

Position Statement

ALLERGIES IN SCHOOLS

M Levin¹ | MBChB, FCPaed (SA), Dip Allergy (SA), MMed (Paed), PhD, EAACI Allergy Exam (UEMS), FAAAAI, FACAAI

A van Niekerk² | MBChB, MMed(Paed)

H Katz³ | BA Hons Soc work

C Stuurman⁴ | BA (Law), LLB

1. *Division of Paediatric Allergy, University of Cape Town*

2. *Department of Paediatrics and Child Health, University of Pretoria and Steve Biko Academic Hospital*

3. *Allergy Alive*

4. *Equal Education Law Centre*

Email | michael.levin@uct.ac.za

SUMMARY

With the increase of allergic conditions in South Africa, it is becoming more common for schools to have children in their care who suffer from asthma, allergic rhinitis, food allergies, insect allergies, anaphylaxis and atopic dermatitis. Unfortunately, inadequate guidelines exist for addressing the needs of such children and existing legislation does not cover many of the issues – being either vague or inadequate.

Since children spend a large proportion of their time at school, it is inevitable that the schools will have to accommodate children with chronic-care needs and also encounter events where children experience allergy emergencies. School authorities have a responsibility to ensure that learners are able to achieve their full potential, despite barriers to learning, and that they are taught and cared for in a safe environment.

This article outlines a practical and implementable policy for use in schools which is aimed at reducing the impact on learning of children suffering chronic health conditions and ensuring the safety of children with severe allergies. The fundamental aspects of the policy include:

- establishing an 'allergy action committee' (or 'chronic illness action committee') at each school;
- ensuring every child with a chronic health condition is identified and has both a chronic and an emergency treatment plan signed by their doctor and that these include an ID photograph;
- implementing measures to reduce potential exposure to identified allergens for those with severe allergies;
- ensuring that emergency medication is available and accessible at all times;
- training staff online in the identification and treatment of severe allergic reactions.

INTRODUCTION

The South African Constitution guarantees every child the right to education. This right is unqualified and immediately realisable, and is to be enjoyed by all learners. Closely linked to the right to education is the right of learners to a safe learning environment, dignity and life, and access to healthcare services.

The growing epidemic of allergic conditions affects approximately 25 per cent of all school-going children and these life-threatening chronic conditions such as asthma, diabetes and food allergies pose a challenge to schools and the education system. A comprehensive and coordinated approach underwritten by all parties involved – schools, families and healthcare providers – is required in order to address the issue of chronic health conditions in schools.

This policy may focus on allergies in schools; however, many of the recommendations are also applicable to other chronic health conditions.

The authors developed this article with the support of the Allergy Foundation South Africa (AFSA). The draft document was reviewed by Dr Michael Pistiner, a paediatric allergist at Harvard Vanguard Medical Associates, co-founder of AllergyHome and a consultant to the Massachusetts Department of Public Health, School Health Services as well as Mrs Laurie Harada, executive director of Food Allergy Canada and Mrs Carla Da Silva, head of the Montreal Anaphylaxis Support Group. Furthermore, the policy is endorsed by the Allergy Alive patient advocacy group, the Allergy Society of South Africa (ALLSA) and the Equal Education Law Centre (EELC). The policy is due to

be revised by 1 June 2017.

ALLERGIES AS A BARRIER TO LEARNING

Every day millions of learners across South Africa ready themselves for school; bright, eager minds looking ahead to a day full of learning and new adventures. However, for an increasing number of learners the idea of going to school fills them with dread; for others it remains an unattainable dream. Many children suffer from allergies that constitute a huge barrier to their learning. These children have to overcome great difficulties to access education.

Allergies are common and contribute to a large burden of disease that leads to a failure to learn, absenteeism, the need for emergency care and, even, death. Learners with allergies require regular medical care in order to achieve and maintain control of their symptoms, leading to absenteeism. Failure to control allergies results in symptoms causing inadequate learning or further absenteeism. Many allergic diseases are inadequately treated due to the perception that they are not controllable.

ASTHMA

Asthma is the most common life-threatening chronic disease of childhood. It cannot be cured, however, with regular treatment the disease can be controlled and symptoms prevented. Asthma causes absenteeism through its requirement for regular preventative doctors' visits as well as unscheduled absenteeism if symptoms occur. In addition, asthma may limit a child's participation in classroom activities, sports and academic events.

ALLERGIC RHINITIS

Allergic rhinitis is not a trivial disease as it constitutes a major cause of failure to learn. Inadequate control of the disease has been proved to reduce school achievement, with sedating antihistamines exacerbating the learning disability, but treatment with intranasal steroids and second-generation antihistamines abolishing it.

ANAPHYLAXIS

Anaphylaxis is a severe, life-threatening allergic reaction that is rapid in onset and requires immediate medical attention and may result in death. It can be caused by exposure to a variety of allergens such as food, insect stings, medications and latex, among other things. Learners at risk of anaphylaxis suffer from a lack of access to treatment and care which limits their freedom to safely attend school.

FOOD ALLERGIES

A food allergy occurs when the immune system identifies a food protein as dangerous and releases substances into the blood which result in the symptoms of a food-allergic reaction. Reactions can vary from mild rashes and swelling to life-threatening anaphylaxis. The amount required to trigger a reaction varies between individuals, however,

some react to minute 'trace amounts'. Those learners who struggle with both food allergy and asthma are more at risk of a fatal allergic reaction.

ATOPIC DERMATITIS

Atopic eczema is a common, chronic itchy skin rash that tends to affect those who already suffer from other allergies such as hayfever and asthma. These children do not sleep well at night and may not focus optimally at school. The rash often impacts on their cosmetic appearance and may become offensive when infected. Atopic dermatitis sufferers are frequently teased, bullied and excluded from social groups. Consequently, their physical and emotional suffering results in a failure to learn to their full potential. In addition, eczema requires frequent and regular preventative emollient therapy to achieve optimal control.

INSECT STINGS AND BITES

Severe, life-threatening allergic reactions (anaphylaxis) to insects are caused by the learner having an allergy to the insect venom. Bee venom – of all insect stings – is the most common cause of anaphylaxis in South Africa.

ALLERGIES IN SCHOOLS

Allergy management regimes in schools should be aimed at avoiding exposure to allergens and preparing for managing allergic emergencies. Avoidance and preparedness strategies should cater for multiple settings (classroom, cafeteria and playground) and multiple care providers (teacher, sports coach and school nurse). This necessitates well thought out and worked-through guidelines.

CHRONIC TREATMENT PLANS

Schools should update policies to routinely include information on allergies and other health conditions on currently enrolled students and for future applicants, subject to privacy laws where applicable. Access to regular medication in schools for children is necessary to ensure optimal control of allergies which reduces morbidity, learning barriers and absenteeism. Every child at school who has asthma and/or an allergy should have a chronic treatment plan signed by a specialist and this should include a photograph of the child and be updated yearly.

Practice points for schools:

1. Every school should allocate a minimum of three staff members to form an 'allergy action committee' (or 'chronic illness action committee'). This committee should gain a better understanding of allergic disease and champion the school's support of allergy sufferers.
2. Ask about allergies on every child's registration form, every year.
3. Every affected child must have a chronic treatment plan, signed by their doctor, including an ID photograph.
4. The chronic treatment plan should be signed by parents and/or legal guardians and should document

which medications the school personnel are mandated to administer, and when they are to be administered.

5. On receipt of the chronic treatment plan, the class teacher and 'allergy action committee' must meet to review the plan.
6. Class-specific records accessible to the class teacher should be kept of all learners with severe allergies and asthma, and detail what they are allergic to.
7. Schools must maintain a record of all medications administered.

ACCESS TO CARE EMERGENCY TREATMENT PLANS

Access to emergency treatment of severe allergic reactions is necessary to ensure a safe learning environment. The Medicines and Related Substances Control Act (101 of 1965, amended in 1997) requires a named patient be prescribed (Schedule 2 and above) medication, which can be dispensed to the parent who can mandate the school to administer such medicines when required.

Parents should sign an indemnity form for ill-effects caused by medication – if administered in cases of suspected need. School teachers (or the allergy action committee) should receive adequate training and agree to administer medication by following the prescribed procedure.

Although current legislation does not allow for the administration of medication to subjects who have not completed such paperwork, it may be an ethical imperative to treat a learner undergoing a suspected severe allergic reaction even if their own medication is not available.

Practice points for schools:

1. Every affected child must have an official AFSA emergency treatment plan (www.allergyfoundation.co.za), signed by their doctor and containing an ID photograph.
2. Specific teachers/staff (minimum three) should be designated as responders. These staff should form the core of an 'allergy action committee'.
3. Those at risk of having severe reactions, or their friends, should be educated to report such a reaction to the nearest available teacher or adult. All adults at the school should be informed as to the identity of these responders and how to locate them.
4. A designated place for the storage of emergency medication under correct conditions is necessary and must be accessible at all times. This should preferably be not locked up but securely out of reach of young children. Stored medications must be examined periodically by the allergy action committee (or their delegate) for expiry dates and parents notified to refill with 'in-date' medication.
5. The emergency treatment plan should document which medications the school personnel are mandated to administer, when they should be administered and be signed by legal guardians.

6. The emergency treatment plan should document the learner's permission to carry and self-administer prescribed medications where developmentally appropriate.
7. Schools must maintain a record of all medications used in an emergency, notify parents immediately and document circumstances of the incident.
8. In the instance of an anaphylactic reaction, a member of the staff or the allergy action committee should administer adrenaline via an auto-injector and the child should be transported by emergency services to the nearest emergency department.

ALLERGEN SAFETY STRATEGIES

Avoidance of allergens is the cornerstone of preventing life-threatening allergic reactions. The risk of anaphylaxis is reduced when avoidance strategies are implemented. General recommendations to reduce the risk of exposure for learners with food and insect allergies are recommended below.

Practice points for schools:

1. Elicit the support of co-learners, their families and school staff to limit or exclude the presence of specified food allergens (usually peanut, tree nut and sesame) on the school premises, in tuckshops and at after-class activities, parties, trips and sport events.
2. Avoid using common food allergens in classroom projects or activities, as rewards or incentives and during school events, parties or celebrations.
3. Ensure learners with severe food allergies are able to eat in a safe environment. Options include:
 - discouraging food sharing, especially among young children;
 - establishing a specified allergen-free area (which is maintained and cleaned regularly) for those with severe or multiple allergies;
 - encouraging all learners to wash their hands thoroughly prior and after food consumption.
4. Implement insect-sting avoidance measures to ensure that both identified and unidentified insect venom-allergic children are protected.
5. Allergy-related teasing or bullying should be treated seriously by activating the school's anti-bullying policies.

TRAINING

Schools should encourage all teachers to complete training in allergy awareness (e.g. Module: Food allergy for your school community) which is available online via www.allergyfoundation.co.za with a certificate obtainable after completion of a quiz (in progress). Members of the allergy action committee must complete training in allergy awareness, prevention and response (e.g. Module: Management of food allergy in schools, production in progress) and maintain records of yearly completion of such training.

1. Ensure teachers, sports coaches, secretaries, cafeteria/lunch staff, drivers and other staff are trained in allergy awareness at schools.
2. Members of the allergy action committee are to be supported on an ongoing basis and allowed time for training in allergen-avoidance measures, recognition of severe reactions and implementing emergency management plans.
3. Train teachers, cafeteria/lunch staff and other staff in basic food-handling and cleaning procedures to prevent cross-contamination from hands, surfaces and utensils if foods containing known allergens are prepared and/or served in a classroom.
4. Establish regular practice drills to test if staff can identify severe allergic reactions and know their role in the emergency protocol. Ensure the drill assesses whether medication is accessible and can be given appropriately and timeously
5. Education for learners regarding allergies can be built into school curricula, for example, health, science or life skill programmes.

CONCLUSION

Providing a safe school environment for learners with life-threatening food allergies is essential in allowing children with barriers to learning to achieve their full potential in a healthy and safe learning environment.

Ethics CPD Questionnaire

ETHICAL ISSUES IN ANAPHYLAXIS

Ethics articles are accredited for ethics CPD points. Log in to the ALLSA website (www.allergysa.org) and click on "My CPD" to submit your answers. Kindly send submissions or suggestions for topics to the section editor, Prof Sharon Kling at sk@sun.ac.za. This CPD activity is for ALLSA members only.

INDICATE TRUE OR FALSE

1. *True or false:* In the Emergency Department (ED) the patient and the doctor are usually not known to each other, and there is therefore no established doctor-patient relationship.
2. *True or false:* In an emergency situation the patient may not be fully autonomous and therefore unable to give informed consent.
3. *True or false:* The principle of beneficence underpins the requirement for informed consent in healthcare.
4. *True or false:* Informed consent implies being able to choose between different treatments as well as being able to refuse treatment, and explicit refusal of treatment by a patient who has the capacity to make decisions should be respected.
5. *True or false:* The fundamental elements of the process of informed consent consist of threshold elements, information elements and consent elements.
6. *True or false:* Informed consent in the ED merely requires the patient to sign a piece of paper without understanding the proposed course of treatment.
7. *True or false:* In a life-and-death emergency, the doctor may proceed without obtaining the patient's consent.
8. *True or false:* In terms of South African legislation, the hierarchy of surrogate decision makers are, in order, the patient's parent, spouse or partner, grandparent, adult child, or brother or sister.
9. *True or false:* A doctor does not require the patient's consent in order to disclose medical information about her.
10. *True or false:* A doctor may disclose medical information about a patient without her consent if he deems it to be in the public's interest.