



Allergies and Anaphylaxis

Frequently Asked Questions (F.A.Q.s)

Q. What are the most common causes of anaphylactic reactions in schools?

A. The most common causes of anaphylactic reactions in schools is related to food allergies as a result of lunches that have been accidentally switched, sharing of food, eating something without checking the ingredients and milder reactions from contact with contaminated surfaces including playground and gym equipment. Severe allergic reactions can also occur from insect stings and medications.

Q. Should parents insist on schools being peanut or allergen free?

A. Schools cannot guarantee an allergy or peanut free environment but can commit to creating an *allergy safe or aware* environment through the implementation of various management strategies to reduce the risk of reaction occurring in an allergic person. Rather than a total ban on food products, schools should focus more on the education and awareness about allergies. This is a more realistic option as both allergic and non-allergic people must co-exist both inside and outside of the school environment. According the Canadian School Boards Association, “the *outright banning of any substance is not only controversial, but it is also less successful than cultivating understanding and enlisting the voluntary support of members of the school community*” (*Anaphylaxis a Handbook for School Boards- September 2001*)

Q. Should anaphylactic children be excluded from certain school activities e.g. cooking classes, field trips, sports events etc.?

A. Students should not be excluded based on their allergy as long as proper planning and preparation is in place, trained staff is on hand and general avoidance strategies are followed. It is important that students are not stigmatized as a result of their condition.

Q. Does hand washing really make a difference in the school setting?

A. Yes. Allergens such as peanut butter can be accidentally transferred from hands to surfaces, such as tables, desks, toys, sports equipment, door handles, books, etc. Hand washing is an important measure for reducing the risks of accidental exposure.

Q. Are hand sanitizers effective in removing allergens?

A. A recent U.S. study suggests that liquid or bar soap and antibacterial wipes can effectively remove peanut butter residue from hands. However, antibacterial hand sanitizers and water alone are **not** as effective. This information should be applied to other allergens as well.



Q. Can you recommend a cleaning product that can be used to clean up allergens, such as peanut butter?

A. Dish soap may not effectively remove residual peanut butter from surfaces. Common household cleaning products such as Clorox and Lysol sanitizing are effective in removing residual peanut allergen from surfaces. AT EIPS, the EP-50 cleaner-disinfectant and Oxivir wipes are approved for use in schools.

Q. We have several children in our school who have peanut and tree nut allergies. Is pea or soy butter (e.g. WOW butter) a safe alternative to serve?

A. Pea and soy butter were created as alternatives for individuals who must avoid peanuts. While these products might be safe for individuals with peanut and tree nut allergies, it is important to consider the following: Children need clear avoidance strategies; these products could cause confusion. There is the potential for mistakes (how would a lunch room supervisor know that the child is eating pea butter, and not peanut butter?). As such this product should be avoided in schools where there are nut allergies.

Q. Who needs to carry an epinephrine auto-injector?

A. Anyone who has been prescribed epinephrine should have a device with them at all times. Children who have demonstrated maturity (usually by the age of 6 or 7) should carry their own epinephrine auto-injector(s). This does not mean they would be expected to administer it themselves although all children should know how to do so. When children are in kindergarten their teacher can easily carry the EpiPen as they are with the child most of the time.

Q. How many EpiPens should a person have at school?

A. A person should have at least two auto injectors at school or work, with one serving as a backup in case a second dose is needed or the first one is administered incorrectly. In a very large school it may make sense for additional auto injectors to be kept in strategic locations. Store back up auto injectors in a central unlocked location. All Alberta schools are now required by legislation to have at least one spare auto-injector on site.

Q. Who should administer the EpiPen?

A. All school staff should be trained in the administration of the EpiPen and undergo refresher training every year. The division's general liability insurance would protect a staff member from any legal liability associated with administering medication in the event of an emergency.



Q. What happens if a person is given adrenaline and they are not having a reaction.

A. There should be no serious side effects unless the child has co-existing heart problems. The heartbeat could increase and the person may have palpitations for a few minutes.

Q. Can I use another child's epinephrine auto-injector if a second dose is needed or if one has not been provided for a child who is experiencing a first time reaction?

A. Epinephrine auto-injectors contain standard doses of medication that are available without a prescription. From a medical perspective, it is possible for one person to use another person's auto-injector in response to an unexpected emergency or if sufficient back-up medication is not available. The caution is that this medication must be replaced as soon as possible.

Schools should confirm with the parent/guardian of allergic children that this is acceptable to them. In the event that only prescribed and authorized medications can be administered, the EMS should be called promptly and informed of the urgency of the situation. This situation is less likely now since schools are required to keep a spare auto-injector on site.

Q. Can expired epinephrine be used?

A. While it is optimal to use an in-date (i.e. unexpired) auto-injector device, using an expired device is better than not administering epinephrine at all. Manufacturers provide a free registry e-mail program, which sends patients a reminder when their devices are about to expire and new devices need to be ordered.

Q. Is milk allergy the same as lactose intolerance?

A. No. Lactose intolerance results when an individual lacks the necessary enzyme to break down milk sugar in the gut. This leads to stomach pain and diarrhea. It is not life-threatening, nor is it caused by allergy. Milk allergies, on the other hand, can cause life-threatening reactions.

Q. Is milk allergy as severe as peanut and nut allergies?

A. Milk allergy can cause life-threatening anaphylactic reactions. Milk allergy is often outgrown, but it can be lifelong. It is important for a patient to follow-up with their allergist regularly after their initial diagnosis.

Q. Do children outgrow peanut allergies?

A. Peanut and tree nut allergies tend to be life-long; however, up to 20% of children outgrow their peanut allergy based on recent US studies. **Note:** Patients should consult with an allergist and be re-tested before assuming that they have outgrown any allergies.



Q. Can you give us a list of allergen safe (e.g. “peanut-free”) foods?

A. No. Circulating lists of safe foods is not recommended, since manufacturers can change their practices at any time and without notice. Lists can quickly become outdated and potentially dangerous. ***It is best to read the label every time.***

It is recommended that schools always check the foods they serve and communicate regularly with the staff and parents of allergic children. Allergic children should not share food or drinks and eat only the food products that have been prepared specifically for them or brought from their homes. Parents are advised to discuss risk management strategies with the school and the foodservice staff before the child consumes food provided there.

Q. Can the smell or the touch of peanuts cause an anaphylactic reaction?

A. Smelling the odor (pyrazines) of peanuts is different from inhaling airborne peanut particles (proteins), which may result from the mass shelling of peanuts in a poorly ventilated area. An individual with peanut allergy may feel unwell if they smell peanuts, but this is likely due to a strong fear or psychological aversion, not an allergic reaction. Inhaling airborne peanut particles, on the other hand, can cause allergic reactions with symptoms that are troublesome, such as rashes, runny nose, itchy eyes, and occasionally wheezing, but anaphylaxis is thought to be unlikely. A small amount of peanut protein can induce a local reaction (i.e. localized rash, swelling, etc.) when touched. The same amount can cause anaphylaxis if it is unintentionally transferred to the mouth or eye.

Q. If a child has a severe reaction to a bee sting but has no record on file of an allergy to insects and has no epinephrine auto-injector, is it safe to use a back-up device?

A. From a medical perspective, it is not harmful to use a back-up epinephrine auto-injector, since the injectors come in two standard pre-measured dosages. For children weighing between 15 kg and 30 kg, a dose of 0.15 mg is recommended. For children and adults weighing over 30 kg or more, the recommended dosage is 0.30 mg. If fast response time is available, it is considered best to have EMS administer un-prescribed medication. If a back-up device is used, it should be replaced immediately.

Q. When can I get training on allergies and anaphylaxis?

A. A free online training course for educators and parents is available through www.allergyaware.ca.