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109TH CONGRESS
1ST SESSION

H. R. 4063

To direct the Secretary of Health and Human Services to develop a policy for managing the risk of food allergy and anaphylaxis in schools.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 17, 2005

Mrs. LOWEY (for herself, Mrs. MALONEY, Mr. EMANUEL, Mr. OWENS, Mr. MEEK of Florida, Ms. JACKSON-LEE of Texas, Ms. MILLENDER-MCDONALD, Mr. SHERMAN, Mr. SANDERS, Mr. LEVIN, and Mr. WEXLER) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To direct the Secretary of Health and Human Services to develop a policy for managing the risk of food allergy and anaphylaxis in schools.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Food Allergy and Anaphylaxis Management Act of 2005''.

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) Food allergy is an increasing food safety and public health concern in the United States, especially among children.

(2) Peanut allergy doubled among children from 1997 to 2002.

(3) In a 2003 survey of 400 elementary school nurses, 37 percent reported having at least 10 students with severe food allergies; 62 percent reported having at least 5.

(4) Forty-four percent of the elementary school nurses surveyed reported that the number of children in their school with food allergy had increased over the past 5 years; only 2 percent reported a decrease.

(5) In a 2001 study of 32 fatal food-allergy induced anaphylactic reactions (the largest study of its kind to date), more than half (53 percent) of the individuals were aged 18 or younger.

(6) Eight foods account for 90 percent of all food-allergic reactions: milk, eggs, fish, shellfish, tree nuts, peanuts, wheat, and soy.

(7) Currently, there is no cure for food allergies; strict avoidance of the offending food is the only way to prevent a reaction.

(8) Anaphylaxis, or anaphylactic shock, is a systemic allergic reaction that can kill within minutes.

(9) Food-allergic reactions are the leading cause of anaphylaxis outside the hospital setting, accounting for an estimated 30,000 emergency room visits, 2,000 hospitalizations, and 150 to 200 deaths each year in the United States.

(10) Fatalities from anaphylaxis are associated with a delay in the administration of epinephrine (adrenaline), or when epinephrine was not administered at all. In a study of 13 food allergy-induced anaphylactic reactions in school-age children (6 fatal and 7 near fatal), only 2 of the children who died received epinephrine within 1 hour of ingesting the allergen, and all but one of the children who survived received epinephrine within 30 minutes.

(11) The importance of managing life-threatening food allergies in the school setting has been recognized by the American Medical Association, the American Academy of Pediatrics, the American Academy of Allergy, Asthma and Immunology, and the American College of Allergy, Asthma and Immunology.

(12) There are no Federal guidelines concerning the management of life-threatening food allergies in the school setting.

(13) Three-quarters of the elementary school nurses surveyed reported developing their own training guidelines.

(14) Relatively few schools actually employ a full-time school nurse. Many are forced to cover more than one school, and are often in charge of hundreds if not thousands of children.

(15) Parents of children with severe food allergies often face entirely different food allergy management approaches when their children change schools or school districts.

(16) In a study of food allergy reactions in schools and day-care settings, delays in treatment were attributed to a failure to follow emergency plans, calling parents instead of administering emergency medications, and an inability to administer epinephrine.

SEC. 3. ESTABLISHMENT OF FOOD ALLERGY AND ANAPHYLAXIS MANAGEMENT POLICY.

(a) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall—

(1) develop a policy to be used on a voluntary basis to manage the risk of food allergy and anaphylaxis in schools; and

(2) make such policy available to local educational agencies and other interested individuals and entities.

(b) CONTENTS.—The policy developed by the Secretary under subsection (a) shall address each of the following:

(1) Parental obligation to provide the school, prior to the start of every school year, with documentation from the student's physician or nurse—

(A) supporting a diagnosis of food allergy and anaphylaxis;

(B) identifying any food to which the student is allergic;

(C) describing, if appropriate, any prior history of anaphylaxis;

(D) listing any medication prescribed for the child for the treatment of anaphylaxis;

(E) detailing emergency treatment procedures in the event of a reaction;

(F) listing the signs and symptoms of a reaction;

(G) assessing the student's readiness for self-administration of prescription medication; and

(H) providing a list of substitute meals that may be offered by school food service personnel.

(2) The maintenance of a file by the school nurse or principal for each student at risk for anaphylaxis.

(3) Communication strategies between individual schools and local providers of emergency medical services, including appropriate instructions for emergency medical response.

(4) Strategies to reduce the risk of exposure to anaphylactic causative agents in classrooms and common school areas such as the cafeteria.

(5) The dissemination of information on life-threatening food allergies to school staff, parents, and students, if appropriate by law.

(6) Food allergy management training of school personnel who regularly come into contact with students with life-threatening food allergies.

(7) The authorization of school personnel to administer epinephrine when the school nurse is not immediately available.

(8) The timely accessibility of epinephrine by school personnel when the nurse is not immediately available.

(9) Extracurricular programs such as non-academic outings and field trips, before- and after-school programs, and school-sponsored programs held on weekends.

(10) The creation of an individual health care plan tailored to the needs of each individual child at risk for anaphylaxis, including any procedures for the self-administration of medication by such children in instances where—

(A) the children are capable of self-administering medication; and

(B) such administration is not prohibited by State law.

(11) The collection and publication of data for each administration of epinephrine to a student at risk for anaphylaxis.

(c) RELATION TO STATE LAW.—Nothing in this Act or the policy developed by the Secretary under subsection (a) shall be construed to preempt State law, including any State law regarding whether students at risk for anaphylaxis may self-administer medication.

(d) DEFINITIONS.—In this Act:

(1) The term ''school'' includes kindergartens, elementary schools, and secondary schools.

(2) The term ''Secretary'' means the Secretary of Health and Human Services.

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