**Inclusion** is at the
**heart** of our trust

# Allergy & Anaphylaxis Policy

Oak Learning Partnership

| Document control table | |
|---|---|
| **Document Title** | Allergies and Anaphylaxis Policy |
| **Version number:** | 1.0 |
| **Date approved:** | |
| **Approved by:** | Executive Leadership Team |
| **Date of next review:** | September 2027 |

| Document History | | | |
|---|---|---|---|
| **Version** | **Date** | **Author** | **Note of revisions** |
| 1.0 | September, 2026 | R Carney – Director of Safeguarding | New Policy to cover all Trust schools |
| | | | |
| | | | |

**Contents**


| | |
|---|---|
| Introduction and Core Principles | 3 |
| Principles of acting in an emergency | 5 |
| Allergies in scope | 5 |
| Asthma | 6 |
| Emergency Treatment and Management of Anaphylaxis | 10 |
| Minimising Risk and Exposure to Allergens | 11 |
| Medication and Adrenaline Devices | 14 |
| Staff Training and Emergency Response | 16 |
| Emergency preparedness | 17 |
| Roles and Responsibilities | 17 |
| Identification of Individuals with Allergies | 18 |

| | |
|---|---|
| Student Individual Healthcare Plans (IHPs) and Allergy Action Plans | 19 |
| School Trips and External Visits | 20 |
| Wraparound Clubs or Extended Services | 20 |
| Serious Incidents and "Near Misses" | 20 |
| Wellbeing and Support | 21 |
| Policy Review and Publication | 23 |
| **Appendices** | |
| 1. School Risk Assessment<br>2. Individual Health Care Plans (Allergy only)<br>3. School Map with Emergency AAIs/Inhalers marked<br>4. Posters and Useful Links<br>5. Key actions for Allergy Leads and School Leaders<br>6. Wellbeing and Therapy Animals<br>7. Early Years only<br>8. Post 16 (College) only<br>9. Consent forms | |

**This policy should be read in conjunction with the following policies:**

- Child Protection and Safeguarding Policy (Trust)
- Medical Conditions Policy (Trust)
- Health and Safety Policy (Trust)

**This policy has been written paying due regard to the following statutory guidance and legislation:**

- Allergy Safety in Schools (DfE, 2026)
- Keeping Children Safe in Education (2026)
- Children and Families Act 2014 (Section 100)
- Early years foundation stage statutory framework For group and school-based providers (DfE, 2026)
- Supporting pupils at school with medical conditions (DfE, 2015)
- Children's Wellbeing and Schools Act 2026 (Section 34)

In addition, other statutory duties are of relevance to children and young people with allergy, including:

- The duty of care under section 3 of the Children Act 1989 for any person with the care of a child to do all that is reasonable for the purposes of safeguarding or promoting the welfare of the child;
- The duties to safeguard and promote the welfare of pupils and students under sections 20 and 157 of the Education Act 2002, the Education (Independent School Standards) Regulations 2014 The duty of the employer under section 2 of the Health and Safety at Work etc Act
  1974 to take reasonable steps to ensure that employees are not exposed to risks to their health and safety;
- The Special Educational Needs and Disability (SEND) SEND code of practice: 0 to 25 years.
- The common law duty of care which requires schools, educational settings, and other persons responsible for children and young people to take reasonable care to avoid acts or omissions which could reasonably be foreseen to cause injury or harm. This includes taking appropriate steps to identify, assess and manage allergy-related risks and to respond appropriately in the event of an allergic reaction.
- This guidance will therefore be of relevance to our early years settings and should be treated as good practice for these settings.
- Human Medicines (Amendment) Regulations 2017

**Introduction and Core Principles**

In line with Benedict's Law, we are committed to providing a safe, inclusive, and welcoming environment for all children, young people, staff, and visitors with allergies. Recognising the serious and potentially life-threatening risk posed by anaphylaxis, this dedicated policy establishes robust risk-mitigation measures and emergency response protocols.

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. Allergy is a spectrum of different allergic diseases. Reactions occur when a susceptible person is exposed to something (an "allergen") they are allergic to. Asthma, food allergy, eczema and seasonal rhinitis (hay fever) are all forms of allergy.

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. Anaphylactic reactions usually begin within minutes of being in contact with the allergen i.e. eating a trigger food, though can occur several hours later (i.e. allergy to Mammalian meat). Anaphylaxis involves difficulty in breathing and affects the heart rhythm. In extreme cases there could be a dramatic fall in blood pressure leading to collapse.

Once started, anaphylaxis reactions progress quickly. Investigations into fatal anaphylaxis show that there is only a 20-30 minute window of opportunity during which steps can be taken to prevent death – therefore giving emergency adrenaline **immediately** and calling Emergency Services (999) is crucial. **Anaphylaxis always requires an emergency response**.

Anaphylaxis can occur without any other signs (such as a skin rash) being present. **Always consider anaphylaxis in someone with a known food allergy who has sudden difficulty in breathing.** Giving adrenaline in this context is very safe and may be lifesaving.

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

- foods (e.g. peanuts, tree nuts, cow's milk/dairy foods, egg, wheat, fish/shellfish and sesame);
- 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 anaphylaxis reactions require the person to have eaten the food, although less serious allergic reactions can happen through skin or other contact. Anaphylaxis reactions due to skin contact are very rare. Students who have a skin reaction need monitoring for at least an hour.

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. 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 (DfE, 2026).

**Oak Learning Partnership** has a whole Trust awareness approach, because it ensures all staff and students are aware of what allergies are, the importance of avoiding the individuals' allergens, the signs and symptoms, how to deal with allergic reactions and to ensure procedures are in place to minimise risk of exposure.

Coeliac disease and food intolerance can present symptoms which are similar to those of food allergy; it is important that Coeliac disease and food intolerance is be managed through dietary avoidance, but these conditions do not pose a risk of anaphylaxis and so they are not within this allergy safety policy.

Eczema, asthma and allergies sometimes occur together – known as the atopic triad. It is important that these are managed well in order to keep the individual healthy. **Asthma awareness is needed by all staff and an individual's asthma care plan needs to be included with their individual healthcare plan (IHP).**

**Oak Learning Partnership** understands that severe allergies are included in the Equality Act, 2010. The act considers a person disabled if they have a physical or mental impairment that has a substantial and long-term negative effect on their ability to carry out normal daily activities. Seasonal rhinitis (such as hay fever) is explicitly excluded from the definition of disability, unless it aggravates the effect of another health condition.

**Principles of acting in an emergency**

If an individual (whether a child, young person, member or staff or visitor) experiences a life-threatening medical emergency, anyone – staff, volunteers or bystanders – may take reasonable action to save their life. The law recognises that rescuers act under extreme pressure. People who attempt to save a life in good faith are protected, even if an injury occurs while giving emergency care (for example, broken ribs during CPR are common and not a sign of wrongdoing). This includes administering adrenaline when an individual is suffering anaphylaxis. Staff in schools, colleges and early years settings should be reassured that mistakes, hesitation, or imperfect technique do not amount to serious and wilful misconduct. The expectation is simply that staff act reasonably, to the best of their ability, in an emergency.

**Allergies in scope**

- Children and young people with food allergy
- Children and young people at risk of anaphylaxis (usually allergic to food or bee/wasp sting)
- Children and young people with allergic rhinitis (hay fever), allergic eye disease or eczema, who may need access to treatments for their condition in school (e.g. eczema creams, nasal sprays, eye drops), particularly if they have more severe allergic disease or need adaptations e.g. with sport
- Children and young people with eczema or asthma, who may need additional precautions (e.g. avoiding sand pits, some swimming pools)
- Children and young people with more severe allergy to animal fur, who may need to take avoidance measures (e.g. exposure to pets in school, visits to petting zoos)

**Asthma**

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. Arrangements for the storage of the child's inhaler will be documented in their IHP and Asthma Care Plan (f they have one). Note, though the principles in this policy for the management of asthma apply, where a pupil has asthma that is not specifically linked to allergies (for instance, asthma may be linked to respiratory infections, emotional stress or physical factors), the IHP in the Medical Conditions Policy should be used, rather than the allergy specific version in this policy's appendices. **Consent to use "spare" salbutamol inhalers should be sought for all pupils with asthma. Spare inhalers can only be used where written consent has been obtained.**

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 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). Refer to Guidance on emergency asthma inhalers for use in schools. It is recommended that schools keep emergency asthma reliever inhalers alongside "spare" adrenaline devices, the risk assessment in appendix 1 will identify where

inhalers are stored within the school. Note: We aim for all of our schools to stock "spare" inhalers by January 2027.

An emergency asthma inhaler kit should include:

- a salbutamol metered dose inhaler;
- at least two plastic spacers compatible with the inhaler;
- instructions on using the inhaler and spacer;
- instructions on cleaning and storing the inhaler;
- manufacturer's information;
- a checklist of inhalers,
- identified by their batch number and expiry date, with termly checks recorded;
- a note of the arrangements for replacing the inhaler and spacers (see below);
- a list of children permitted to use the emergency inhaler (see section 4) as detailed in their individual healthcare plans;
- advice about where to record administration of medication

Salbutamol is a relatively safe medicine, particularly if inhaled, but all medicines can have some adverse effects. Those of inhaled salbutamol are well known, tend to be mild and temporary and are not likely to cause serious harm. The child may feel a bit shaky or may tremble, or they may say that they feel their heart is beating faster. The main risk of allowing schools to hold a salbutamol inhaler for emergency use is that it may be administered inappropriately to a breathless child who does not have asthma. It is essential therefore that schools ensure that the inhaler is only used by children who have asthma or who have been prescribed a reliever inhaler, and for whom written parental consent has been given.

Schools will wish to ensure that the inhaler and spacers are kept in a safe and suitably central location in the school, such as the school office, or staffroom, which is known to all staff, and to which all staff have access at all times, but in which the inhaler is out of the reach and sight of children. The inhaler and spacer should not be locked away.

The inhaler should be stored at the appropriate temperature (in line with manufacturer's guidelines), usually below 30C, protected from direct sunlight and extremes of temperature. The inhaler and spacers should be kept separate from any child's inhaler which is stored in a nearby location and the emergency inhaler should be clearly labelled to avoid confusion with a child's inhaler.

An inhaler should be primed when first used (e.g. spray two puffs). As it can become blocked again when not used over a period of time, it should be regularly primed (during checks) by spraying two puffs. To avoid possible risk of cross-infection, the plastic spacer should not be reused where possible. It can be given to the child to take home for future personal use. The inhaler itself however can usually be reused, provided it is cleaned after use. The inhaler canister should be removed, and the plastic inhaler housing and cap should be washed in warm running water, and left to dry in air in a clean, safe place The canister should be returned to the housing when it is dry, and the cap replaced, and the inhaler returned to the designated storage place. However, if there is any risk of contamination with blood (for example if the inhaler has been used without a spacer), it should also not be re-used but disposed of per the manufacturer's instructions or by returning to a pharmacy.

**Children who can use a "spare inhaler"**

The emergency salbutamol inhaler should only be used by children:

- who have been diagnosed with asthma, and prescribed a reliever inhaler;
- OR who have been prescribed a reliever inhaler;

**AND for whom written parental consent for use of the emergency inhaler has been given.**

This information should be recorded in a child's individual healthcare plan.

**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. **Never give the reliever inhaler instead of adrenaline to treat anaphylaxis.**

**Figure 1**

A child may be prescribed an inhaler for their asthma which contains an alternative reliever medication to salbutamol (such as terbutaline). The salbutamol inhaler should still be used by these children if their own inhaler is not accessible – it will still help to relieve their asthma and could save their life.

Common 'day to day' symptoms of asthma are:

- Cough and wheeze (a 'whistle' heard on breathing out) when exercising
- Shortness of breath when exercising
- Intermittent cough

These symptoms are usually responsive to use of their own inhaler and rest (e.g. stopping exercise). They would not usually require the child to be sent home from school or to need urgent medical attention.

Signs of an asthma attack include:

- Persistent cough (when at rest)
- A wheezing sound coming from the chest (when at rest)
- Being unusually quiet
- The child complains of shortness of breath at rest, feeling tight in the chest (younger children may express this feeling as a tummy ache)
- Difficulty in breathing (fast and deep respiration)
- Nasal flaring
- Being unable to complete sentences
- Appearing exhausted
- A blue / white tinge around the lips
- Going blue

If a child is displaying the above signs of an asthma attack, the guidance below in figure 2 "Responding to an asthma attack" should be followed.

**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**

**Figure 2**

**Responding to signs of an asthma attack**

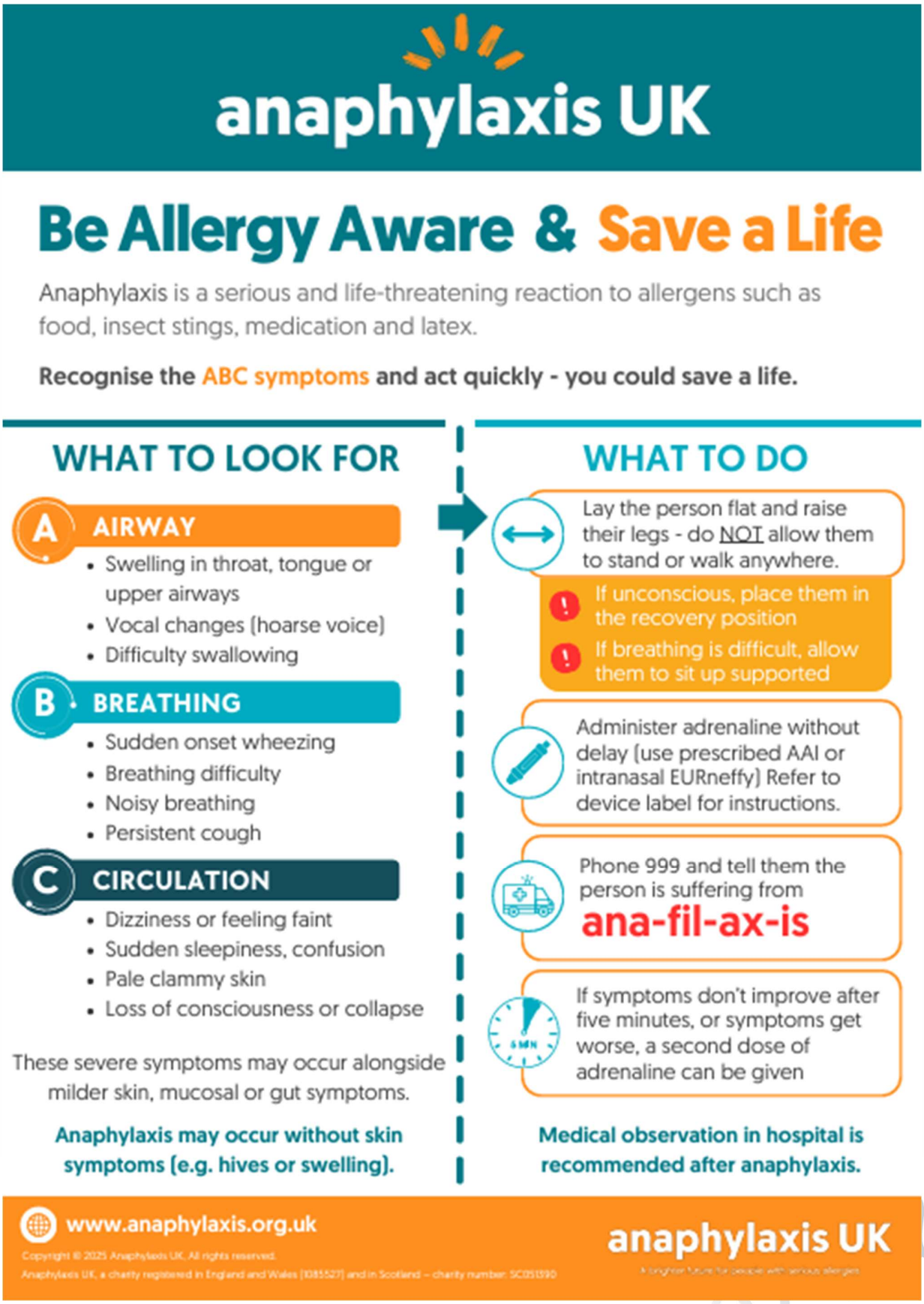
- Keep calm and reassure the child
- Encourage the child to sit up and slightly forward.
- Use the child's own inhaler – if not available, use the emergency inhaler
- Remain with child while inhaler and spacer are brought to them
- Immediately help the child to take two separate puffs of the salbutamol via the spacer immediately
- If there is no immediate improvement, continue to give two puffs every two minutes up to a maximum of 10 puffs, or until their symptoms improve. The inhaler should be shaken between puffs.
- 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 The child's parents or carers should be contacted after the ambulance has been called.

- A member of staff should always accompany a child taken to hospital by ambulance and stay with them until a parent or carer arrives.




(Source: Anaphylaxis UK Posters | Anaphylaxis UK | Anaphylaxis UK) date: 13.07.26)

**What to look for:**

Symptoms usually come on quickly, within minutes of exposure to the allergen.

Mild to moderate allergic reaction symptoms may include:

- a red raised rash (known as hives or urticaria) anywhere on the body
- a tingling or itchy feeling in the mouth
- swelling of lips, face or eyes
- stomach pain or vomiting
- mild throat tightness
- sudden change in behaviour

These symptoms are treated with antihistamines. **These individuals should be actively monitored for 60 minutes in a quiet area such as a medical room after such reactions, in the event that anaphylaxis develops.**

More serious symptoms are often referred to as the **ABC symptoms** and can include:

- **AIRWAY** - swelling in the throat, tongue or upper airways (tightening of the throat, hoarse voice, difficulty swallowing).
- **BREATHING** - sudden onset wheezing, breathing difficulty, noisy breathing, persistent cough.
- **CIRCULATION** - dizziness, feeling faint, sudden sleepiness, tiredness, confusion, pale clammy skin, loss of consciousness.

The term for this more serious reaction is anaphylaxis. In extreme cases there could be a dramatic fall in blood pressure. The person may become weak and floppy and may have a sense of something terrible happening. This may lead to collapse and unconsciousness an d, on rare occasions, can be fatal.

As soon as anaphylaxis is suspected, adrenaline must be administered without delay. Action:

- Keep the individual where they are, call for help and do not leave them unattended.
- **LIE individual FLAT WITH LEGS RAISED** – they can be propped up if struggling to breathe but this should be for as short a time as possible.
- **USE ADRENALINE DEVICE WITHOUT DELAY** and note the time given. AAIs should be given into the muscle in the outer thigh or nasal into the nostril. Specific instructions vary by brand – always follow the instructions on the device.
- CALL **999** and state **ANAPHYLAXIS (ana-fil-axis).**
- If no improvement after 5 minutes, administer second adrenaline device
- If no signs of life commence CPR.
- Call parent/carer as soon as possible.

Whilst you are waiting for the ambulance, keep the individual where they are. Do not stand themup, or sit them in a chair, even if they are feeling better. This could lower their blood pressure drastically, causing their heart to stop.

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

**Learning from anaphylaxis deaths in schools**

One in five anaphylaxis deaths among school-aged children in the UK happen in school. Key learnings from these events are listed below.

- Always give adrenaline **immediately** to treat anaphylaxis. **If in doubt, give adrenaline.** Delays in giving adrenaline are associated with fatal outcomes.
- NEVER let a person having anaphylaxis stand or walk around: always bring help and medicines to the person, and not the other way round.
- Always dial 999.
- Give a further dose of adrenaline if there is no improvement after 5 minutes.
- If someone known to have asthma and food allergy suddenly gets difficulty in breathing, always consider anaphylaxis. Giving adrenaline in this context is very safe and may be lifesaving.
- Children and young people may be at risk of anaphylaxis while travelling to or from school, college or their early years settings. If they have been prescribed adrenaline devices, they should carry these devices with them at all times, including while travelling to or from school.

(DfE, 2026)

**Minimising Risk and Exposure to Allergens**

Minimising risk and the exposure to allergens is central to ensuring that individuals with allergies are safe from harm. Even a small amount of allergen can cause a reaction. Any food can cause a reaction with serious consequences for the individual and **Oak Learning Partnership** will only eliminate a food following a risk assessment supported by medical advice when necessary. Where a food is restricted, this will be to the smallest area for the time necessary; for example, the cooking room for the duration of the lesson when the student with allergy is cooking. Blanket bans, especially to nuts, create a false sense of security. Whilst there are 14 key food allergens that cause over 90% of reactions, any food can cause a reaction.

The 14 regulated food allergens are:

- **Celery:** Includes stalks, leaves, seeds, and celeriac (often in soups, salads, and stock cubes).
- **Cereals containing gluten:** Specifically wheat, rye, barley, and oats.
- **Crustaceans:** Such as prawns, crab, and lobster.
- **Eggs:** Common in baked goods, mayonnaise, and pasta.
- **Fish:** Found in many fish sauces, dips, and ready meals.
- **Lupin:** A flower that is frequently used in flour mixes for breads and pastries.
- **Milk:** Found in dairy products, butter, and cream.
- **Molluscs:** Includes mussels, oysters, squid, and snails.
- **Mustard:** Found in dressings, marinades, and processed meats.
- **Peanuts:** A legume found in various snacks and sauces.
- **Sesame:** Found in breads, crackers, and tahini.
- **Soybeans (Soya):** Used in tofu, soy sauce, and many desserts.
- **Sulphur dioxide and sulphites:** Used as preservatives in dried fruit, wine, and pickled foods.

- **Tree nuts:** Such as almonds, hazelnuts, walnuts, Brazil nuts, cashews, pecans, pistachios, and macadamia nuts. (Source: Allergy UK Top 14 Food Allergens | Allergy UK | National Charity Visited: 13.07.26).

By UK and EU law, the 14 regulated allergens must be declared on food packaging and communicated clearly for all food sold, including loose and non-prepacked foods. However, it is possible to have a serious allergic reaction to any food. Increasing attention is being given to serious allergic reactions to legumes other than peanut and soya (such as peas, lentils, chickpeas), certain fruits, and less commonly recognised foods. It is important to recognise that any food can cause an allergy, and all should be taken seriously.

**Oak Learning Partnership** is allergy aware ensuring that the staff and students are actively aware of the risk posed by allergens, take steps to minimise the risk of exposure and have robust emergency response plans in place.

**Oak Learning Partnership** schools completes a school wide allergy risk assessment that seeks to minimise the risks of exposure to known allergens. The risk assessment will include:

- Identifying the food used within the curriculum and making adaptions to remove allergens that pose a risk for the whole group not just the student who has the allergy.
- Conducting specific risk assessments to manage the risks of exposure to allergens in individuals when planning external visits or trips
- Identify measures to manage risks of exposure to a food allergen through food brought in by others (for example, parents, students, staff).
- Identify measures to manage the risks of exposure to a food allergen through food provided by the school, college or setting
- Putting in reasonable measures to manage the risk of individuals being exposed to allergens where they have a known allergy to airborne or contact allergens
- Identifying non-food allergens within the environment and making adaptions to remove/reduce allergens that pose a risk; for example, therapy or school dogs would require enhanced cleaning and limiting to specific areas, hygiene measures after students have worked with the therapy dog

See appendix 1 for school risk assessment.

**Oak Learning Partnership** will ensure that allergy is included in key school risk assessments to identify risks and plan control measures to minimise the risk of exposure. **Allergy risks should be considered in: School visits/trips, curriculum, wraparound care, use of instruments and sporting activities (this is not an exhaustive list).**

**Oak Learning Partnership** will ensure that the risk of exposure is minimised by:

- All school staff allergy training every year
- Educating students through awareness assemblies or within PSHE/PD Curriculum
- Educating Local Governing Bodies about school expectations for allergy management
- Communicating with all visitors, temporary staff and cover staff that they will be teaching a student with an allergy and ensuring that the member of staff has been trained in allergy and anaphylaxis emergency response
- Working closely with parents/carers and health professionals to understand the student's allergy
- Monitoring this policy to ensure that the agreed practices are implemented
- Establishing and maintaining high hygiene standards amongst staff, students and visitors
- Ensuring each school has practice drills and records near misses and incidents to support a lessons-learned culture with shared understanding and accountability

**Food Provision and Catering:**

**The school** will manage the risk of food allergy and provide clear information on allergens in food provided by:

- Ensure that where catering is subcontracted, the contract with the school catering company is compliant with the Food Standards Authority allergen management regulations
- Ensuring school caterers provide information on food allergens to parents/carers and have this available for the students to check independently
- Provide student's allergen information to the caterers in a timely manner to ensure that students can eat safely
- Enabling parents/carers to liaise with the catering company or school chef alongside a designated senior leader
- Identify students with allergies at point of service by implementing protocols to ensure that there are robust identification methods in place. See appendix 1.
- Ensure that food is always labelled as unlabelled food poses a potentially greater risk of allergen exposure than packaged food with precautionary ("may contain") labelling suggesting a risk of contamination with allergen. This applies to foods used within the classroom curriculum (e.g. cooking) as well that from the school kitchen or canteen.
- Teach students not to food share, trade food or share utensils or food containers with the reasons why

When staff provide food for the students, they receive additional training to ensure they understand how to read labels for food allergens and how to prevent cross-contamination during the handling, preparation and serving of food.

Where food is not directly provided by the school (for example brought in as treats or to celebrate birthdays) staff will seek authorisation from the in-school allergies lead who should ensure that there are sufficient safeguards in place to prevent exposure to an allergen for pupils with known food allergies.

These procedures apply to school led breakfast and after school provision. Where this is provided by a third party, the school, will ensure that this policy is shared and the third-party provider meets the same procedures.

Where relevant, the school will ensure that Parent Teacher Association (PTA) events, as best practice, follow FSA (Food Standards Agency) legislation for food labelling, creating allergen matrices as necessary. Ensuring that PTA members who are serving food have a basic awareness of allergen management (signpost to free FSA training).

Students eligible for benefits based Free School Meals are entitled to their free school meal entitlement. School will work with parents/carers to determine the best way of ensuring that students receive their meal.

**Medication and Adrenaline Devices**

**People at risk of anaphylaxis are prescribed two adrenaline devices which they should carry with them at all times**. This includes the journey to and from;

- school,
- the classroom
- lunch area
- playground
- sports field
- when on visits or trips

Serious anaphylaxis is a time critical situation; delays in administering adrenaline have been associated with fatal reactions. An adrenaline device needs to be administered within 5 minutes so if the adrenaline device cannot be with them in the classroom, the adrenaline device should be stored in an appropriate central location that is unlocked and accessible at all times **(including during wrap around care).**

Adrenaline devices must be stored at room temperature (in line with manufacturer's guidelines) and not be exposed to extremes of heat. They should not be refrigerated or left in direct sunlight.

**Spare Adrenaline Devices**

The Human Medicines (Amendment) Regulations 2017 permit "spare" adrenaline devices to be used for the purpose of saving a life. This might be, for example, a child presenting for the first time with anaphylaxis due to an undiagnosed allergy.

The school holds spare adrenaline devices for use in emergency situations. These are not a replacement for a student's own adrenaline device. Students prescribed adrenaline are expected to have their own adrenaline devices with them at school for use in an emergency. See appendix 1 for the brand, doses, quantity and location of the schools' AAI devices.

**Please note that by law, early years settings are not permitted to purchase or stock "spare" AAIs, however under Regulation 238 of the Human Medicines Regulations 2012, they may use a device belonging to someone else where they reasonably believe it will save the person's life, for example this could be a device that is prescribed for another pupil or one of the school's spare devices. This means our EYFS settings within schools will not stock "spare" AAIs specifically but in an emergency where there is reasonable belief there is a threat to life, they will be able to access spare devices held in school.**

The Operations Manager and School Allergies Lead are responsible for checking that adrenaline devices are in date and remain clear (not cloudy) on a termly basis. The Operations Manager will secure replacements one month before the current adrenaline device expires.

Adrenaline devices that are used will be disposed of in a sharps box, or given to the paramedic. Adrenaline devices that are out of date or where the adrenaline has degraded will be taken to a pharmacy to be disposed of. In order to receive a sharps box the school should register with the Local Authority which will be collected by them.

**In the event of anaphylactic reaction:**

- Adrenaline should be administered as soon as possible, within five minutes. **Do not wait** to contact the emergency services before administering adrenaline.
- The child, young person or individual should not be moved. Adrenaline devices should be brought to them (whether their own prescribed ADs or "spare" ADs).
- If the child, young person or individual **has their own prescribed adrenaline devices**, these should be used in the first instance.
- If the child, young person or individual **does not have prescribed adrenaline devices**, "spare" adrenaline devices can be used.
- If the child, young person or individual's **prescribed adrenaline devices are not available or misfire**, "spare" adrenaline devices can be used.

- If the individual has serious allergy and asthma and there is any doubt if they are presenting with anaphylaxis or having an asthma attack always administer the adrenaline first.

The Human Medicines (Amendment) Regulations 2017 do not require consent to have been obtained for "spare" adrenaline devices to be used. It can be good practice for the school, college or setting to obtain advance consent from parents or the young person for "spare" adrenaline devices to be used, so that in an emergency, consent can be assumed to be in place. However, in an emergency situation anyone may take reasonable action to save a life without checking whether prior consent has been given.

Anaphylaxis UK confirms:
What the Law Allows (Clarification on Regulation 238):

Under Regulation 238 of the Human Medicines Regulations 2012, anyone—including school staff—can administer adrenaline in an emergency to save a life, even without formal medical training.

This life-saving exemption ensures that nobody is denied emergency treatment in a situation that could not have been anticipated.

In addition:

- Schools can legally purchase spare AAIs without a prescription for use in emergencies.
- The original intent was for use only in pupils with a known allergy who have medical authorisation and written parental consent.
- **Updated clarification confirms: schools may also use a spare AAI in exceptional emergencies where a child or adult has a severe allergic reaction without a prior diagnosis or known allergy.**

(Anaphylaxis UK visited 23.07.26)

**Student self-management:**

Depending on their level of understanding and competence, students will be encouraged to take responsibility for and to always carry their own two adrenaline devices on them in a suitable bag/container. See appendix 1 for details; the bag/container should be the same across the school to prevent confusion/delay in identification.

Older students and teenagers should, whenever possible, assume responsibility for their emergency kit under the guidance of their parents. However, symptoms of anaphylaxis can come on **very suddenly**, so school staff need to be prepared to administer medication if the young person cannot.

**Staff Training and Emergency Response**

All staff, including teaching staff, support staff, catering staff and others who may oversee students including at breakfast or after school clubs will be trained in allergy awareness and emergency response. The school is responsible for ensuring that supply, cover, coaching, peripatetic staff have received allergy awareness training.

Training can be online or face to face. The content needs to include:

- Allergy awareness, the risks it poses, how allergic reactions occur and how to manage them
- Allergy includes multiple co-existing conditions: asthma, eczema, hay-fever
- Understand the difference between food allergy, intolerance and coeliac disease
- That a student can be allergic to any food, not just the top 14 allergens
- Know the symptoms of allergic reactions and how to treat

- Know the symptoms of anaphylaxis and how to treat
- How to locate and administer adrenaline or an asthma inhaler
  - All adrenaline devices should be used to train with as the student may have different ones to the spare adrenaline
- How to report an allergic reaction including
  - Mild to moderate
  - Anaphylaxis
  - Near miss/incident
- Understand their responsibilities in risk reduction, to ensure that students are prevented from coming into contact with their allergens
- Understand the impact that allergy can have on a student's wellbeing
- Understand the school's allergy safety policy and
  - How to check if a student is on the record of those with a known allergy
  - How to use an allergy or asthma action plan

**Emergency preparedness**

The school will annually hold a practice response to anaphylaxis, review how the practice went and update the Trust to enable policy and procedures.

Throughout the year staff will be reminded of key aspects of the policy such as:

- how to find out who has an allergy
- the storage of spare adrenaline
- practice with adrenaline trainer devices

The school will communicate key messages regarding risk reduction leading up to festivals, trips and end of term celebrations.

During fire drills and lockdown practices, the school will ensure that a student's adrenaline device is with them. Should a real evacuation happen, the student may have to go home without adrenaline if this has not been taken out during a fire evacuation.

**Roles and Responsibilities**

**Allergy lead and Trust:**

The Trust are responsible for ensuring that the Trust's policy sets out the arrangements to reduce the risk of individuals coming into contact with their known allergens and sets out the emergency response plan for cases of anaphylaxis. The Executive Team in the Trust monitor this policy. Headteachers should report any serious incidents or near misses to their Executive Phase Leader so that learning reviewed by the Executive Leadership Team and shared across our schools to support the culture of reflective practice and shared accountability.

Each school has a named member of the senior leadership team who is responsible for allergy safety which includes driving the implementation of the allergy safety policy and contributing to the review of the policy.

The allergy lead is responsible for:

- systems to collect allergy information during the enrolment process, ensuring that this information is shared with catering. Outside of the normal admission point, ensures that information is shared with staff and catering teams as soon as possible. Where pupils begin mid-term, the school should ensure that all necessary arrangements are in place within 2 weeks.

- holding a register of students and staff with allergies including whether they hold adrenaline and whether they have an allergy action plan
- ensures that systems are robust for the identification of students at mealtimes
- Communication about:
  - the policy
  - the students who are on the register of those with allergies
  - the importance of recording and reporting near misses and incidents
- communication with:
  - governors to provide updates about the policy implementation
  - Business Operations Lead and the Designated Safeguarding Lead so that they are aware of the expectations and can provide support and challenge to ensure decisions are made in the best interests of pupils with health and safety and safeguarding in mind
  - Outside agencies, supported by the Business Operations Lead such as Health and Safety Executive (HSE) if a report under RIDDOR is needed
  - Caterer supported by the Business Operations Lead; the procedures in the kitchen and the procedures for ensuring that the students with allergies are provided with a safe meal
  - Parents/carers to enable them to input into IHPs (Individual Healthcare Plans) and to request allergy action plans when appropriate
  - Students to develop an understanding of allergy through information assemblies and workshops/PSHE/Wellbeing Curriculum, participating in awareness days and weeks
- spare adrenaline devices and inhalers and making sure these are checked and in date, with replacements being secured before the current ones expire
- that IHPs are created and communicated
- Training
  - ensuring that all staff participate in annual training and that allergy is included in induction even for short term members of staff.
  - ensures that all staff have the opportunity to observe a training AAI device in use at least annually but ideally on more than one occasion.

**All Staff:**

Responsible for:

- understanding their role in implementing this policy, recognising signs of allergic reactions, and acting swiftly in an emergency
- supporting the creation of the students IHP
- implementing the students IHP
- creating an inclusive curriculum
- curriculum adaptation to minimise risks
- contributing to and following risk assessments for curriculum activities involving food, trips and visits including sporting events
- building proactive relationships with parents/carers
- reporting near misses and incidents
- attending de-briefs and training

**Parents:**

Responsible for:

- Adhering to this policy
- Providing school with the information they need to create individual health care plans
- Updating school when reactions happen outside of school or any changes to the student's allergy and its management.
- Ensuring that the student always has in date medication with them at school

**Identification of Individuals with Allergies**

**Admissions Data Collection:** School collects detailed medical information from parents/carers regarding known allergies, dietary restrictions, and treatment histories prior to admission.

**Information Sharing:** UK GDPR does not prevent the sharing of a student's health information (special category data). Relevant information is securely compiled and shared as necessary in a controlled way with teaching staff, support staff, supply cover, and catering teams while maintaining appropriate data privacy. This is done through: Arbor, Allergies Register, and Pastoral Briefings. Schools made add specific school-wide communication methods to their risk assessment in appendix 1.

**Transition:** Allergy information and existing care plans are shared as part of a student's transition. The School will request allergy information from the previous school or setting and will consider whether any of the arrangements are suitable to implement. The School work with parents/carers and the student if appropriate to write a new IHP. Staff will provide information about students for transition visits ahead of a formal move. **Where a pupil is staring at a normal transition point (e.g. beginning of the school term), it is expected that arrangements are in place to support the pupil's allergy at the start of the term. For mid-year transitions, arrangements should be in place within two weeks or sooner.**

**Staff:** Pre-employment questionnaires will ask whether staff have any medical conditions. If an allergy is declared, there will be a discussion and action plan created to ensure that the member of staff has a safe working environment.

**Visitors and regular volunteers:** Will be asked to declare allergies and medical conditions upon arrival. If an allergy is declared, the allergy lead will be notified, and this information will be communicated as necessary to ensure that the visitor or regular volunteer has a safe working environment.

**Student Individual Healthcare Plans (IHPs) and Allergy Action Plans**

**Allergy action plans**

- These are clinical documents that are created by a GP / allergy nurse or allergy clinic. They detail the student's allergy and medication.
- These contain parent/carer contact details and must be signed by the parent/carer as this is the parental authority to administer medication including the administration of spare adrenaline devices.
- These will only be updated by the medical professional following a review of the student's allergy management, this could be annually or 5 yearly. Parents/carers or school need to update the photo of the student annually so that the student is recognisable.

Allergy action plans are issued for students who have an IgE food allergy (An IgE-mediated food allergy occurs when your immune system overreacts to a specific food by producing Immunoglobulin E (IgE) antibodies) and often a venom allergy that could lead to anaphylaxis. They are not issued for all allergies. Students with non-IgE allergies don't experience anaphylaxis and so an allergy action plan is not issued.

**Individual Healthcare Plans (IHPs)**

Individual healthcare plans are an essential communication tool that provide clarity about the arrangements which need to be in place to ensure that a student is fully included in the life of the school. It will identify exact risk-mitigation measures that need to be followed. Individual Healthcare Plans are school owned documents that are co-created by school, parents/carers and students.

They should include any advice received from health professionals. If there is no advice from health professionals, information and support can be requested from the school nurses if this is needed. Where a child has an allergy action plan and or an asthma plan, this must be included with the IHP.

It is good practice to review IHPs annually or when a change occurs however they must be reviewed if an incident or near miss occurs. They need to be brought to the attention of supply or cover staff and be passed on during transition to a new school.

The school will ensure that:

- students with an allergy action plan and/or an asthma care plan have an individual healthcare plan
- students without an allergy action plan or asthma care plan but have an allergy that needs active management over and above what other students need will have an individual healthcare plan
- individual healthcare plans are created whilst students are waiting for a diagnosis

**School Trips and External Visits**

The school ensures that students with allergies are fully included in every trip, sporting event, or extracurricular activities. A risk assessment addressing allergen exposure in each activity, emergency medication, transport, and proximity to local emergency care will be undertaken with control measures identified. In order to ensure that the student is safe and included, alternative activities will be planned. This will include the safe storage adrenaline for the duration of the school trip.

Staff leading school trips will ensure they carry all relevant emergency supplies. Trip leaders will check that all students have their medication including adrenaline devices with them before departure. Students unable to produce their required medication will not be able to attend the excursion.

In conjunction with the allergy lead, the trip leader will review the risk assessment to determine whether the school's spare adrenaline devices should be taken on the trip. The school will provide additional spare adrenaline devices should the risk assessment for the trip deem necessary to take them ensuring that students remaining in school still have access to spare adrenaline devices should the need arise.

The school will notify the host school, when arranging a sporting fixture, that a member of the team has an allergy. When a sports tea is provided, the students' school will ensure the students' allergies are communicated and appropriate food is provided.

**Wraparound Clubs or Extended Services**

Our schools who provide wraparound support such as before and after school clubs or holiday clubs should follow this policy. Where the running of such childcare clubs is outsourced to other providers, leaders should seek written assurance that staff have accessed appropriate annual training, and have appropriate polices and procedures in place for food safety, first aid, incident and near miss reporting. Providers should receive a copy this policy and the appendices which relate directly to the school including the map which indicates where spare devices are located. The provider should have a key contact in school to report any incidents including the use of AAIs so that these may be replaced as soon as practicably possible.

**Early Years and College Provisions**

Within our Trust we operate Early Years and College Provisions at some of our schools, for details of how this policy applies specifically to those settings, please see appendix 7 and 8.

**Serious Incidents and "Near Misses":**

Our schools approach serious incidents and "near misses" in a "no blame" spirit, seeking to learn lessons and address any issues which the incident identified, so that students are better protected in the future.

Our schools are aware, when an incident occurs that materials such as residues of food consumed or handled or samples of fluids may constitute evidence, which may need to be seized and retained.

Our schools are all expected to record allergic reactions (incidents) and near misses (e.g., accidental exposure without reaction, or labelling errors) immediately. The incident or near miss will be reviewed and further actions to prevent re-occurrence should be recorded. The learning should be communicated whole school. Any near misses should be reviewed by the Allergy Lead.

Incidents should be recorded in the accident book/system and should set out:

- Who was affected
- What happened, when and where;
- Why the incident occurred (as far as is known);
- How staff and students responded; what was done to support the individual; whether emergency services where called;
- How the incident concluded.

Recordings should be made as soon as practicably possible after the event.

The Allergy Lead or a senior leader will share the report with the student's parents/carers*, the student and the individual involved. They should be given the opportunity to discuss what happened and to contribute their views to the consequent lessons learned review. The school will confirm what it has learned from the incident and outline any actions it is taking as a result. The student's IHP will be updated if necessary. The Executive Phase Leader should be informed.

If unsafe food was supplied by the school operating as a food business, the incident must be reported to the local authority environmental health team. Leaders should consider if the incident is reportable to RIDDOR, for example if a young person has been given their allergen by a member of staff and this has caused harm. Leaders are not required to report incidents to RIDDOR where a pupil or staff member is taken to hospital as a precaution.

*where the pupil is 16 or older, they should confirm that they agree their parents can be informed.

Where there is a serious incident relating to the delivery of a care plan, the healthcare professional or relevant team should be informed so that plans can be jointly reviewed. Where difficulty arises in engaging the relevant healthcare provider, the Integrated Care Board Designated Clinical Officer may assist.

**Wellbeing and Support**

At Oak Learning Partnership allergy safety is a priority and actions to ensure that students are included and safe are embedded into the Trust's culture. We recognise that students with

allergies can 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.

**Our schools will:**

- regularly communicate to students, parents and staff about allergies, ensuring ongoing awareness and appreciation of the severity of the potential risks
- include allergy and anaphylaxis lessons during assembly, tutor time or in PSHE
- plan school celebrations, rewards, and communal events inclusively from the outset to eliminate social isolation
- consider learning from incidents related to allergies including family voice, in the development and review of the policy and procedures for allergy management
- recognise that allergy bullying is extremely serious and actively monitor, prevent, and address any stigmatisation or bullying directed at individuals due to their allergies or dietary constraints
- consider roles for staff and students (not just within the catering team) who act as a point of contact for students and staff with allergies, they can share feedback and support new joiners or anxious students
- invite new joiners with allergies to have a tour of the kitchen and canteen so they can meet staff and get used to the mealtime environment which may help to reduce anxiety and enable staff to identify students with allergies in the dining hall
- be proactive in our engagement with new joiners with known allergies, setting out the school's policies and the support available

**Safeguarding**

Our schools recognise that a safeguarding referral may be needed if an incident highlighted concern that the child or young person might be at an increased risk of being neglected, abused or exploited by persons inside or outside of their family unit because of their medical condition. This might occur where relevant information about a child or young person's medical condition is not provided to a school, college or setting, or where they are repeatedly sent without essential medication, thereby putting the individual at risk.

**Unacceptable practice**

Our Trust staff are clear about what constitutes unacceptable practice and are committed to ensuring that only good practice occurs. Should unacceptable practice occur the school will follow its own procedures to identify and address this using staff conduct policies.

Examples of unacceptable practice include (but are not limited to):

- preventing children and young people from easily accessing and administering their medication in line with what is agreed in their Individual Healthcare Plan (for example prescribed adrenaline devices and asthma reliever inhalers) when and where necessary;
- assuming that every child with the same condition requires the same support;
- assuming that older children and young people do not require support related to their allergy, even if they are able to take increasing responsibility for its management;
- ignoring the views of the child or young person or their parents or carer;
- ignoring medical evidence or the opinion and advice of healthcare professionals;
- assuming that a child or young person does not have an allergy because they do not yet have a diagnosis, for example while medical investigation is under way;
- sending a child or young person who becomes unwell to a school office or medical room without suitable supervision. **In the case of an emergency or suspected emergency (for example anaphylaxis) help should come to the child or young person;**

- penalising children or young people for their attendance record if their absences are related to their medical condition, e.g. hospital appointments and health management.
- preventing children and young people from participating or creating unnecessary barriers to them participating in any aspect of school, college or setting life, including external visits and trips, e.g. by requiring parents to accompany the child.
- requiring parents/carers to attend the school or college to administer medication agreed in an IHP / allergy care plan, providing that the parent has provided the necessary allergy related medications and given written consent for school staff to administer.

**Policy Review and Publication**

This policy will be published openly on the school website and reviewed at least annually, or more frequently in response to local incident trends or updated statutory guidelines. It will be shared with staff via training and via the shared policies drives. **A copy should be displayed in the staff room/work room where available.**

**Appendices:**

1. School Risk Assessment
2. Individual Health Care Plans (Allergy only)
3. School Map with Emergency AAIs/Inhalers marked
4. Posters and Useful Links
5. Key actions for Allergy Leads and School Leaders
6. Wellbeing and Therapy Animals
7. Early Years only
8. Colleges only
9. Consent forms