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# [Commitee Print]

[SHOWING THE TEXT OF THE BILL AS FORWARDED BY THE SUBCOMMITTEE ON HEALTH ON MARCH 11, 2008]

110TH CONGRESS
1ST SESSION

# H. R. 2063

To direct the Secretary of Health and Human Services, in consultation with the Secretary of Education, to develop a voluntary policy for managing the risk of food allergy and anaphylaxis in schools, to establish school-based food allergy management grants, and for other purposes.

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IN THE HOUSE OF REPRESENTATIVES

APRIL 26, 2007

Mrs. LOWEY (for herself, Mr. EMANUEL, Mr. MCDERMOTT, and Mr. KENNEDY) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Education and Labor, 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, in consultation with the Secretary of Education, to develop a voluntary policy for managing the risk of food allergy and anaphylaxis in schools, to establish school-based food allergy management grants, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the "Food Allergy and Ana-
3 phylaxis Management Act of 2008".

4 **SEC. 2. FINDINGS.**

5 Congress finds as follows:

6 (1) Food allergy is an increasing food safety
7 and public health concern in the United States, es-
8 pecially among students.

9 (2) Peanut allergy doubled among children from
10 1997 to 2002.

11 (3) In a 2004 survey of 400 elementary school
12 nurses, 37 percent reported having at least 10 stu-
13 dents with severe food allergies and 62 percent re-
14 ported having at least 5.

15 (4) Forty-four percent of the elementary school
16 nurses surveyed reported that the number of stu-
17 dents in their school with food allergy had increased
18 over the past 5 years, while only 2 percent reported
19 a decrease.

20 (5) In a 2001 study of 32 fatal food-allergy in-
21 duced anaphylactic reactions (the largest study of its
22 kind to date), more than half (53 percent) of the in-
23 dividuals were aged 18 or younger.

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

1 (7) Currently, there is no cure for food aller-
2 gies; strict avoidance of the offending food is the
3 only way to prevent a reaction.
4 (8) Anaphylaxis is a systemic allergic reaction
5 that can kill within minutes.
6 (9) Food-allergic reactions are the leading cause
7 of anaphylaxis outside the hospital setting, account-
8 ing for an estimated 30,000 emergency room visits,
9 2,000 hospitalizations, and 150 to 200 deaths each
10 year in the United States.
11 (10) Fatalities from anaphylaxis are associated
12 with a delay in the administration of epinephrine
13 (adrenaline), or when epinephrine was not adminis-
14 tered at all. In a study of 13 food allergy-induced
15 anaphylactic reactions in school-age children (6 fatal
16 and 7 near fatal), only 2 of the children who died
17 received epinephrine within 1 hour of ingesting the
18 allergen, and all but 1 of the children who survived
19 received epinephrine within 30 minutes.
20 (11) The importance of managing life-threat-
21 ening food allergies in the school setting has been
22 recognized by the American Medical Association, the
23 American Academy of Pediatrics, the American
24 Academy of Allergy, Asthma and Immunology, the
25 American College of Allergy, Asthma and Immu-

1 nology, and the National Association of School
2 Nurses.
3 (12) There are no Federal guidelines con-
4 cerning the management of life-threatening food al-
5 lergies in the school setting.
6 (13) Three-quarters of the elementary school
7 nurses surveyed reported developing their own train-
8 ing guidelines.
9 (14) Relatively few schools actually employ a
10 full-time school nurse. Many are forced to cover
11 more than 1 school, and are often in charge of hun-
12 dreds if not thousands of students.
13 (15) Parents of students with severe food aller-
14 gies often face entirely different food allergy man-
15 agement approaches when their students change
16 schools or school districts.
17 (16) In a study of food allergy reactions in
18 schools and day-care settings, delays in treatment
19 were attributed to a failure to follow emergency
20 plans, calling parents instead of administering emer-
21 gency medications, and an inability to administer ep-
22 inephrine.
23 **SEC. 3. DEFINITIONS.**
24 In this Act:

1 (1) ESEA DEFINITIONS.—The terms ''local
2 educational agency'', ''secondary school'', and ''ele-
3 mentary school'' have the meanings given the terms
4 in section 9101 of the Elementary and Secondary
5 Education Act of 1965 (20 U.S.C. 7801).
6 (2) SCHOOL.—The term ''school'' includes pub-
7 lic—
8 (A) kindergartens;
9 (B) elementary schools; and
10 (C) secondary schools.
11 (3) SECRETARY.—The term ''Secretary'' means
12 the Secretary of Health and Human Services, in
13 consultation with the Secretary of Education.
14 **SEC. 4. ESTABLISHMENT OF VOLUNTARY FOOD ALLERGY**
15 **AND ANAPHYLAXIS MANAGEMENT POLICY.**
16 (a) ESTABLISHMENT.—Not later than 1 year after
17 the date of enactment of this Act, the Secretary shall—
18 (1) develop a policy to be used on a voluntary
19 basis to manage the risk of food allergy and anaphy-
20 laxis in schools; and
21 (2) make such policy available to local edu-
22 cational agencies and other interested individuals
23 and entities to be implemented on a voluntary basis
24 only.

1 (b) CONTENTS.—The voluntary policy developed by
2 the Secretary under subsection (a) shall contain guidelines
3 that address each of the following:
4 (1) Parental obligation to provide the school,
5 prior to the start of every school year, with—
6 (A) documentation from the student's phy-
7 sician or nurse—
8 (i) supporting a diagnosis of food al-
9 lergy and the risk of anaphylaxis;
10 (ii) identifying any food to which the
11 student is allergic;
12 (iii) describing, if appropriate, any
13 prior history of anaphylaxis;
14 (iv) listing any medication prescribed
15 for the student for the treatment of ana-
16 phylaxis;
17 (v) detailing emergency treatment
18 procedures in the event of a reaction;
19 (vi) listing the signs and symptoms of
20 a reaction; and
21 (vii) assessing the student's readiness
22 for self-administration of prescription
23 medication; and

1 (B) a list of substitute meals that may be
2 offered to the student by school food service
3 personnel.
4 (2) The creation and maintenance of an indi-
5 vidual health care plan tailored to the needs of each
6 student with a documented risk for anaphylaxis, in-
7 cluding any procedures for the self-administration of
8 medication by such students in instances where—
9 (A) the students are capable of self-admin-
10 istering medication; and
11 (B) such administration is not prohibited
12 by State law.
13 (3) Communication strategies between indi-
14 vidual schools and local providers of emergency med-
15 ical services, including appropriate instructions for
16 emergency medical response.
17 (4) Strategies to reduce the risk of exposure to
18 anaphylactic causative agents in classrooms and
19 common school areas such as cafeterias.
20 (5) The dissemination of information on life-
21 threatening food allergies to school staff, parents,
22 and students, if appropriate by law.
23 (6) Food allergy management training of school
24 personnel who regularly come into contact with stu-
25 dents with life-threatening food allergies.

(7) The authorization and training 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 that are addressed in the individual health care plan.

(10) 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.

**SEC. 5. VOLUNTARY NATURE OF POLICY AND GUIDELINES.**

The policy developed by the Secretary under section 4(a) and the food allergy management guidelines contained in such policy are voluntary. Nothing in this Act or the policy developed by the Secretary under section 4(a)

1 shall be construed to require a local educational agency
2 or school to implement such policy or guidelines.