers and students who are anxious about their allergies</li> </ul>	<ul style="list-style-type: none"> <li>Provision of school menus in advance</li> <li>Communication of ingredient statement information with school staff, caregivers, and students</li> </ul>	<ul style="list-style-type: none"> <li>Support for caregivers and students who are anxious about their allergies</li> <li>Encouragement of an inclusive environment among students</li> </ul>	<ul style="list-style-type: none"> <li>Support for caregivers and students who are anxious about their allergies</li> <li>Facilitating communication with caregivers of children with and without food allergies</li> </ul>	<ul style="list-style-type: none"> <li>Communication with designated school contact</li> </ul>	<ul style="list-style-type: none"> <li>Engagement with health care providers to identify any changes in food allergy status</li> <li>Communication of changes in food allergy status to schools</li> </ul>	<ul style="list-style-type: none"> <li>Self-advocacy for food allergen exposure prevention</li> </ul>

# Conclusions

Comprehensive food allergy plans should be collaborative, consistent, and inclusive.

- A **collaborative** approach promotes partnership among the team of administrators, staff, school nurses, volunteers, caregivers, and students who are involved in food allergy management in schools
- A **consistent** approach uses clear communication of standardized policies, protocols, and procedures across all school-based activities
- An **inclusive** approach fosters a safe and equitable learning environment for all students with food allergies

These recommendations are based on expert opinion and, where available, literature, data, and existing guidelines. However, data on food allergy management in schools are limited. Ongoing research is needed to find the most effective methods for keeping students with food allergies safe in schools.

Because these recommendations may not be appropriate or feasible for every school, districts should first determine what must be implemented based on federal and state law and local policies, and implement those recommendations. Because these recommendations are voluntary, schools may consider them in determining what actions may be appropriate for an individual student. However, any actions that school districts take for individual students must be implemented consistent with applicable federal, state, and local laws, including regulations. And while these recommendations provide information related to certain applicable laws, they should not be construed as giving legal advice. Schools should consult local legal professionals for such advice.

# References

1. Nowak-Wegrzyn A, Conover-Walker MK, Wood RA. Food-allergic reactions in schools and preschools. *Arch Pediatr Adolesc Med.* 2001;155(7):790-795. doi:10.1001/archpedi.155.7.790
2. Brough HA, Makinson K, Penagos M, et al. Distribution of peanut protein in the home environment. *J Allergy Clin Immunol.* 2013;132(3):623-629. doi:10.1016/j.jaci.2013.02.035
3. Volerman A, Brindley C, Amerson N, Pressley T, Woolverton N. A National Review of State Laws for Stock Epinephrine in Schools. *J Sch Health.* 2022;92(2):209-222. doi:10.1111/josh.13119
4. Lyon RC, Taylor JS, Porter DA, Prasanna HR, Hussain AS. Stability profiles of drug products extended beyond labeled expiration dates. *J Pharm Sci.* 2006;95(7):1549-1560. doi:10.1002/jps.20636
5. Cantrell FL, Cantrell P, Wen A, Gerona R. Epinephrine Concentrations in EpiPens After the Expiration Date. *Ann Intern Med.* 2017;166(12):918-919. doi:10.7326/L16-0612
6. Simons FE, Gu X, Simons KJ. Outdated EpiPen and EpiPen Jr autoinjectors: past their prime? *J Allergy Clin Immunol.* 2000;105(5):1025-1030. doi:10.1067/mai.2000.106042
7. Kassel L, Jones C, Mengesha A. Epinephrine drug degradation in autoinjector products. *J Allergy Clin Immunol Pract.* 2019;7(7):2491-2493. doi:10.1016/j.jaip.2019.04.028
8. White MV, Hogue SL, Odom D, et al. Anaphylaxis in Schools: Results of the EPIPEN4SCHOOLS Survey Combined Analysis. *Pediatr Allergy Immunol Pulmonol.* 2016;29(3):149-154. doi:10.1089/ped.2016.0675
9. Lieberman JA, Weiss C, Furlong TJ, Sicherer M, Sicherer SH. Bullying among pediatric patients with food allergy. *Ann Allergy Asthma Immunol.* 2010;105(4):282-286. doi:10.1016/j.anai.2010.07.011
10. Shemesh E, Annunziato RA, Ambrose MA, et al. Child and parental reports of bullying in a consecutive sample of children with food allergy. *Pediatrics.* 2013;131(1):e10-17. doi:10.1542/peds.2012-1180
11. Tan BM, Sher MR, Good RA, Bahna SL. Severe food allergies by skin contact. *Ann Allergy Asthma Immunol.* 2001;86(5):583-586. doi:10.1016/s1081-1206(10)62908-0
12. Leonardi S, Pecoraro R, Filippelli M, et al. Allergic reactions to foods by inhalation in children. *Allergy Asthma Proc.* 2014;35(4):288-294. doi:10.2500/aap.2014.35.3755
13. Zablotzky B, Black LI, Akinbami LJ. Diagnosed Allergic Conditions in Children Aged 0-17 Years: United States, 2021. *NCHS Data Brief.* 2023;(459):1-8.
14. Food Allergy Research & Education (FARE). Estimated Food Allergy Population by State and Age Group – 2023. Accessed July 15, 2024. <https://www.foodallergy.org/resources/estimated-food-allergy-population-state-pdf>
15. Gupta RS, Warren CM, Smith BM, et al. The Public Health Impact of Parent-Reported Childhood Food Allergies in the United States. *Pediatrics.* 2018;142(6):e20181235. doi:10.1542/peds.2018-1235
16. US Food & Drug Administration. Food allergies: what you need to know. April 12, 2023. Accessed July 26, 2024. <https://www.fda.gov/food/buy-store-serve-safe-food/food-allergies-what-you-need-know>
17. Motosue MS, Bellolio MF, Van Houten HK, Shah ND, Campbell RL. National trends in emergency department visits and hospitalizations for food-induced anaphylaxis in US children. *Pediatr Allergy Immunol.* 2018;29(5):538-544. doi:10.1111/pai.12908
18. Foong RX, Patel NB, Turner P, Roberts GC, Fox AT. Preventing food allergy fatalities. *Arch Dis Child.* 2023;108(9):698-702. doi:10.1136/archdischild-2022-324911

19. Sundquist BK, Jose J, Pauze D, Wang H, Jarvinen KM. Anaphylaxis risk factors for hospitalization and intensive care: A comparison between adults and children in an upstate New York emergency department. *Allergy Asthma Proc.* 2019;40(1):41-47. doi:10.2500/aap.2019.40.4189
20. Michelson KA, Monuteaux MC, Neuman MI. Glucocorticoids and Hospital Length of Stay for Children with Anaphylaxis: A Retrospective Study. *J Pediatr.* 2015;167(3):719-724 e711-713. doi:10.1016/j.jpeds.2015.05.033
21. Patel N, Herbert L, Green TD. The emotional, social, and financial burden of food allergies on children and their families. *Allergy Asthma Proc.* 2017;38(2):88-91. doi:10.2500/aap.2017.38.4028
22. Sampson MA, Munoz-Furlong A, Sicherer SH. Risk-taking and coping strategies of adolescents and young adults with food allergy. *J Allergy Clin Immunol.* 2006;117(6):1440-1445. doi:10.1016/j.jaci.2006.03.009
23. McIntyre CL, Sheetz AH, Carroll CR, Young MC. Administration of epinephrine for life-threatening allergic reactions in school settings. *Pediatrics.* 2005;116(5):1134-1140. doi:10.1542/peds.2004-1475
24. Department of Public Health, Commonwealth of Massachusetts. Life-threatening allergies and anaphylactic events in schools. 2017. Accessed July 26, 2024. <https://www.mass.gov/lists/life-threatening-allergies-and-anaphylactic-events-in-schools>
25. Centers for Disease Control and Prevention. Voluntary guidelines for managing food allergies in schools and early care and education programs. 2013. Accessed July 26, 2024. <https://www.cdc.gov/healthyschools/foodallergies/index.htm>
26. Sicherer SH, Simons FER, Section On A, Immunology. Epinephrine for First-aid Management of Anaphylaxis. *Pediatrics.* 2017;139(3)doi:10.1542/peds.2016-4006
27. American Academy of Dermatology. Hives: signs and symptoms. September 28, 2021. Accessed May 30, 2024. <https://www.aad.org/public/diseases/a-z/hives-symptoms>
28. US Food & Drug Administration. Food Code 2022 (10th edition). December 28, 2022. Accessed July 26, 2024. <https://www.fda.gov/food/fda-food-code/food-code-2022>
29. Wang J, Bingemann T, Russell AF, Young MC, Sicherer SH. The Allergist's Role in Anaphylaxis and Food Allergy Management in the School and Childcare Setting. *J Allergy Clin Immunol Pract.* 2018;6(2):427-435. doi:10.1016/j.jaip.2017.11.022
30. US Department of Education Office for Civil Rights. Section 504 protections for students with food allergies. February 2024. Accessed May 30, 2024. <https://www2.ed.gov/about/offices/list/ocr/docs/ocr-factsheet-food-allergies-202402.pdf>
31. Discrimination prohibited. 34 CFR §104.4 1980. Amended 2017. <https://www.ecfr.gov/current/title-34/section-104.4>
32. Panel NI-SE, Boyce JA, Assa'ad A, et al. Guidelines for the diagnosis and management of food allergy in the United States: report of the NIAID-sponsored expert panel. *J Allergy Clin Immunol.* 2010;126(6 Suppl):S1-58. doi:10.1016/j.jaci.2010.10.007
33. Muraro A, de Silva D, Halken S, et al. Managing food allergy: GA(2)LEN guideline 2022. *World Allergy Organ J.* 2022;15(9):100687. doi:10.1016/j.waojou.2022.100687
34. Morisset M, Moneret-Vautrin DA, Kanny G, et al. Thresholds of clinical reactivity to milk, egg, peanut and sesame in immunoglobulin E-dependent allergies: evaluation by double-blind or single-blind placebo-controlled oral challenges. *Clin Exp Allergy.* 2003;33(8):1046-1051. doi:10.1046/j.1365-2222.2003.01734.x
35. Hicks A, Palmer C, Bauer M, Venter C. Accidental ingestions to known allergens by food allergic children and adolescents. *Pediatr Allergy Immunol.* 2021;32(8):1718-1729. doi:10.1111/pai.13573
36. Evaluation and placement. 34 CFR §104.35 1980. <https://www.ecfr.gov/current/title-34/section-104.35>.
37. US Department of Agriculture. School meals FAQs. 2019. Accessed July 26, 2024. <https://www.fns.usda.gov/cn/school-meals-faqs>

38. US Department of Agriculture. Final Rule - Child Nutrition Programs: Meal Patterns Consistent With the 2020-2025 DGAs. April 25, 2024. Accessed July 23, 2024. <https://www.fns.usda.gov/cn/fr-042524>
39. Vollmer RL, Girsch V, Foster JS. A Qualitative Investigation of Parent and Child Perceptions of School Food Allergy Policies in the United States. *J Sch Health*. 2022;92(2):185-193. doi:10.1111/josh.13121
40. Kanter AB, Yasik AE, Zaccario ML, Saviano JC. Self-Reported Anxiety Ratings in Children With and Without Food Allergies and Teacher Knowledge of Food Allergies. *J Sch Health*. 2022;92(6):541-549. doi:10.1111/josh.13181
41. Cooke F, Ramos A, Herbert L. Food Allergy-Related Bullying Among Children and Adolescents. *J Pediatr Psychol*. 2022;47(3):318-326. doi:10.1093/jpepsy/jsab099
42. Annunziato RA, Rubes M, Ambrose MA, Mullarkey C, Shemesh E, Sicherer SH. Longitudinal evaluation of food allergy-related bullying. *J Allergy Clin Immunol Pract*. 2014;2(5):639-641. doi:10.1016/j.jaip.2014.05.001
43. Wasserman S, Cruickshank H, Hildebrand KJ, et al. Prevention and management of allergic reactions to food in child care centers and schools: Practice guidelines. *J Allergy Clin Immunol*. 2021;147(5):1561-1578. doi:10.1016/j.jaci.2021.01.034
44. Bartnikas LM, Huffaker MF, Sheehan WJ, et al. Impact of school peanut-free policies on epinephrine administration. *J Allergy Clin Immunol*. 2017;140(2):465-473. doi:10.1016/j.jaci.2017.01.040
45. Banerjee DK, Kagan RS, Turnbull E, et al. Peanut-free guidelines reduce school lunch peanut contents. *Arch Dis Child*. 2007;92(11):980-982. doi:10.1136/adc.2006.113118
46. Nguyen-Luu NU, Ben-Shoshan M, Alizadehfar R, et al. Inadvertent exposures in children with peanut allergy. *Pediatr Allergy Immunol*. 2012;23(2):133-139. doi:10.1111/j.1399-3038.2011.01235.x
47. Cherkaoui S, Ben-Shoshan M, Alizadehfar R, et al. Accidental exposures to peanut in a large cohort of Canadian children with peanut allergy. *Clin Transl Allergy*. 2015;5(1):16. doi:10.1186/s13601-015-0055-x
48. Brown JC, Simons E, Rudders SA. Epinephrine in the Management of Anaphylaxis. *J Allergy Clin Immunol Pract*. 2020;8(4):1186-1195. doi:10.1016/j.jaip.2019.12.015
49. Dribin TE, Wasserman S, Turner PJ. Who Needs Epinephrine? Anaphylaxis, Autoinjectors, and Parachutes. *J Allergy Clin Immunol Pract*. 2023;11(4):1036-1046. doi:10.1016/j.jaip.2023.02.002
50. Whyte AF, Soar J, Dodd A, Hughes A, Sargant N, Turner PJ. Emergency treatment of anaphylaxis: concise clinical guidance. *Clin Med (Lond)*. 2022;22(4):332-339. doi:10.7861/clinmed.2022-0073
51. Fleming JT, Clark S, Camargo CA, Jr., Rudders SA. Early treatment of food-induced anaphylaxis with epinephrine is associated with a lower risk of hospitalization. *J Allergy Clin Immunol Pract*. 2015;3(1):57-62. doi:10.1016/j.jaip.2014.07.004
52. Trainor JL, Pittsenbarger ZE, Joshi D, Adler MD, Smith B, Gupta RS. Outcomes and Factors Associated With Prehospital Treatment of Pediatric Anaphylaxis. *Pediatr Emerg Care*. 2022;38(1):e69-e74. doi:10.1097/PEC.0000000000002146
53. Russell AF, Bingemann TA, Cooke AT, et al. The Need for Required Stock Epinephrine in All Schools: A Work Group Report of the AAAAI Adverse Reactions to Foods Committee. *J Allergy Clin Immunol Pract*. 2023;11(4):1068-1082 e1061. doi:10.1016/j.jaip.2022.12.047
54. Davis CM, Apter AJ, Casillas A, et al. Health disparities in allergic and immunologic conditions in racial and ethnic underserved populations: A Work Group Report of the AAAAI Committee on the Underserved. *J Allergy Clin Immunol*. 2021;147(5):1579-1593. doi:10.1016/j.jaci.2021.02.034
55. Shah SS, Parker CL, O'Brian Smith E, Davis CM. Disparity in the availability of injectable epinephrine in a large, diverse US school district. *J Allergy Clin Immunol Pract*. 2014;2(3):288-293 e281. doi:10.1016/j.jaip.2013.09.016
56. Jiang J, Warren CM, Brewer A, Soffer G, Gupta RS. Racial, Ethnic, and Socioeconomic Differences in Food Allergies in the US. *JAMA Netw Open*. 2023;6(6):e2318162. doi:10.1001/jamanetworkopen.2023.18162
57. National Association of School Nurses. School nursing evidence-based clinical practice guideline: students with allergies and risk for anaphylaxis. 2023. Accessed July 26, 2024. <https://learn.nasn.org/courses/58496>

# Appendix

## A1. FAMS Advisory Council Members

**Michael Pistiner, MD, MMSc (Chairperson)**

Mass General for Children

**Brooke Balchan, DO, FAAP**

American Academy of Pediatrics (AAP), Council on School Health

**Andrea Boudreaux, PsyD, MPH, MHA, FACH**

American School Health Association (ASHA)

**Kelly Cleary, MD, FAAP**

Food Allergy Research and Education (FARE)

**Liz Dixon, MS**

Institute for Child Nutrition (ICN)

**Eleanor Garrow-Holding**

**Amelia G. Smith, JD**

Food Allergy & Anaphylaxis Connection Team (FAACT)

**Kayla Jackson**

AASA, The School Superintendents Association

**Susan Maffe, MS, RD, SNS**

School Nutrition Association (SNA)

**Lynda Mitchell, MA, CAE**

Allergy & Asthma Network

**Linda Neumann, RN**

National Association of School Nurses (NASN)

**Jenna Riemenschneider, MSc**

Asthma and Allergy Foundation of America (AAFA)

**Thomas Silvera, MSHS-PH**

Elijah-Alavi Foundation

**Mary Vargas, JD**

Stein & Vargas LLP

**Julie Wang, MD**

American Academy of Pediatrics (AAP), Icahn School of Medicine at Mount Sinai

## A2. Staff Training and Educational Resources

### Toolkits, Training, and Resources for Curricula

Program	Type	Fee?	Audience						
			Administrators	Health care staff	School nutrition staff and monitors	Teachers	Caregivers	Support staff	Students
<b>FAMS-validated resources</b> — The following resources have been updated to reflect the 2024 Food Allergy Management in Schools Expert Recommendations. Additional resources will be added to this list as they are updated and validated to reflect the 2024 Recommendations.									
<a href="#">FARECheck Food Service Training K-12</a>	eLearning	Free			X			X	
<a href="#">FARECheck Food Service Training Instructor Training</a>	Virtual instructor-led	Free, \$			X			X	
<a href="#">Keeping Students Safe and Included for Staff and Caregivers (FARE)</a>	eLearning	Free		X	X	X	X	X	
<a href="#">Keeping Students Safe and Included for Administrators (FARE)</a>	eLearning	Free	X						
Keeping Students Safe and Included Volunteer Handout (FARE)	Digital download/ Print	Free					X		
<b>Additional resources</b> — as of the date of publication these resources may not reflect all 2024 FAMS Expert Recommendations—the following will be updated online as the resources are validated.									
<a href="#">Be a PAL® Instructional Program (FARE)</a>	In-classroom PPT and materials for school-aged children	Free							X
<a href="#">FARE Recognizing and Responding to Anaphylaxis</a>	eLearning course	Free	X	x	X	X	X	X	
<a href="#">FAACTs for Schools Staff Education Program</a>	PPT with companion manual, talking points, and evaluation questions	Free	X		X	X		X	
<a href="#">FAACT's Food Allergy Curricula Program for Schools</a>	Curricula	Free							X
Institute of Child Nutrition	<a href="#">Scheduled face-to-face training, self-paced online courses, fact sheets, and sample Standard Operating Procedures</a>	Free			X				
<a href="#">National Association of School Nurses Allergy and Anaphylaxis Toolkit</a>	PDF toolkits and sample training PPTs	Free		X					
<a href="#">St. Louis Children's Hospital Food Allergy Management &amp; Education (FAME)</a>	PDF toolkits	Free	X		X	X	X	X	X
<a href="#">Code Ana Online Learning</a>	Online courses	Free, \$	X	X	X	X	X	X	X
<a href="#">Kyah EPICourse for Schools</a>	Online training course and toolkits	Free	X	X	X	X		X	

# A3. Allergy and Anaphylaxis Emergency Plan (AAEP) Template

[AAP\\_Allergy\\_and\\_Anaphylaxis\\_Emergency\\_Plan.pdf](#)

## Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN®



Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

Date of birth: \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Weight: \_\_\_\_\_ kg

Child has allergy to \_\_\_\_\_



- Child has asthma.  Yes  No (If yes, higher chance severe reaction)  
 Child has had anaphylaxis.  Yes  No  
 Child may carry medicine.  Yes  No  
 Child may give him/herself medicine.  Yes  No (If child refuses/is unable to self-treat, an adult must give medicine)

### IMPORTANT REMINDER

**Anaphylaxis is a potentially life-threatening, severe allergic reaction. If in doubt, give epinephrine.**

#### For Severe Allergy and Anaphylaxis What to look for

If child has ANY of these severe symptoms after eating the food or having a sting, **give epinephrine**.

- Shortness of breath, wheezing, or coughing
- Skin color is pale or has a bluish color
- Weak pulse
- Fainting or dizziness
- Tight or hoarse throat
- Trouble breathing or swallowing
- Swelling of lips or tongue that bother breathing
- Vomiting or diarrhea (if severe or combined with other symptoms)
- Many hives or redness over body
- Feeling of "doom," confusion, altered consciousness, or agitation

**SPECIAL SITUATION:** If this box is checked, child has an extremely severe allergy to an insect sting or the following food(s): \_\_\_\_\_. Even if child has MILD symptoms after a sting or eating these foods, **give epinephrine**.



#### Give epinephrine! What to do

1. Inject epinephrine right away! Note time when epinephrine was given.
2. Call 911.
  - Ask for ambulance with epinephrine.
  - Tell rescue squad when epinephrine was given.
3. Stay with child and:
  - Call parents and child's doctor.
  - Give a second dose of epinephrine, if symptoms get worse, continue, or do not get better in 5 minutes.
  - Keep child lying on back. If the child vomits or has trouble breathing, keep child lying on his or her side.
4. Give other medicine, if prescribed. Do not use other medicine in place of epinephrine.
  - Antihistamine
  - Inhaler/bronchodilator

#### For Mild Allergic Reaction What to look for

If child has had any mild symptoms, **monitor child**.

Symptoms may include:

- Itchy nose, sneezing, itchy mouth
- A few hives
- Mild stomach nausea or discomfort



#### Monitor child What to do

Stay with child and:

- Watch child closely.
- Give antihistamine (if prescribed).
- Call parents and child's doctor.
- If more than 1 symptom or symptoms of severe allergy/anaphylaxis develop, use epinephrine. (See "For Severe Allergy and Anaphylaxis.")

#### Medicines/Doses

Epinephrine, intramuscular (list type): \_\_\_\_\_ Dose:  0.10 mg (7.5 kg to less than 13 kg)\*  
 0.15 mg (13 kg to less than 25 kg)  
 0.30 mg (25 kg or more)

Antihistamine, by mouth (type and dose): \_\_\_\_\_ (\*Use 0.15 mg, if 0.10 mg is not available)

Other (for example, inhaler/bronchodilator if child has asthma): \_\_\_\_\_

Parent/Guardian Authorization Signature \_\_\_\_\_

Date \_\_\_\_\_

Physician/HCP Authorization Signature \_\_\_\_\_

Date \_\_\_\_\_

© 2017 American Academy of Pediatrics, Updated 03/2019. All rights reserved. Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor. Page 1 of 2.



### A3. Allergy and Anaphylaxis Emergency Plan (AAEP) Template (Continued)

[AAP\\_Allergy\\_and\\_Anaphylaxis\\_Emergency\\_Plan.pdf](#)

#### Allergy and Anaphylaxis Emergency Plan

American Academy of Pediatrics  
DEDICATED TO THE HEALTH OF ALL CHILDREN®



Child's name: \_\_\_\_\_ Date of plan: \_\_\_\_\_

#### Additional Instructions:

#### Contacts

Call 911 / Rescue squad: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

#### Other Emergency Contacts

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

© 2017 American Academy of Pediatrics, Updated 03/2019. All rights reserved. Your child's doctor will tell you to do what's best for your child. This information should not take the place of talking with your child's doctor. Page 2 of 2.