ALLERGY SAFETY, ASTHMA and ANAPHYLAXIS MANAGEMENT POLICY

Policy Statement

Values:

Christ Church CE Primary School believes that the safety and wellbeing of those members of the school community suffering from specific allergies, asthma and who are at risk of anaphylaxis is the responsibility of the whole school community. The School position is not to guarantee a completely allergen free environment, but rather to minimise the risk of exposure, encourage self-responsibility, and plan for an effective response to possible emergencies. The following named member of the senior leadership team of this School is the allergy safety lead, Emma Clarke.

The School is committed to:

- Providing, as far as practicable, a safe and healthy environment in which people at risk of Allergies, asthma and anaphylaxis can participate equally in all aspects of the school program;
- The encouragement of self-responsibility and learned avoidance strategies amongst pupils suffering from allergies;
- Raising awareness about allergies, asthma and anaphylaxis amongst the school community;
- Ensuring each staff member has adequate knowledge of allergies, asthma and anaphylaxis and the emergency procedures;
- Close liaison with parents/guardians of pupils who suffer allergies, to assess risks, develop risk minimisation strategies, and management strategies for their child;
- Facilitating communication to ensure the safety and wellbeing of the person with an allergy who is at risk of anaphylaxis.

Purpose.

The aim of the policy is to:

- Minimise the risk of an allergic/ asthma/ anaphylactic reaction while the person is involved in school related activities.
- Ensure that staff members respond appropriately to an allergic/ asthma/ anaphylactic reaction by initiating appropriate treatment, including competently administering an adrenaline auto-injection device.
- Raise, within the Christ Church CE Primary School community the awareness of allergy/ asthma/ anaphylaxis and its management through education and policy implementation

This Policy will be reviewed annually.

Definitions:

Allergy is a medical condition in which the body's immune system has an abnormal reaction to normally harmless substances such as food, insect stings, contact allergens and airborne allergens.

Anaphylaxis is a potentially fatal reaction affecting the Airway/Breathing/Circulation ("ABC"). Many individuals with allergies to food or insect stings are at risk of anaphylaxis.

Asthma is a lung disease caused by inflammation and tightening of the airways, it is frequently associated with allergy and anaphylaxis, because exposure to allergens can provoke an asthma attack, a potentially life-threatening condition.

Intolerance to foods or an ingredient that the body is unable to digest is different to allergy and does not cause a serious allergic reaction. It can cause long term health problems if not avoided. Common food intolerances include lactose and gluten. Coeliac disease is intolerance to gluten, found in rye, barley and wheat.

Allergic Conditions:

Common allergic conditions include:

- **Hay Fever (Allergic Rhinitis),** triggered by allergens carried in the air ("aeroallergens"), such as pollen, house dust mite, animal fur/feathers, or mould. Symptoms include sneezing, a runny or stuffed nose, itchy or watery eyes.

- **Skin allergies** (e.g. eczema, contact dermatitis, contact urticaria/hives) caused by contact with allergens including house dust mite, pollen and substances like nickel, latex and some chemicals. Symptoms include itching, hives and dry, flaky skin. Reactions can be delayed, occurring many hours after contact.
- **Food allergy**, which can cause symptoms ranging from mild itching in the mouth to "whole body" reactions including anaphylaxis (see below). Some food allergies do not cause immediate reactions, but result in delayed gastrointestinal symptoms (e.g. stomach pain, vomiting, diarrhoea) some hours later, sometimes occurring with an eczema flare. While 90% of food allergic reactions are caused by peanut/tree nuts, cow's milk, egg, wheat, fish/seafood and sesame, any food can cause an allergic reaction.
- **Asthma** in children is usually allergic in nature, meaning that it may be triggered by airborne allergens such as e.g. dust mite, animal dander or pollen. On average, there are two or three children with asthma in every classroom in the UK.
- **Less common allergic conditions** in children include allergy to insect stings (e.g. bee, wasp) and medicines.

Allergic reactions vary in severity: from mild local reactions (e.g. mild hay fever) to "whole body" (anaphylaxis) reactions (common with food allergy) to more serious reactions like anaphylactic shock. In general, most allergic reactions are not severe. Even for food allergy, most allergic reactions do not affect the Airway/Breathing/Circulation ("ABC") and can be treated with a non-drowsy oral antihistamine (available over-the-counter for those aged over 6 years) or local treatments such as nose sprays or eye drops.
However, some children and young people are at risk of anaphylaxis and require emergency medication (e.g. self-administered adrenaline).

The most common causes of "whole body" allergic reactions – including anaphylaxis are:

- **Food allergens;**
- **Insect stings (e.g. bee, wasp);**
- **Medication (e.g. antibiotics, pain medicines such as ibuprofen);**
- **Latex (e.g. rubber gloves, balloons, swimming caps).**

Even for food allergy, the vast majority of anaphylactic reactions require the person to have eaten the food, although less severe allergic reactions can happen through skin or other contact. Anaphylaxis reactions due to skin contact are very rare.

Rarely, anaphylaxis may occur without obvious exposure to an allergen, for example, after exercise or in people with an underlying "mast cell" disorder such as mast cell activation syndrome (MCAS). Such individuals should have a personalised plan provided by a healthcare professional to assist the school/ educational setting.

This policy sets out how Christ Church CE Primary School will support pupils with allergies, asthma and anaphylaxis to ensure they are safe and are not disadvantaged in any way whilst taking part in school life.

Asthma

Asthma is the most common long-term condition among children and young people and one of the leading causes of school absence. Asthma remains among the top 10 causes of emergency hospital admissions among children and young people in the UK. There were 54 child deaths due to asthma and 19 from anaphylaxis between April 2019 and March 2023, as set out in the National Child Mortality Database Report on Asthma and Anaphylaxis.

All of the children who died from anaphylaxis and had known allergies were also diagnosed with asthma. All of the children who died due to asthma were exposed to air pollution above WHO guidelines.
Asthma exacerbations are typically precipitated by identifiable triggers. In individuals with allergic asthma, exposure to airborne allergens such as pollen, house dust mite debris, pet dander and mould spores is a common trigger of worsening symptoms and exacerbations in sensitised people. Viral respiratory infections (such as rhinovirus, flu, RSV, and COVID-19), allergen exposure, and air pollution are recognised as among the most common contributors to acute asthma exacerbations, with evidence of synergistic interactions which can increase severity in sensitised children. Exercise and cold air can also cause symptoms.

Common symptoms include coughing, wheezing and breathlessness out of proportion to effort, and a tight chest. An asthma attack occurs when symptoms are severe, and breathing becomes difficult.
Poor air quality worsens asthma and increases asthma attacks, and those in deprived areas with poorer nutrition suffer increased negative health effects from poor air quality. Clean air is a core asthma control measure.

Children and young people known to have asthma should have their own reliever inhaler at school to treat symptoms and for use in the event of an asthma attack. If they are able to manage their asthma themselves they should keep their inhaler on them, and if not, it should be easily accessible to them. In some cases children and young people with suspected asthma will be prescribed a reliever inhaler before they receive a formal diagnosis.

Following amendment in 2014, the Human Medicines Regulations 2012 permit Schools/ Colleges to buy an emergency asthma reliever inhaler (salbutamol inhaler device and spacer), without a prescription, for use in emergencies. The inhaler can be used if the child or young person's prescribed inhaler is not available (for example, because it is broken or empty). **This school has emergency asthma reliever inhaler devices and spacers.** This Schools protocols for recognising and treating asthma attacks are shown in Appendix No.1.

Coeliac disease (For Information).

Coeliac disease is an autoimmune condition where the small intestine (gut) is hypersensitive to gluten in wheat and other gluten-containing grains (e.g. rye, barley). It is not an intolerance. Consuming gluten can cause significant illness (including abdominal pain and vomiting shortly after eating) which may be prolonged and result in absence from school for several days.
Repeated exposure to gluten carries serious long term health risks. However, such events are not "allergic" and should not be treated as an allergic reaction.
Coeliac disease cannot cause anaphylaxis, although anaphylaxis can occur in some with coeliac disease if they also have an allergy.
Effective management of coeliac disease depends on strict and consistent avoidance of gluten and robust cross-contamination controls – similar to the measures needed for a child or young person with food allergy to wheat.
This School will support children and young people with coeliac disease, normally through dietary avoidance. This will be arranged as part of the School wider medical conditions policy and does not fall in scope of this allergy safety policy.

Food intolerances (For Information).

Food intolerance is a non-immune system reaction where the body struggles to digest specific foods, causing symptoms like abdominal pain, bloating and diarrhoea for hours or days after eating. Unlike food allergies, intolerances cannot cause anaphylaxis. They are usually managed by identifying specific triggers, for example lactose intolerance or non-coeliac gluten sensitivity.
This School will support children and young people with food intolerance, normally through dietary avoidance. This will be arranged as part of the School wider medical conditions policy and does not fall in scope of this allergy safety policy.

Allergic reactions.

Allergic reactions occur when a susceptible person is exposed to something (an "allergen") they are allergic to. Most allergic reactions do not affect the Airway/Breathing/ Circulation ("ABC") and can be treated with an oral antihistamine. Parents/ Carers of pupils/ students with known allergic reactions can give their written permission for this school to administer such an oral antihistamine e.g., Piriton etc. When school staff deem this action to be required to support the pupil, parents/ carers will be contacted before administering the oral antihistamine and a written notification provided at the end of the school day.

Allergic reactions are unpredictable. Most reactions do not result in anaphylaxis.
However, when anaphylaxis occurs, reactions usually start off as less severe (e.g. Allergic reactions).

Symptoms of a mild to moderate allergic reaction (not anaphylaxis) include:

- Swollen lips, face or eyes
- Itchy/tingling mouth
- Mild throat tightness
- Hives or itchy skin rash
- Abdominal pain or vomiting
- Sudden change in behaviour

Mild reactions can worsen and become anaphylaxis, affecting the Airway/Breathing/Circulation ("ABC"):

SIGNS OF ANAPHYLAXIS (a potentially life-threatening allergic reaction)
A: Airways: Swelling in the throat, tongue or upper airways (tightening in the throat, hoarse voice, difficulty swallowing).
B: Breathing: Sudden onset wheezing, breathing difficulty, persistent cough, noisy breathing.
C: Circulation: Dizziness, feeling faint, sudden sleepiness, tiredness, confusion, pale clammy skin, loss of consciousness.
Anaphylaxis reactions involve the Airway/Breathing/Circulation ("ABC"). Reactions usually progress quickly and can be life-threatening – so anaphylaxis always requires an immediate emergency response. The features of an anaphylaxis reaction are shown in Appendix No.2.
The vast majority of anaphylactic reactions require the individual to have eaten food to which they are allergic.
Contact through skin or the air tends to produce less severe allergic reactions. Anaphylactic reactions solely due to skin contact are very rare.
As noted above, anaphylaxis may rarely occur without a clearly identified allergen or without ingestion of a food trigger. Our emergency response planning is based on the individual child or young person's documented triggers and clinical history, rather than any assumption over whether the person has eaten a trigger food. Anaphylaxis can occur without any other signs (such as a skin rash) being present. Our First Aid trained staff will always consider anaphylaxis in someone with a known food allergy who has sudden difficulty in breathing.

School responses to an allergic reaction and anaphylaxis.

Mild to moderate allergic reactions which do not involve Airway/Breathing/Circulation can be treated with oral antihistamines, providing parental permission has been obtained. For a child or young person, school staff will contact (ideally by telephone) their parent/ carer to tell them about the reaction. School staff will not leave the child or young person unattended. The child or young person does not normally need to be sent home or require urgent medical attention. They will be observed in a safe place for at least 60 minutes after reaction, as mild reactions can sometimes develop into anaphylaxis.
Anaphylaxis commonly occurs alongside mild symptoms or signs, such as an itchy mouth or skin rash. Anaphylaxis can also occur on its own, without a skin rash or other mild signs being present.
Anaphylaxis (i.e. any reactions which involve the Airway/Breathing/Circulation) will be treated promptly with emergency adrenaline (see Appendix No.2). The individual's prescribed adrenaline device – for example an adrenaline auto-injector (AAI) or nasal adrenaline device – will be used if it is available. If not, a "spare" adrenaline device will be used. If in doubt whether the reaction is anaphylaxis, treat with adrenaline.
School staff will always dial 999 to request an ambulance if someone is experiencing anaphylaxis.
The Ambulance Control ('999') operator can provide advice over the telephone if needed.
School First Aid trained staff will always stay with someone having an allergic reaction for at least one hour.

- **If in doubt, we always treat for anaphylaxis potential, regardless of whether the person has been diagnosed.**
- If the child or young person has an Allergy Action Plan issued by a healthcare professional, it should be followed.
- Treatment of anaphylaxis is with a dose of adrenaline (e.g. an AAI "pen" or nasal adrenaline device)

ACTIONS FOR ANAPHYLAXIS:

- Stay with the child and call for help. DO NOT MOVE CHILD OR LEAVE UNATTENDED.
- Remove trigger if possible (e.g. Insect stinger, swill out mouth with cold water).

- Lie child flat (with or without legs elevated) – A sitting position may make breathing easier.
- USE ADRENALINE WITHOUT DELAY and note time given. (AAI's - inject at upper, outer thigh - through clothing if necessary).
- CALL 999 for Ambulance Service and state *ANAPHYLAXIS EMERGENCY for XX (male/female/ age)*
- If no improvement after 5 minutes, administer second adrenaline auto-injector*.
- If no signs of life e.g., non-responsive and non breathing - commence CPR.
- Phone parent/carer as soon as possible.

All pupils must go to hospital for observation after anaphylaxis even if they appear to have recovered as a reaction can reoccur after treatment.

Food allergy and asthma.

Many food-allergic children also have asthma. "Wheeze" is a common symptom of asthma and also happens during food-induced anaphylaxis. The Allergy Action Plan may include instructions to give a reliever medicine (e.g. using a salbutamol inhaler) after giving a dose of adrenaline if the person is still wheezing. This school keeps emergency asthma reliever inhaler(s) containing a salbutamol inhaler device and spacers. Our First Aid trained staff will never give the reliever inhaler instead of adrenaline to treat anaphylaxis.

Role and Responsibilities.

Parent responsibilities:

- On entry to the school, it is the parent's responsibility to inform the school office of any allergies. This information should include all previous severe allergic reactions, history of anaphylaxis and asthma and details of all prescribed medication.
- Parents are to supply a copy of their child's Allergy Action Plan (BSACI plans preferred) or Asthma Action Plan to School. If they do not currently have an Allergy or Asthma Action Plan this should be developed as soon as possible in collaboration with a healthcare professional e.g. schools nurse/ GP/ allergy specialist.
- Parents are responsible for ensuring any required medication is supplied, in date and replaced as necessary. Clinical advice now recommends that **two** adrenaline devices (AD's) are carried by the anaphylaxis sufferer at all times, since two doses may be required (if appropriate for that pupil).

Parents are requested to keep the school up to date with any changes in allergy or asthma management. The Allergy/ Asthma Action Plan will be kept updated accordingly. Parents can subscribe to expiry alerts for the relevant adrenaline auto-injectors their child is prescribed, to make sure they can get replacement devices in good time.

School and Staff Responsibilities:

- This School will use Individual Healthcare Plans (IHPs) to set out the arrangements on how we will put in place to support a specific child or young person with their allergy which are additional to or different from those offered generally. The IHP will be developed in collaboration with the child or young person and their parents/ carers. IHPs are not clinical documents. The school will attach relevant care and action plans issued by healthcare professionals. A blank IHP is attached as Appendix No.3. IHP's will be reviewed annually by our SENCo or whenever new advice from healthcare professionals dictate.
- Where a healthcare professional has drawn up an emergency action plan for a pupil or young person (for example an Allergy or Asthma Action Plan) which the school must follow, the IHP will refer to the attached action plan, including the issuing health provider, the responsible healthcare professional and the review date. The IHP will set out the actions required of staff in an emergency and specify which staff are involved.
- Where a healthcare professional has offered advice on management of a pupil or young person's allergy, this School will reflect upon their advice.
- In some cases, a pupil or young person will have or be suspected of having allergy where no clinical advice is available. This may be the case where symptoms have newly emerged or where the process of diagnosis is still under way. In such cases this School will not dismiss the child or young person or the

information we receive, but will put arrangements in place to support based on the best assessment that can be made of the likely risk to the pupil or young person's health, education and wellbeing.
- All staff will complete anaphylaxis training. Training is provided for all staff on a yearly basis and on an ad-hoc basis for any new members of staff.
- Staff must be aware of the pupils in their care (regular or cover classes, breakfast and after school clubs) who have known allergies as an allergic reaction could occur at any time and not just at mealtimes. Any food-related activities must be supervised with due caution.
- Staff leading school trips will ensure they carry all relevant emergency supplies. Trip leaders will check that all pupils with medical conditions, including allergies, carry their medication. Pupils unable to produce their required medication will not be able to attend the excursion.
- A designated member of staff will ensure that the up to date Allergy Action Plan is kept with the pupil's medication.
- This School will not penalise pupils or young people for their attendance record if their absences are related to their allergy, e.g. hospital appointments and health management. This includes excluding children and young people from rewards for 100% attendance where their non-attendance is the result of a medical condition or allergy. This is reflected in our Attendance policies;
- It is the parent's responsibility to ensure all medication is in date however the designated member of staff will check medication kept at school on a termly basis and send a reminder to parents if medication is approaching expiry/ stock running low.
- It is good practice for schools to conduct allergy safety drills, in the same way as fire drills or in an active training exercise. A simulated case of anaphylaxis will be used to test out how our staff respond, without risk to any individual. The results of the drill should be recorded in a similar way to an incident or "near miss" and used to inform the ongoing review of the allergy safety policy. In some cases, it may be appropriate to include children and young people in such drills, for example where one of their peers has a high risk of anaphylaxis. If so, the child or young person will be involved in the planning of the drill to avoid a negative impact on their wellbeing.
- School Leadership will record any significant incident or near miss e.g., Anaphylaxis, on the School Accident Incident Form.

A designated member of staff keeps a register of pupils who have been prescribed an AAI and a record of use of any AAI(s) and emergency treatment given.

Pupil Responsibilities:
- Where possible, pupils are encouraged to have a good awareness of their symptoms and to let an adult know as soon as they suspect they are having an allergic reaction.
- Pupils who are trained and confident to administer their own AD's will be encouraged to take responsibility for carrying them on their person at all times ensuring they have access to them when travelling to or from the school, college or setting.
- Where the pupil or young person is deemed unsuitable to carry their own AD's with them whilst on our site, their AD's are kept in a rigid box and clearly labelled with the pupil's name, their up to date photograph and a up-to-date copy of their allergy action plan.
- A Pupil 'Do's and Don'ts regarding their AD's is attached as Appendix No.4.

Allergy and Asthma Action Plans

Allergy action plans are designed to function as Individual Healthcare Plans for children with food allergies, providing medical and parental consent for schools to administer medicines in the event of an allergic reaction, including consent to administer a spare adrenaline auto- injector. It is the parent/carer's responsibility to complete the allergy action plan with help from a healthcare professional (e.g. GP/School Nurse/Allergy Specialist) and provide this to the school.
Children and young people with asthma should be provided with an Asthma Action Plan by the relevant healthcare professional. This provides everything our staff need to know about a child or young person's asthma

in one place, including information about their triggers, symptoms, medicines to be used if they have asthma symptoms and when to seek emergency help when they have an asthma attack.
This School keeps a central record with photos of all individuals with allergy, including whether children and young people have Individual Healthcare Plans (IHP'S) and/or an Allergy or Asthma Action Plans.

Supply, storage and care of medication

There are 'spare' Adrenaline and Asthma kits which are kept safely, not locked away, clearly labelled and accessible to all staff.
The kits contain:

- Spare Adrenaline injectors i.e. EpiPen® or Jext® (2 x 150mcg and 2x 300mcg) two of the same type being prescribed) – to prevent confusion these AAI's are marked 'SCHOOL SPARE'
- EurNeffy nasal spray* *not currently allowed by UK law*.
- Antihistamine as tablets or syrup (spoon if required).
- Spare Asthma Reliever containing salbutamol.
- Spare Asthma Reliver spacers (if included on plan).

Our lead 'First Aider' (Office Co-ordinator) will maintain these kit(s) and check on a half-termly basis for expiry dates etc.

Storage

AAIs should be stored at room temperature, protected from direct sunlight and temperature extremes. EURneffy is an adrenaline nasal spray approved in the UK to treat anaphylaxis by delivering the adrenaline directly into the nose. It is only approved, at present, for use in adults and children who weigh 30kg (66 pounds) or more.

Disposal

AAIs are single use only and must be disposed of as sharps. Used AAIs can be given to ambulance paramedics on arrival or can be disposed of in a pre-ordered sharps bin. Sharps bins to be obtained from and disposed of by a clinical waste contractor. The sharps bin is kept in the school office.

Staff Training.

Is provided by approved First Aid providers. Note, staff who currently hold either the 18-hour First Aid at Work or the 12-hour Paediatric First Aid certificates are trained in anaphylaxis and use of AAI's/ Nasal Sprays.
School are aware of proposals from Government to direct the extent and scope of allergy training, at August 2026 not as yet implemented.

Inclusion, Wellbeing and Safeguarding.

Christ Church CE Primary School is committed to ensuring that all pupils with medical conditions, including allergies are properly supported in school so that they can play a full and active role in school life, remain healthy and achieve their academic potential.
Many children and young people with allergy become anxious as a result of the risk of exposure to allergens and the potential for anaphylaxis, which may be compounded by living with difficult-to-control
asthma or eczema. This school is active in providing support, both in providing reassurance that steps are being taken to minimise the risks of exposure to allergen and that robust measures are in place in the event of anaphylaxis. We are also mindful of the potential of bullying related to allergy.
Bullying can range from excluding peers from activities by deliberately using known allergens, to denigrating or making fun of the need to avoid allergens – and even threats to force-feed known allergens. This contributes to higher levels anxiety among children and young people with allergy, not least since
they may already feel singled out or different by virtue of the arrangements in place to support them (e.g. at meal times). This School will apply robust sanctions upon any person found to have bullied another school member because of their allergy.

Minimising risks of exposure to known allergens.

Catering

All food businesses (including school caterers) must follow the Food Information Regulations 2014 which states that allergen information relating to the 'Top 14' allergens must be available for all food for Health https://www.food.gov.uk/business-guidance/prepacked-for-direct-sale-ppds-allergen-labelling-changes-for-schools-colleges-and-nurseries

The Requirements for School Food Regulations 2014 (known as 'The School Food Standards') regulates the food and drink provided at breakfast service, lunchtime and across the school day. Compliance with the School Food Standards is mandatory for maintained schools, academies and free schools.

Food allergy quality standards (The National Institute for Health and Care Excellence, March 2016) https://www.nice.org.uk/guidance/qs118

Anaphylaxis: assessment and referral after emergency treatment (The National Institute for Health and Care Excellence, 2020) https://www.nice.org.uk/guidance/cg134?unlid=22904150420167115834

Guidance on the use of adrenaline auto-injectors in schools (Department of Health, 2017) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/645476/Adrenaline_auto_injectors_in_schools.pdf products.

The school office will inform the Catering/Kitchen Manager staff of pupils with food allergies.

The kitchen will display all allergen sensitive children and young persons in a manner that supports servers to provide food safely e.g. a photograph of the child and their allergens and verifying with the child concerned.

The school adheres to the following Department of Health guidance recommendations:

Food should not be given to primary school age food-allergic children without parental engagement and permission (e.g. birthday parties, food treats).

Foods containing nuts are discouraged from being brought into School. This School is a 'Nut Aware' establishment – we are not 'Nut Free'.

EYFS

Whilst babies and young children in early childhood settings, such as nurseries, childminders and pre-school settings, are eating there will always be a member of staff in the room with a valid full paediatric first aid certificate. Before a child is admitted to the above setting, the school office will obtain information about any special dietary requirements, preferences, food allergies and intolerances that the child has, and any special health requirements.

Curriculum activities

Use of food in crafts, cooking classes, science experiments and special events needs to be considered and may need to be revised / risk assessed depending on the allergies of particular children and their age. Pupils and young people will not be prevented from taking part in activities alongside their peers simply because of a risk of coming into contact with one of their allergens.

Staff will consider:

- Old food boxes or packaging may contain traces of allergens;
- Some products contain wheat flour, including "play dough";
- Some glues contain milk, wheat or soya;
- Bird feed may contain nuts and sesame.

Anaphylaxis reactions due to skin contact are very rare.

Food that is brought into the school

- **Packed Lunches** - parents / carers must not send nuts in any form as part of a child's packed lunch. This includes all forms of loose nuts, nut bars, cereal bars with nut content or nut spreads (including Nutella or other chocolate nut spreads). Where a child has any other allergy that can impact a child through air transference, it may be communicated to families that this item will be unexpectable across the time the child attends the school.

- **Events** - Where home cooked food is brought into school, all ingredients must be listed. Where shop bought items are used as an ingredient, the full ingredients of said shop bought item must be listed on the ingredients list. Children will only participate in sharing home cooked food at community events under the watch of their parents or carers.

School Offsite Trips and Fixtures.

Staff leading school trips and offsite sports fixtures will ensure they carry all relevant emergency supplies. Trip leaders will check that all pupils with medical conditions, including allergies, carry their medication. Pupils unable to produce their required medication will not be able to attend the excursion.

All the activities on the offsite trip will be risk assessed to see if they pose a threat to allergic pupils and alternative activities planned to ensure inclusion.

Overnight school trips may be possible with careful planning and a meeting for parents with the lead member of staff planning the trip should be arranged. Staff at the venue for an overnight school trip should be briefed early on that an allergic child is attending and will need appropriate food (if provided by the venue).

Useful Links.

Anaphylaxis Campaign - https://www.anaphylaxis.org.uk/
https://www.allergyuk.org/schools/whole-school-allergy-awareness- and management
Spare Pens in Schools - http://www.sparepensinschools.uk
Education newsletter: https://www.anaphylaxis.org.uk/education/allergy-management-newsletter/
https://www.nhs.uk/conditions/anaphylaxis

APPENDIX NO.1

HOW TO RECOGNISE AN ASTHMA ATTACK

The signs of an asthma attack are

- Persistent cough (when at rest)
- A wheezing sound coming from the chest (when at rest)
- Difficulty breathing (the child could be breathing fast and with effort, using all accessory muscles in the upper body)
- Nasal flaring
- Unable to talk or complete sentences. Some children will go very quiet.
- May try to tell you that their chest 'feels tight' (younger children may express this as tummy ache)

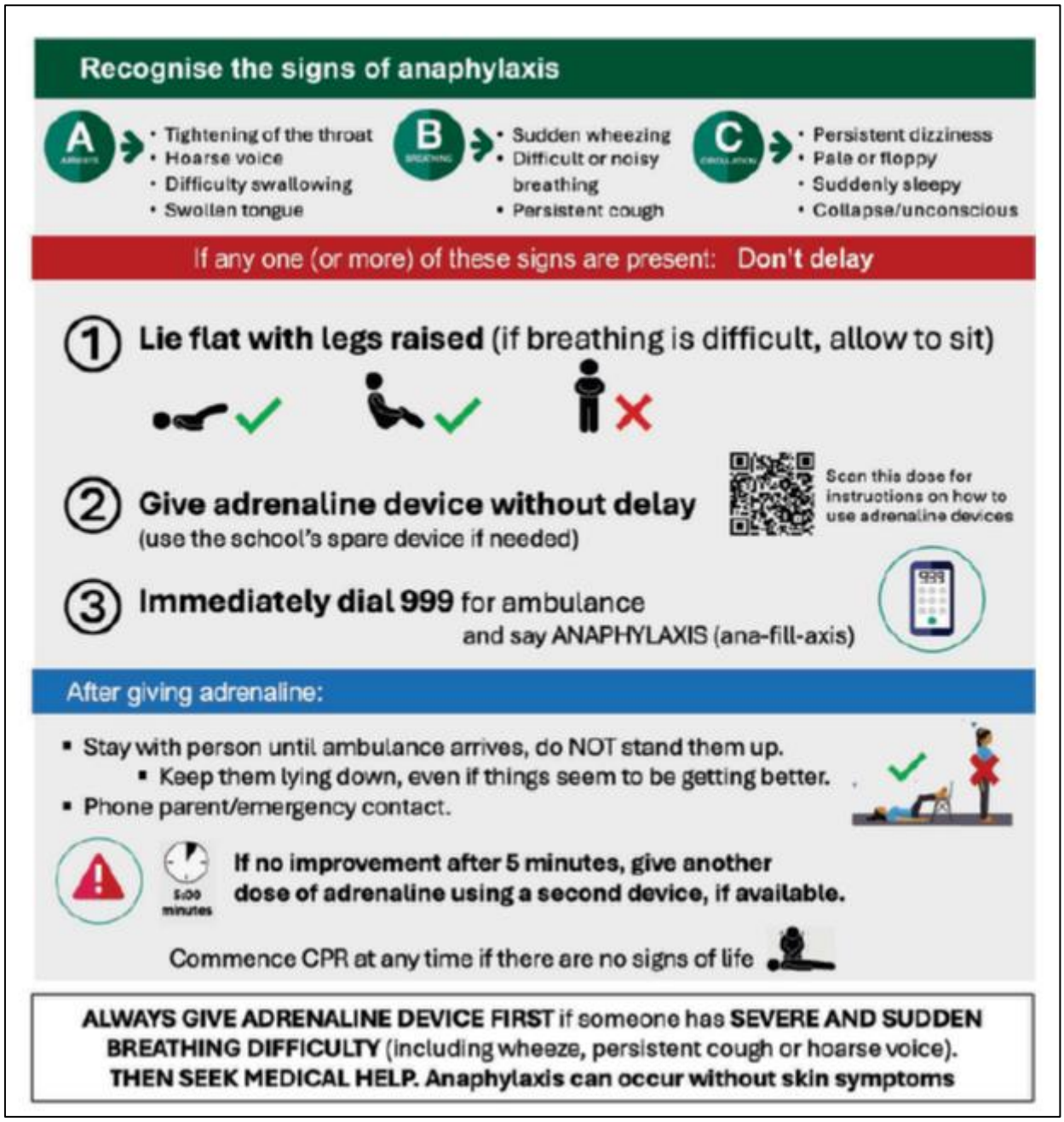
CALL AN AMBULANCE IMMEDIATELY AND COMMENCE THE ASTHMA ATTACK PROCEDURE WITHOUT DELAY IF THE CHILD

- Appears exhausted
- Has a blue/white tinge around lips
- Is going blue
- Has collapsed

WHAT TO DO IN THE EVENT OF AN ASTHMA ATTACK

- Keep calm and reassure the child
- Encourage the child to sit up and slightly forward
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with the child while the inhaler and spacer are brought to them
- Immediately help the child to take two separate puffs of salbutamol via the spacer
- If there is no immediate improvement, continue to give two puffs at a time every two minutes, up to a maximum of 10 puffs. Have a 10-minute timeframe to see improvement, if no improvement seen, contact Ambulance Control to seek advice for next steps.
- Stay calm and reassure the child. Stay with the child until they feel better. The child can return to school activities when they feel better
- If the child does not feel better or you are worried at ANYTIME before you have reached 10 puffs, CALL 999 FOR AN AMBULANCE
- If an ambulance does not arrive in 10 minutes give another 10 puffs in the same way

APPENDIX NO.2



APPENDIX NO.3

Separate Document – Draft Individual Health Careplan

APPENDIX NO.4

Do

- ✔ avoid the food, medicine or thing that you're allergic to – for example, if you have a food allergy, check food labels carefully and tell staff at restaurants and cafes about your allergy
- ✔ carry 2 adrenaline auto-injectors with you at all times
- ✔ check your adrenaline auto-injector expiry dates regularly and get new ones before they expire
- ✔ practise how to use your adrenaline auto-injector by using a trainer injector (an injector that has no needle or medicine in it) – you can order one online from the company that makes your injector
- ✔ teach friends, family, colleagues or carers how and when to use your adrenaline auto-injector
- ✔ use your adrenaline auto-injector if you think you may have anaphylaxis, even if your symptoms are mild
- ✔ wear medical alert jewellery such as a bracelet with information about your allergy – this tells other people about your allergy in case of an emergency

Don't

- ✘ do not leave your adrenaline auto-injectors anywhere too hot or cold such as in the fridge or outside in the sun