

Caring for children with anaphylaxis in a child care program



**A resource manual for
Child Care personnel who provide
care to children in community programs**

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Manitoba

Unified Referral and Intake System

Manitoba Family Services and Housing • Manitoba Education and Youth • Manitoba Health

anaphylaxis

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Introduction

Background

The **Unified Referral and Intake System (URIS)**, a partnership between the provincial departments of Health, Family Services and Housing and Education and Youth, supports community programs in the care of children with special health care needs when they are apart from their families.

URIS provides policy direction and assistance to community programs (i.e., school divisions, child care centres, family child care, nursery schools, recreation programs, and agencies providing respite service) to address the needs of children with life-threatening allergies. As well, URIS provides funding to community programs for a registered nurse to:

- develop an Individual Health Care Plan and an Emergency Response Plan for a child with known risk of anaphylaxis;
- provide child-specific training to personnel in the community program involved with the child (e.g. family child care providers, early childhood educators, child care assistants, resource staff, custodians, bus drivers); and
- monitor personnel in the community program involved with the child, as necessary.

It is the responsibility of the community program to apply for URIS support. The URIS Committee reviews the application and written notification of eligibility is sent to the community program. When approval is received, the community program contacts a publicly funded health care provider to determine if a registered nurse is able to provide service. If a publicly funded health care provider is unable to complete all or part of the approved interventions, the community program may then hire a private nursing agency or an independent registered nurse. If readers are unfamiliar with the process of applying for URIS support they may wish to consult their designated Provincial Child Care Coordinator.

Caring for Children with Life-threatening Allergies

This resource manual includes guidelines and tools to assist child care directors/providers and board personnel in developing local policies regarding life-threatening allergies. The desired outcome is for these children to be managed in a comprehensive and coordinated manner that allows them to participate safely and to the fullest extent possible in the community program.

When a child care facility is notified that a child has been diagnosed with a life-threatening allergy and may require the immediate injection of adrenaline by auto-injector, this procedure must be followed:

1. When a child care facility is made aware that a child has a life-threatening allergy and carries an adrenaline auto-injector, appropriate planning can begin. Based on this information a **URIS application should be submitted**.
2. The child care director/provider or designate will **advise the parents/guardians** of the child that:
 - (a) A URIS (Unified Referral and Intake System) application will be completed on an annual basis. See Appendix “A”.
 - (b) Parents/guardians are required to sign an “*Authorization for the Release of Information*” form to the child care facility on behalf of URIS, Regional Health Authority and/or nursing agency. See Appendix “B” sample.
 - (c) Parents/guardians must complete the “*Authorization Form for Administration of Adrenaline Auto-Injector*” form. See Appendix “C” sample.
 - (d) A Health Care Plan/Emergency Response Plan will be developed in consultation with the parents/guardians on an annual basis.
 - (e) When an adrenaline by auto-injector is used, an ambulance is to be called immediately and the child will be transported to the hospital.
3. The child care director/provider (or designate) will **submit the URIS Application** to URIS for approval.
4. Once the URIS application has been approved, the child care director/provider (or designate) is responsible for telephone **contact with the nurse** to notify him/her of the approved URIS application, and request their services for staff training and Health Care Plan development.
5. The child care director/provider (or designate) will ensure that the Public Health Nurse (or contracted nursing agency if Public Health Nurse is not available) **develops an Individual Health Care Plan /Emergency Response Plan**. This is completed in collaboration with the parents/guardians, administration and other appropriate and relevant personnel. The plan will be specific to the age and maturity level of the child, the specific properties of the allergen and the parameters of the program.

Anaphylaxis

Anaphylaxis

The following information is considered “best practice” and is the basis for all anaphylaxis information in this resource manual. The nurse who completes the child care facility’s staff training sessions will review the information in this section in detail.

What is an Allergy?

An allergy is the immune system’s excessive reaction to a normally harmless substance, called an allergen. Examples of common allergens are nuts, milk and insect stings.

At its first exposure to an allergen, the body responds by creating IgE antibodies. When the body is exposed to the allergen again, the IgE antibodies cause chemicals (e.g., histamine) to be released from mast cells, which are found in many areas of the body including the mouth, nose, eyes and stomach. When mast cells release these chemicals, signs such as hives, itching and swelling are seen.

Allergic reactions can vary from mild to life-threatening. Anaphylaxis is a term used to describe a life-threatening allergy.

Statistics

- The rate of anaphylaxis from food allergies and insect stings in the general population is between 1-2%. (AAAI Board of Directors)
- The number of life-threatening allergies, especially to peanut products, is increasing. (Canadian School Board Association)
- The number of deaths from anaphylaxis in Canada is estimated at 12 to 50 annually. (Canadian School Board Association)
- Fatalities from anaphylaxis more often occur away from home and are associated with either not using or a delay in the use of epinephrine. In one study, four out of six deaths from food allergies occurred in school and none of these children had epinephrine at the time of their reaction. (Sampson, Mendelson & Rosen)

What is Anaphylaxis?

Anaphylaxis (“allergic shock” or “generalized allergic reaction”) is a severe allergic reaction that can result in death due to airway obstruction or a severe drop in blood pressure. It is an extreme total body reaction.

When Does Anaphylaxis Occur?

The course of a life-threatening allergy can vary from person to person. Anaphylaxis can potentially occur when a person has experienced only minor allergic reactions previously. Others may show a general progression of increasingly severe allergic reactions that lead up to anaphylaxis. Another person may experience an anaphylactic reaction without any previous signs of an allergy.

Anaphylactic reactions can be triggered by minute amounts of an allergen – measured in micrograms. For example, children have developed anaphylactic reactions after coming into contact with residual peanut butter on tables that were wiped clean of visible material.

A person with a life-threatening allergy must be diagnosed and treatment prescribed by a doctor. It is recommended that an allergy specialist assess the child.

Food Allergens

A person can be allergic to any food. The following foods commonly cause anaphylaxis.

- Peanut allergies are the leading causes of anaphylaxis in response to foods. Peanut butter is a common food for children. Peanut and nut residue is oily in nature and persists on surfaces, putting the child with a life-threatening allergy at risk.
- Nuts
- Fish, Shellfish
- Milk
- Eggs
- Soy

Children may outgrow their allergy to milk or eggs. Allergies to nuts and fish are often lifelong.

Non-food Allergens

The following non-food items can cause anaphylaxis.

- Bees, wasps, hornets and yellow jackets can cause anaphylaxis from their stings.
- Medications such as antibiotics, muscle relaxants and anti-convulsants can cause anaphylaxis.
- Latex may be an allergen (e.g., children who have had multiple surgeries with exposure to latex). An increase in latex use has occurred since the mid 80’s and may be a contributing factor to the increase of latex allergies.

The following items are **rare** allergens.

- Anaphylaxis may occur with vigorous exercise alone or with vigorous exercise that occurs after eating certain foods. It may not occur every time the child exercises.
- Anaphylaxis may occur when a child is exposed to a cold and wet environment, such as jumping into a pool or immediately immersing the entire body in cold water.

Strategies to Avoid Allergens

To date, avoidance of allergens is the only way to prevent an anaphylactic reaction. Although it can be difficult to achieve complete avoidance of an allergen, reducing the child's exposure to the allergen is possible. Young children are at greatest risk of accidental exposure, while deaths among teenagers may occur because of their increased independence, peer pressure and a reluctance to carry an adrenaline auto-injector.

The greatest risk of exposure to food allergens occurs in new situations or when normal daily routines are interrupted such as field trips, birthday parties and other special events. Precautions should be taken when changes in routines occur.

It is highly recommended that a child with a life-threatening allergy wear a MedicAlert® bracelet.

The following strategies are *some* ways to reduce the risk of exposure to allergens. Strategies that are implemented should be relevant to the child's allergen and the setting.

Risk reduction strategies for food

- Implement a "nut-aware" policy. This has been a proven strategy in reducing the risk of exposure to peanut products. Nut-aware rooms are recommended when there is a child with a peanut/nut allergy.
- Discourage children from trading and sharing food or eating utensils.
- Children with food allergies should not eat food that has been brought in by someone other than their parent/guardian.
- Encourage good handwashing with soap and water before and after eating.
- Clean surfaces with soap and water or a grease-cutting solution where food has been eaten. Care should be taken to clean all surfaces that the children might touch such as tabletops and under-hangs of tables and chairs.
- Look for hidden allergens in items such as playdough, pet food or stuffed animals.
- Craft supplies that contain the child's allergen should be avoided.

Risk reduction strategies for stinging insects

- Avoid areas where insects congregate.
- Keep outdoor garbage covered and away from play areas. Yellow jackets tend to congregate around garbage and food.
- Avoid eating outdoors, especially sweet products such as pop drinks and juice. Insects often fly into pop cans and sting the person when drinking from the can.
- Avoid perfume and sprays and bright colors. Insects are attracted to bright colors and odors.
- Remove nests or hives from play areas. The City of Winnipeg has a bug line (986-3210) and will come to remove nests and hives within the city.
- Only the honeybee leaves a stinger. When removing the stinger, scrape your nail over the skin. Grabbing the stinger between your fingers will compress the sac of venom and inject more venom into the body.

Risk reduction strategies for latex

- Provide non-latex gloves for use by staff and children (e.g. first aid kits).
- Inflate and deflate balls outdoors and away from children. Balls that contain latex will send latex particles into the air when inflated or deflated.
- Do not use balloons in the facility if a child has a life-threatening allergy to latex. When balloons break, the latex particles become aerosolized.
- Avoid soft rubber balls and stretchy rubber items, such as pink erasers and rubber bands.

Signs of Anaphylaxis

After exposure to the allergen, any combination of the following signs may occur to signal the onset of anaphylaxis. Signs do not always occur in the same sequence, even in the same individual.

The following signs of anaphylaxis are due to airway obstruction and a severe drop in blood pressure:

- Throat tightness or closing – A child may feel like something is stuck in the throat, gag or clear the throat, grab at the throat or put fingers in the throat.
- Change of voice
- Difficulty swallowing
- Difficulty breathing
- Coughing
- Wheezing – sounds like a whistling noise when the child breathes.
- Change in skin color
- Dizziness
- Fainting or loss of consciousness

Other signs of anaphylaxis are:

- Red watery eyes
- Runny nose
- Hives – red, raised and itchy rash. It may appear anywhere on the body. If a person has eaten a food that contains the allergen, hives often appear around the mouth.
- Itching – may occur on any part of the body.
- Swelling – may occur on any part of the body, most often in eyes, lips, face or tongue. Swelling may be described by the child as itching, stinging or burning.
- Vomiting
- Diarrhea
- Stomach cramps
- Sense of doom
- Change in behaviour – The child may say he doesn't feel right, become unusually quiet or withdrawn, become suddenly tired, scream, appear very agitated or stop eating in the midst of eating well.

An anaphylactic reaction most commonly begins within seconds or minutes of exposure to the allergen. The time from the first signs of anaphylaxis to death can be as little as a few minutes, if the reaction is not treated.

It is possible, but rare, for signs of anaphylaxis to occur up to four hours after exposure to the allergen. Even when signs have subsided after initial treatment, they can return as long as eight hours after exposure when the epinephrine starts to wear off.

Treatment of Anaphylaxis

Epinephrine is the drug used to treat anaphylaxis. It is a chemical that the body naturally produces and is responsible for the “adrenaline-rush” under stress. Antihistamines are not recommended in the immediate treatment of anaphylaxis.

Epinephrine is effective in treating anaphylaxis by constricting muscles around blood vessels, which elevate blood pressure, relaxing airway muscles, reducing swelling, reducing the release of chemicals that cause anaphylaxis and stimulating the heart.

If ANY combination of signs is present and there is reason to suspect anaphylaxis, give epinephrine immediately and activate 911/EMS (Emergency Medical System). There is clear evidence that a delay in injecting epinephrine increases the odds of the person dying from anaphylaxis.

There is no significant cause for concern if epinephrine is given to a child for whom it is prescribed and an anaphylactic reaction is not actually taking place. **The life-saving benefit of epinephrine in cases of suspected anaphylaxis outweighs any small risk of side effects.**

Epinephrine (adrenaline)

Epinephrine is available in self-administration devices. The adrenaline auto-injector is the device of choice due to its simplicity of use. It is a disposable spring-loaded, self-injectable syringe containing epinephrine and has a concealed needle. It is for single use only. It should always be given in the outer middle thigh.

The child should carry the adrenaline auto-injector at all times (developmentally appropriate). If the child is not developmentally able to carry the adrenaline auto-injector, it should be worn by the adult responsible or kept in an **unlocked**, safe, easily accessible location, and a staff member will be designated its responsibility. Children should be encouraged to take as much responsibility as possible in preventing and managing anaphylaxis. However, it can never be assumed that a person of any age will have the ability to judge when epinephrine is required and to self-inject in an emergency situation.

Where a question arises regarding the urgency of a medication or the capability of a child, the registered nurse in consultation with the parent/guardian, physician, and child care personnel shall develop an appropriate plan.

The adrenaline auto-injector should be stored in protective tubing and kept at stable room temperature. Do not refrigerate or leave it outdoors in the winter. It is stamped with an expiry date and should be replaced when expired. The medication in the adrenaline auto-injector is clear and colorless. If the solution appears brown, replace the adrenaline auto-injector.

Giving an Adrenaline Auto-injector

Note: Upon URIS approval, a registered nurse will train staff on the procedures outlined below.

1. Remove the child's clothing, if bulky. The adrenaline auto-injector will penetrate regular clothes but snowsuits or other bulky clothing should be removed.
2. Secure the child's leg and identify the injection area on the outer middle thigh. The child should be sitting or lying down. It may be necessary to hold or straddle the child. Infants and toddlers should be held in an adult's lap. The middle of the thigh can be found by dividing the leg between the knee and hip into three sections. The outer portion of the thigh is found between the outer seam and centre crease of a pant leg. Feel the spot with your hand to avoid seams or items in a pocket.
3. Hold the adrenaline auto-injector around its middle and remove the safety cap.
4. Firmly press the tip of the adrenaline auto-injector into the thigh at a 90° angle until a click or whooshing sound is heard.

5. Hold the adrenaline auto-injector in place for a slow count of 10. If the needle is not visible at the end of the adrenaline auto-injector after injection, it has not been used properly. Check to see if the safety cap is removed and inject again, pressing more firmly.
6. Discard the adrenaline auto-injector by placing it into a sharps container or sending it with EMS personnel to be discarded at the hospital. There will be liquid that remains in the adrenaline auto-injector after it has been injected.

After an adrenaline auto-injector is given, the child may appear pale, complain of headache, dizziness, pounding heart, nausea or shakiness. The child may become very quiet. These effects are from the epinephrine and will pass quickly. Improvements in the signs of anaphylaxis will occur within minutes.

Emergency Response Plan

1. Give the adrenaline auto-injector.
2. Activate 911/EMS. Activating 911/EMS should be done simultaneously with injecting the adrenaline auto-injector by delegating the task to a responsible person. NEVER leave the child who is experiencing an anaphylactic reaction alone. It is essential that a person having an anaphylactic reaction be taken to a hospital to receive immediate medical attention, even if the adrenaline auto-injector has been given and the signs of anaphylaxis disappear.
3. Contact the child's parent/guardian.
4. If signs of anaphylaxis persist or recur, give a back-up adrenaline auto-injector (if available) every 10 to 15 minutes. In most areas, Emergency Medical Services (EMS) will arrive before 10-15 minutes has elapsed. Check your local EMS to determine response time.
5. The person who gave the adrenaline auto-injector should stay with the child until the EMS personnel arrive. Information that should be provided to EMS personnel includes signs of anaphylaxis seen in child, time frames, where adrenaline auto-injector was given (right or left thigh) and effect of epinephrine on the child.
6. Following treatment, ensure the incident is documented and a Serious Injury Report is made to Manitoba Child Day Care.

Guidelines for Developing an Anaphylaxis Policy

Overview

The following information reflects best practice in supporting children with life-threatening allergies and is intended to serve as an aid to policy development. Although URIS is able to provide certain supports to community programs, it has no jurisdiction to create policy within these programs. It is therefore suggested that community programs develop a local policy based on the following policy components.

Guidelines

Child care centres/family child care home policies and guidelines on anaphylaxis vary according to the needs and organizational requirements of individual boards and communities.

Objectives of policy development include:

- Providing a safe environment for children with anaphylaxis.
- Providing guidelines for staff/provider to respond.
- Promoting understanding to the community.
- Promoting a community approach.

Protecting children with life threatening food allergies means imposing some limitations in the foods that other children and staff can bring into the centre/family child care home or the places where those foods can be enjoyed. Because one of the most common allergies is peanuts, and peanut butter is one of the most popular items for lunches, emotions have run high in some facilities and with some boards, where attempts have been made to "ban" peanut butter. In fact, experience suggests that outright banning of any substances is not only controversial but is also less successful than cultivating understanding and enlisting the voluntary support of members of the child care community. See Appendix "D" and "E".

When the child care community recognizes the right of parents to feed their children whatever they choose, but acknowledges the right to life and safety as greater, most families are receptive to policies and procedures that protect the child with life-threatening allergies.

Child care centres/family child care homes and boards must recognize and communicate to parents that, in spite of their best efforts, cooperation cannot be guaranteed and accidents may occur. No child care facility should ever assume responsibility for providing a complete allergen-free environment.

The policy development process itself can help set a tone of mutual concern and cooperation if the facility uses an inclusive approach. Administrators of community programs/providers are encouraged to develop a committee to develop a local policy. This can be accomplished by consulting with parents, representatives of the community programs, public health,

medical personnel, the local allergy association, or Manitoba Child Day Care in the policy development process. An important consideration for committees/providers to address is what position/approach they wish to take regarding children who arrive at a child care facility without their auto-injector. Once this is determined, it is suggested this be incorporated into their local policy. Once policies and procedures have been developed, administrators/providers will want to ensure that they are communicated, distributed, implemented and reviewed on an annual basis.

What Should Program Policies Include?

Across Canada, child care facilities, family child care homes and school boards are introducing a wide range of policies and procedures to meet the needs of children with anaphylaxis. To be successful, policies should be flexible enough to adapt to different allergens, to varying ages and maturity levels of children, and to different physical properties and organizational structures of child care facilities. Although they differ in detail, most comprehensive policies include the following three components:

1. **Information and awareness** for the entire child care community;
2. **Avoidance** of the allergen; and
3. **Emergency response** procedures in case of accidental exposure.

It is incumbent upon child care boards/providers and others to carefully consider each of these components and develop policies and procedures that reflect their particular environment.

1. Information and Awareness

Identification of the individual child with anaphylaxis and a child care wide understanding of the procedures to prevent exposure and treat an emergency are the cornerstones of successful policies. Child care facilities/family child care homes should consider the following components when developing policies and procedures:

- identification of children with anaphylaxis to child care administration/provider;
- identification of children with anaphylaxis to all providers/staff;
- in-service for child care personnel/providers and other staff in anaphylaxis, child care policy and the use of the auto-injector training in all first-aid courses provided to staff/providers;
- sharing information with, and asking for co-operation from other children, and parents, and maintaining open communication between parents and the child care facility.

2. Avoidance

Protecting children with anaphylaxis from exposure to life-threatening substances creates a major challenge for child care centres/providers. The goal of avoidance is to reduce risk recognizing that risk can never be completely eliminated. Policies and procedures may vary depending on the age of the child; the organization and physical layout of the child care facility/family child care home, and the properties of the allergen itself. The following considerations may guide policy development in this area:

- providing “allergen-aware” areas;
- establishing safe eating-area procedures, including cleaning and hand-washing routines;
- avoiding allergens hidden in child care activities (playdough, stuffed toys, pet foods, etc.);
- taking special precautions during the holidays and special celebrations, and attempting to plan activities that are not food-oriented; and
- take special precautions in planning field trips and extra-curricular events.

3. Emergency Response

When accidental exposure triggers an anaphylactic reaction, there is no time to waste. In co-operation with parents, the child’s physician, and the Public Health Nurse (or contracted nursing agency if Public Health Nurse is not available) child care facilities should establish a separate emergency response plan for each child, including a rapid response procedure to:

- administer adrenaline auto-injector;
- contact an ambulance or drive the child to the hospital (drive **only** if advised by your rural Emergency Medical Service).
- include a familiar and trusted adult to accompany the child;
- contact the hospital; and
- contact the child’s parents.

Despite the best efforts of parents and child care facilities/providers, no individual or organization can guarantee an “allergy-free” environment. The only way to protect children who are known to be at risk of anaphylaxis is to avoid the allergen. It is a matter of life and death. Child care facilities must have a clear plan for responding to an anaphylactic emergency. When an anaphylactic emergency occurs, the injection of epinephrine usually allows enough time to get the child to a hospital. Without epinephrine, death can occur within minutes. **Epinephrine will only be administered in child-care facilities through the use of an Adrenaline Auto-Injector.**

Division of Responsibilities

Ensuring the safety of children with known risk of anaphylaxis in a community setting depends on the co-operation of the entire community. To minimize risk of exposure, and to ensure rapid response to an emergency, parents/guardians, children and program personnel/providers must all understand and fulfil their responsibilities. The interrelatedness of these roles is vital, for failure of any group to respond appropriately will negatively impact upon all others.

Developmental factors such as age, and physical or cognitive ability, may affect a child’s ability to:

- safely carry an adrenaline auto-injector;
- take responsibility to avoid allergens;
- recognize and communicate symptoms of anaphylaxis; and
- use an auto-injector

Whenever possible, responsibility should be encouraged, recognizing that children who are able to take responsibility for their own care are probably the safest. It should also be recognized that the severity of a reaction may hamper anyone in adrenaline self-administration, regardless of his or her age, and that assistance may be required.

Anaphylaxis (Life-Threatening Allergies) Policy

Note: The *sample* anaphylaxis policy contained in this resource manual includes the key elements of a comprehensive policy, but it cannot begin to reflect the unique differences inherent among each individual child care facility/family child care home. Therefore, you are strongly encouraged to review the *sample* policy and make the necessary changes in wording and content to adequately reflect and address the needs of your centre/family child care home.

Child Care Facility Response

When a child care facility is notified that a child has been diagnosed with a life-threatening allergy and may require the immediate injection of adrenaline by auto-injector, this procedure must be followed:

1. When the child care facility is made aware that a child has a life-threatening allergy and carries an adrenaline auto-injector, appropriate planning can begin. Based on this information, a URIS application should be submitted.
2. The child care director/provider or designate will advise the parents/guardians of the child that:
 - (a) A URIS (Unified Referral and Intake System) application will be completed on an annual basis. See Appendix "A".
 - (b) Parents/guardians of the child with the life-threatening allergy are required to sign an "Authorization for the Release of Information" form to the child care facility on behalf of URIS, Regional Health Authority and/or nursing agency. See Appendix "B" sample.
 - (c) Parents/guardians of the child with the life-threatening allergy must complete the *Authorization Form for Administration of Adrenaline Auto-Injector* form. See Appendix "C" sample.
 - (d) A Health Care Plan/Emergency Response Plan will be developed in consultation with the parents/guardians of the child on an annual basis.
 - (e) When an adrenaline by auto-injector is used, an ambulance is to be called immediately and the child will be transported to the hospital.
3. The child care director/provider (or designate) will submit the URIS Application to URIS for approval.
4. Once the URIS application has been approved, the child care director/provider (or designate) is responsible for telephone contact with the nurse to notify him/her of the approved URIS application and request their services for staff training and Health Care Plan development. The child care director/provider (or designate) will ensure that the Public Health Nurse (or contracted nursing agency if Public Health Nurse is not available) develops an Individual Health Care Plan /Emergency Response Plan. This is completed in collaboration with the parents/guardians, administration/provider and other appropriate and relevant personnel. The plan will be specific to the age and maturity level of the child, the specific properties of the allergen and the parameters of the program.

Roles and Responsibilities

Ensuring the safety of children with known risk of anaphylaxis in a community setting depends on the co-operation of the entire community. To minimize risk of exposure, and to ensure rapid response to an emergency, parents/guardians, children and program personnel/provider must all understand and fulfil their responsibilities. The interrelatedness of these roles is vital, for failure of any group to respond appropriately will negatively impact upon all others.

1. Responsibilities of the child with a life-threatening allergy:

- (a) Take as much responsibility as possible for avoiding allergens, including checking labels and monitoring intake (developmentally appropriate).
- (b) Eat only foods brought from home (if applicable).
- (c) Wash hands before and after eating.
- (d) Learn to recognize symptoms of an anaphylactic reaction (developmentally appropriate).
- (e) **Promptly** inform an adult, as soon as accidental exposure occurs or symptoms appear (developmentally appropriate).
- (f) Wear a medical identification bracelet.
- (g) Keep an auto-injector on their person at all times i.e. fanny pack (developmentally appropriate).
- (h) Know how to use the auto-injector (developmentally appropriate).

2. Responsibilities of the Parents/Guardians of a child with a "life-threatening allergy":

- (a) Identify their child's allergies and needs to the child care director/provider.
- (b) Ensure that their child has and carries an up-to-date auto-injector (developmentally appropriate), the auto-injector is in a specified location, or on the person of the adult responsible for the care of the child.
- (c) Ensure their child has and wears a medical identification bracelet.

- (d) Submit all necessary documentation as required.
- (e) Provide the child care facility with adrenaline auto-injectors (pre-expiry date).
- (f) Ensure that auto-injectors are taken on field trips.
- (g) Participate in the development of a written Individual Health Care Plan for their child, updated annually.
- (h) Be willing to provide safe foods for their child for special occasions.
- (i) Provide support to the facility and staff as required.
- (j) Teach their child: (developmentally appropriate)
 - to recognize the first signs of an anaphylactic reaction;
 - to know where their medication is kept and who can get it;
 - to communicate clearly when he or she feels a reaction starting;
 - to carry his/her own auto-injector on their person (e.g. fanny pack);
 - not to share snacks, lunch or drinks;
 - to understand the importance of hand washing;
 - to cope with teasing and being left out;
 - to report bullying and threats to an adult in authority; and
 - to take as much responsibility as possible for his/her own safety.
- (g) Notify staff/providers of the child with known risk of anaphylaxis, the allergens and the treatment.
- (h) Post allergy alert forms with photograph, in the staff room and/or appropriate location (with parent approval).
- (i) Maintain up-to-date emergency contacts and telephone numbers.
- (j) Ensure all staff/providers (and possibly volunteers) have received instruction in the use of the auto-injector.
- (k) Ensure all substitute staff/providers are informed of the presence of a child with known risk of anaphylaxis, and that appropriate support/response is available should an emergency occur.
- (l) Inform parents/guardians that a child with a life-threatening allergy is in direct contact with their child, and ask for their support and co-operation (with parent approval). See appendix “D” for sample letter.
- (m) Arrange an annual in-service through the Public Health Nurse (or contracted nursing agency if Public Health Nurse is not available) to train staff /providers and monitor personnel involved with the child with life-threatening allergies.
- (n) Ensure an Individual Health Care Plan, which includes an Emergency Response Plan, is completed and reviewed annually for each child with a life-threatening allergy.

3. Responsibilities of the Director/Provider:

- (a) Obtain a signed Release of Information Form from parent/guardian.
- (b) Annually submit a URIS Application form to URIS.
- (c) Ensure the parents/guardians have completed all the necessary consent and authorization forms.
- (d) Identify a contact person to liaise with the contracted health care professional, if other than him/herself.
- (e) Assist with the implementation of policies and procedures for reducing risk in the centre/family child care home.
- (f) Work as closely as possible with the parents/guardians of the child with known risk of anaphylaxis.

4. Responsibilities of the Child Care Staff/Provider:

- (a) Ensure you receive annual training in caring for a child with anaphylaxis.
- (b) Display a photo-poster in the child care facility/family child care home (with parent approval).

- (c) Discuss anaphylaxis with the other children, in age-appropriate terms.
- (d) Encourage children not to share lunches or trade snacks.
- (e) Choose products that are safe for all children in the program/family child care home (parental input is recommended).
- (f) Instruct children with life threatening allergies to eat only what he/she brings from home (if applicable).
- (g) Reinforce hand washing to all children before and after eating.
- (h) Facilitate communication with other parents.
- (i) Follow policies for reducing risk in eating and common areas.
- (j) Enforce rules about bullying and threats.
- (k) Leave information in an organized, prominent and accessible format for substitute staff/provider.
- (l) Plan appropriately for field trips. Ensure that auto-injectors are taken on field trips and emergency response plans are considered when planning the trip.

5. Responsibility of Registered Nurse:

- (a) Consult with and provide information to parents/guardians, children and child care personnel/providers.
- (b) Provide anaphylaxis training to personnel.
- (c) In collaboration with parents/guardians, develop an Individual Health Care Plan and an Emergency Response Plan for the child with known risk of anaphylaxis.
- (d) Facilitate staff/provider training and provide monitoring to personnel involved with children with known risk of anaphylaxis.

6. Responsibilities of All Parents:

- (a) Respond co-operatively to requests from the child care centre/family child care home to eliminate allergens from packed lunches and snacks.
- (b) Participate in parent information sessions.
- (c) Encourage children to respect the child with known risk of anaphylaxis and program policies.
- (d) Inform the staff/provider **prior** to distribution of food products to any children in the program.

7. Responsibilities of All Children: (developmentally appropriate)

- (a) Learn to recognize symptoms of anaphylactic reaction.
- (b) Avoid sharing food, especially with children with known risk of anaphylaxis.
- (c) Follow rules about keeping allergens out of the centre/home and washing hands (developmentally appropriate).
- (d) Refrain from bullying or teasing a child with known risk of anaphylaxis.

NOTE: Child specific avoidance strategies will be detailed in each Individual Health Care Plan.

References

Anaphylaxis: A Handbook for School Boards, The Canadian School Board Association, 2001.

Anaphylaxis: Caring for children with anaphylaxis in a community program by Sandra Dalke, RN, Unified Referral and Intake System (URIS), 2001.

Anaphylaxis in Schools and Other Child Care Settings by Drs. Milton Gold, Gordon Sussman, Michael Loubser and Karen Binkley. Published jointly by The Canadian Society of Allergy and Clinical Immunology, The Ontario Allergy Society, and The Allergy, Asthma Information, 1995.

The Canadian Allergy and Asthma Handbook by Dr. Barry Zimmerman, Dr. Milton Gold, Dr. Sasson Lavi, Dr. Stephen Feanny. Random House/Lorraine Greey, 1991.

“Fatal Anaphylactic Reactions to Food in Children.” Position Statement, Allergy Section, Canadian Pediatric Society, *Canadian Medical Association Journal*, 1994.

“Fatal and near Fatal Anaphylactic Reactions to Food in Children and Adolescents” by Hugh A. Sampson, M.D., Louise Mendelson, M.D., James P. Rosen, M.D., *New England Journal of Medicine*, 6 August 1992.

“Medication of Pupils and Related Issues” by William F. Foster, 1995.

“Surviving Anaphylaxis” by Dr. Karen Binkley. *Ontario Medicine*, 5 October 1992.

“Foods That Can Kill” by Sidney Katz. *Reader’s Digest*, September 1991.

Resources

The following list includes some of the agencies or organizations that are relevant to anaphylaxis. The purpose, goals and resources of these agencies/organizations may not reflect the purpose and content of this resource manual. Appropriate use of these resources is left to the discretion of the child care facility.

Allergy, Asthma Information Association (AAIA)

AAIA is a national membership-based organization of patients helping patients. Members receive information pamphlets, quarterly AAIA newsletters, discounts on product sales, telephone and group support in copying with allergy/asthma/anaphylaxis from other members.

Prairies/NWT Office

16531 – 114 Street

Edmonton, Alberta T5X 3V6

Phone: (780) 456-6651

Fax: (780) 456-6651

E-Mail: aaiabyrt@superiway.net

Website: www.cadvision.com/allergy

Anaphylaxis Foundation of Canada

The Anaphylaxis Foundation of Canada (AFC) is a national charitable organization that funds and promotes clinical and scientific research, education and public awareness. The AFC works closely with the Anaphylaxis Network of Canada on combined projects.

2054-3080 Younge Street

Toronto, Ontario M4N 3N1

Phone: (416) 438-1917

Fax: (416) 431-3270

Website: www.anaphylaxis.org/foundation

Anaphylaxis Network of Canada

Anaphylaxis Network of Canada consists of people who are affected by life-threatening allergies. It provides members with information and support, raises public awareness and advocates for changes in society that will provide safer environments for people with anaphylaxis. Resources that are available include:

Information line (416) 785-5666;

Assistance in establishing local support groups;

Regular newsletter and food-alert bulletins; and

Trained speakers provided to interested groups through the Network's Speakers Bureau.

416 Moore Ave. Suite 306

Ontario, Canada M4G 1C9

Phone: (416) 785-5660

Fax: (416) 785-0458

Website: www.anaphylaxis.org

Food Allergy Network

Food Allergy Network (FAN) is a nonprofit organization that is supported by grants, donations, membership fees and the sale of publications and products. FAN members receive newsletters and other information that assists in managing their allergy. Products for anaphylaxis awareness and education including a mock adrenaline auto-injector, posters, brochures and videos can be ordered from FAN. Other products that are available include carrying cases, recipe books, children's books, buttons and stickers.

10400 Eaton Place, Suite 107

Fairfax, VA. USA 22030-2208

Tel: 1-800-929-4040

Fax: (703) 691-2713

Website: <http://www.foodallergy.org/>

Canadian MedicAlert Foundation

2005 Sheppard Ave. E.

Suite 800

Toronto, ON

M2J 5O4

Canadian School Boards Association

The Canadian School Boards Association is comprised of provincial school boards associations. They have published an excellent resource entitled *Anaphylaxis: A handbook for School Boards*. This can be downloaded from their website.

Website: www.cdnsba.org

Manitoba Anaphylaxis Information Network (MAIN)

MAIN is a support group for individuals and families living with life-threatening allergies.

c/o 27 East Springs Cove

Winnipeg, Manitoba R2G 4C3

Phone: 654-2676 (Nancy) or 669-6148 (Val)

Manitoba Lung Association

The Manitoba Lung Association is a non-profit and volunteer-based organization. It provides information and resources for individuals living with anaphylaxis and people working with individuals who have anaphylaxis.

629 McDermot Ave., 2nd Floor

Winnipeg, Manitoba R3A 1P6

Phone: (204) 774-5501

Fax: (204) 772-5083

Email: reception@manitobalung.org

Website: www.mb.lung.ca



Unified Referral and Intake System (URIS) Application

Classification of Health Care Procedures and Request for URIS Support

Applicants are required to apply for funding each year.

Identifying Information	
Child	Community Program (e.g., school, child-care facility, etc.)
Name: _____ <div style="text-align: center;">last/first</div> Date of Birth: _____ <div style="text-align: center;">day/month/year</div>	Name of Community Program: _____ Address: _____ _____ _____ Contact Person: _____ Phone Number: _____ Fax Number: _____

Group A Health Care Procedures	Support Requested from URIS
<p>The following are <i>complex medical procedures that must be performed by a registered nurse.</i> Please check (✓) the health care procedure(s) required by the child.</p> <p style="margin-left: 20px;">Ventilator Care</p> <p style="margin-left: 20px;">Tracheostomy Care</p> <p style="margin-left: 20px;">Suctioning (Tracheal/Pharyngeal)</p> <p style="margin-left: 20px;">Nasogastric tube care and/or feeding</p> <p style="margin-left: 20px;">Complex administration of medication, i.e., via infusion pump, nasogastric tube, or injection (other than Auto-injector)</p> <p style="margin-left: 20px;">Central or peripheral venous line intervention</p> <p style="margin-left: 20px;">Other clinical interventions requiring judgements and decision making by a medical or nursing professional.</p>	<p>Please check (✓) the support required by the child in the community program. Refer to the URIS Policy and Procedure Manual for additional information.</p> <p style="margin-left: 20px;">Registered nurse to perform health care procedure(s) required by the child</p> <p style="margin-left: 20px;">Orientation/training for the registered nurse</p> <p style="margin-left: 20px;">Coverage by an alternate registered nurse to allow the primary nurse to attend interdisciplinary planning meetings related to the child</p> <p style="margin-left: 20px;">Some specialized medical equipment and required maintenance</p> <p style="margin-left: 20px;">Limited consumable health care items</p> <p style="margin-left: 20px;">Some transportation costs related to medical needs of child</p> <p style="margin-left: 20px;">Auditory intercom system/pager/cell phone</p> <p style="margin-left: 20px;">Other</p>

The Applicant will receive a written response to this request for URIS support.

Group B procedures on reverse side.

Child's Name: _____

Group B Health Care Procedures	Support Requested from URIS
<p>The following <i>health care routines are performed by non health care personnel who receive training and monitoring by a registered nurse.</i> Please check (✓) the health care routine(s) required by the child.</p> <p>Clean intermittent catheterization</p> <p>Condom application for urinary drainage</p> <p>Gastrostomy care and feeding</p> <p>Emptying an ostomy bag and/or changing an established appliance</p> <p>Administration of medications by:</p> <ul style="list-style-type: none">oral route (requiring measurement)instillation (i.e., eye/ear drops)topical (i.e., ointment, therapeutic dressing)inhalation (i.e., bronchodilators)gastrostomy <p>Suctioning (oral or nasal)</p> <p>Responding to seizures when specific skills are required</p> <p>Administration of sublingual lorazepam</p> <p>Assistance with blood glucose monitoring requiring specific action based on results</p> <p>Responding to low blood sugar emergencies</p> <p>Administration of pre-set oxygen</p> <p>Administration of adrenaline auto-injector</p> <p>Other health care routines required by the child and approved by URIS</p>	<p>Please check (✓) the support required by the child in the community program.</p> <p>Registered Nurse to:</p> <ul style="list-style-type: none">Develop an Individual Health Care PlanDevelop an Emergency Response PlanTrain non-health-care personnelMonitor non-health-care personnel

The Applicant will receive written response to this request for URIS support.

Date: _____

Signature: _____
(e.g., Student Services Administrator, Child-Care Director, Case Coordinator)

Send to: The URIS Committee
c/o 219 - 114 Garry Street
Winnipeg MB R3C 4V6
Fax: (204) 948-4656
Telephone: (204) 945-5898

Sample Letter to Parents/Guardians Regarding Life-Threatening Allergies

(Date)

Dear Parents/Guardians,

There is a child in our care, who has a severe allergy to _____. Even exposure to a tiny amount of this item could be potentially serious and life threatening. We can all play a role in preventing such a dangerous and frightening situation at the child care centre/home. Although the specific child and their family must take responsibility to avoid exposure, staff, other children and their families can also help to make the environment safer. Your co-operation is asked to:

- Please check the list of ingredients on items you send to the centre.
- Avoid sending _____ or items containing _____ with your child, including: _____.
- Teach your child to respect this very serious situation; discourage teasing or threatening of this child.

This may be an inconvenience for you, but please realize how important your co-operation is. We would take the same care should your child have such a health care need.

Thank you for your co-operation. For more information, call _____.

Sincerely,

Child Care Director/Provider

Sample Thank You /Reminder Letter

Dear Parents/Guardians:

Re: Peanut and Nut Product Allergies

The child(ren) in our care with severe peanut and nut product allergies, and their families, would like to join me in thanking you for your understanding and co-operation as a result of the request to avoid sending peanut and nut products to the child care centre/family child care home . There has been a reduction in the number of peanut and nut products brought to the centre/family child care home in snacks and lunches, and we would like to thank you for continuing not to send these products with your child.

Since even a minute amount of the allergic substance can cause a life-threatening reaction, keeping it out of the centre/family child care home is our best method of preventing a serious reaction.

Thank you again for your co-operation in this important issue.

Yours sincerely,

Child Care Director/Provider