

FOOD ALLERGIES IN PUBLIC SCHOOLS: TOWARD A MODEL CODE

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INTRODUCTION

On February 26, 1993, sixteen-year-old John Federico of Portsmouth, Rhode Island died after eating food at a dorm party at his boarding school.¹ On September 29, 1995, six-year-old Alex Handy of Kenosha, Wisconsin died after eating a school lunch.² In November 1996, eighteen-year-old German Lopez of New York died after eating a candy bar at his high school.³ On May 18, 2001, nine-year-old Nathan Walters of Spokane, Washington died after eating a school lunch.⁴ On September 13, 2003, thirteen-year-old Sabrina Shannon of Pembroke, Ontario, Canada died after eating French fries in a school cafeteria.⁵ All of these children were known to have severe food allergies. Thus, their tragedies are two-fold—not only did they die, but their deaths were preventable.

Each year, thousands of parents send children with food allergies to public schools. For children who suffer from the most severe forms of food allergies, those subject to anaphylactic shock, parents do so with trepidation.⁶ Children with food allergies are especially susceptible to allergic

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1. Federico v. Order of Saint Benedict, 64 F.3d 1, 2–3 (1st Cir. 1995).
2. Dennis A. Shook, *Medical Examiner Confirms Boy Died From Eating Fish*, MILWAUKEE J. SENTINEL, Jan. 31, 1996, at 5.
3. Ray Alexander Smith, *FDA Looking into Paterson Asthma Death: High School Student Had Reaction to Peanuts in Candy Bar*, THE RECORD, Nov. 14, 1996, at L03.
4. Virginia de Leon, *District 81 Settles in Boy's Anaphylactic Death: School Officials Agree to Protect Children with Food Allergies*, SPOKANE SPOKESMAN-REV., Aug. 21, 2001, at A1.
5. *Deaths from Allergic Reactions Spark Call for Action*, May 7, 2007, <http://www.canada.com/victoriatimescolonist/news/story.html?id=4a27fff1-70b8-452e-9896-a7f69bb2db6e&k=14228>.
6. Jim Rogalski, *Schools Need to Face Nut Threat*, ALBANY TIMES UNION, Nov. 24, 1998, at F1.

reactions in school settings, due to their tender age as well as a lack of education and policy at public schools regarding food allergy management.⁷

Despite a growing awareness of food allergies and the potentially deadly outcome of an allergic reaction, U.S. federal law and most states' laws have yet to sufficiently address this issue. Only one federal law is directed to food allergies, while there is a hodge-podge of state laws that vary dramatically between the states. Some states have passed detailed laws and regulations and have published guidelines for food allergy management in public schools. Others have no legislation or guidelines at all on the topic. Within a state, different school districts may have different policies for how they handle children with food allergies.⁸ Even within a school, not all teachers have a common understanding of the severity of food allergies and what they need to do when a child under their care has an allergic reaction.

The U.S. needs a set of laws and regulations that determine a common, nationwide baseline for food allergy management in all public schools. These laws should put the children first by emphasizing preventative measures that can greatly reduce the risk life-threatening allergic reactions. Furthermore, these laws should mandate regular food allergy management education and training for all school personnel, including specific direction on what to do when an allergic reaction occurs. Moreover, these laws should require that schools support, when necessary, individualized health care plans for children with food allergies. Finally, these laws should ensure that allergic children and school personnel always have rapid access to appropriate medication, regardless of where allergic children are on school grounds or whether they are on a school bus or a field trip.

This article is organized as follows. Section I provides a medical and social background on food allergies, including the difficulties of managing food allergies in school settings. Section II reviews federal laws that may apply to some food allergy sufferers. Section III presents the results of a survey of state laws, regulations, and guidelines addressing food allergies. Section IV develops a proposed model code that states could adopt in order

7. *Students with Food Allergies Often Not Prepared*, SCIENCE DAILY, Aug. 6, 2008, available at <http://www.sciencedaily.com/releases/2008/08/080806081451.htm> (“[G]rade-school students are often in school environments where there is no food allergy policy, and where instructors are not trained how to treat an emergency food allergy reaction.”).

8. PAUL J. HANNAWAY, ON THE NATURE OF FOOD ALLERGY (Lighthouse Press 2007), reprinted in *Managing Food Allergies at School*, KIDS WITH FOOD ALLERGIES SUPPORT NET (Kids with Food Allergies, Inc.), Fall 2007, at 3 (“The amount of awareness in schools and school districts about keeping food allergic children safe at school varies greatly.”).

to provide a reasonable baseline for food allergy management in public schools.

I. MEDICAL AND SOCIAL BACKGROUND

A food allergy is an immune system response to specific proteins.⁹ After ingesting one or more of these proteins, the immune system of a food allergy sufferer may respond with a chemical reaction affecting one or more of the sufferer's respiratory, cardiovascular, integumentary, and neurological systems.¹⁰ One of the most severe reactions is anaphylactic shock, where the sufferer may have difficulty breathing and may experience a sudden drop in blood pressure.¹¹ An allergic individual can have an anaphylactic reaction to a minuscule amount of an allergen and can die within minutes if not properly treated.¹²

The recommended form of treatment for anaphylactic shock is an immediate injection of epinephrine.¹³ Medical professionals suggest that any person with a history of anaphylactic reactions have an epinephrine auto-injector available at all times.¹⁴ An epinephrine injection is not an "antidote" and will only temporarily alleviate the symptoms of anaphylaxis, giving the allergy sufferer an additional ten to fifteen minutes to receive proper medical attention.¹⁵

An estimated four percent of Americans (about twelve million people) suffer from food allergies.¹⁶ Over the last twenty years, incidences of food

9. See Rhoda Sheryl Kagan, *Food Allergy: An Overview*, 111 ENVTL. HEALTH PERSP. 223 (2003). It is important to distinguish food allergies from food intolerances. The latter are non-immunological, and associated reactions are less severe than food allergy reactions. See, e.g., Steve L. Taylor, *Emerging Problems with Food Allergens*, 26 FOOD, NUTRITION AND AGRIC. 14, 14-15 (2000), available at [ftp://ftp.fao.org/docrep/fao/003/x7133m/x7133m02.pdf](http://ftp.fao.org/docrep/fao/003/x7133m/x7133m02.pdf) (for example, a milk allergy may result in an immunological reaction that can be fatal, whereas a milk intolerance is a non-immunological reaction that can be unpleasant, but is non-fatal).

10. See Susan D. Dibs & M. Douglas Baker, *Anaphylaxis in Children: A 5-Year Experience*, 99 PEDIATRICS e7 (1997), <http://pediatrics.aappublications.org/content/vol99/issue1/index.shtml>.

11. Jonathan Bridges, Note, *Suing For Peanuts*, 75 NOTRE DAME L. REV. 1269, 1273 (2000).

12. Dibs & Baker, *supra* note 10, at e7.

13. Ray Formanek Jr., *Food Allergies: When Food Becomes the Enemy*, FDA CONSUMER MAG., July/Aug. 2001 (rev. Apr. 2004), <http://www.medicinenet.com/script/main/art.asp?articlekey=40649>.

14. Epinephrine auto-injectors, more commonly known by the brand names Epipen or Anakit, are hypodermic needles contained within a hardened case. Their design is intended to facilitate injection of epinephrine by an allergy sufferer or by someone else trained to administer the shot. Someone who needs to self-administer epinephrine presses the auto-injector against his or her leg, and the needle springs out and injects a dose of epinephrine into the user's muscle, even through clothing.

15. Marie Plicka, *Mr. Peanut Goes to Court: Accommodating an Individual's Peanut Allergy in Schools and Day Care Centers under the Americans with Disabilities Act*, 14 J.L. & HEALTH 87, 91 (1999/2000).

16. Laura E. Derr, *When Food is Poison: The History, Consequences, and Limitations of the Food Allergen Labeling and Consumer Protection Act of 2004*, 61 FOOD & DRUG L.J. 65, 70 (2006); see also

allergies and severe allergic reactions have been on the rise.¹⁷ Thus, the percentage of children with food allergies today may be higher than four percent. Thousands of people suffer anaphylactic shock from food allergies each year, and it is estimated that 150-200 of these people, mostly children, die from these reactions.¹⁸

Food allergies have no cure; therefore, avoidance is the only safe strategy for food allergy sufferers.¹⁹ Common food allergens include wheat, milk, soy, peanuts and tree nuts, fish and shellfish, and eggs.²⁰ These foods are staples of most American diets and are used in preparing and processing many food products. Thus, food allergy sufferers rely on accurate labeling of store-bought and restaurant food in order to avoid allergens.²¹ However, such labeling frequently is not present.²² Consequently, the dangers of food allergies remain significant for adults, but are especially concerning for minors.

In particular, small children with life-threatening food allergies rely upon their parents and other adults to help them avoid foods containing allergens. These children cannot be expected to manage their allergies themselves. While parents of such children can effectively have an allergen-free environment at home, parents cannot exert the same degree of control over their child's diet and surroundings while their child is at school.²³

Other children may bring allergens into classrooms or lunchrooms. Peanut butter and milk are very popular foods with American children, and wheat, soy, and egg products are found in many foods. But, even if children are sufficiently aware of their allergies to avoid food served in school cafeterias and to avoid sharing food with other children, they are still at risk from cross-contamination.²⁴ It is no secret that some children are messy

Food Allergy and Anaphylaxis Network, Frequently Asked Questions, <http://www.foodallergy.org/questions.html>. Generally, obtaining accurate statistics on the number of food allergy sufferers in the United States is difficult, as many sufferers may not yet have had a reaction, had only a minor reaction, or not have reported a reaction.

17. See Derr, *supra* note 16, at 70-71; H.R. 2063, 110th Cong. § 2(2) (2008) ("Peanut allergy doubled among children from 1997 to 2002.").

18. Derr, *supra* note 16, at 72; H.R. 2063 § 2(5), § 2(9).

19. Derr, *supra* note 16, at 77; Katharine Van Tassel, *The Introduction of Biotech Foods to the Tort System: Creating a New Duty to Identify*, 72 U. CIN. L. REV. 1645, 1661 n. 95 (2004).

20. Kagan, *supra* note 9, at 223; H.R. 2063 § 2(6) (these eight foods account for over ninety percent of all allergic reactions).

21. Derr, *supra* note 16, at 77-78.

22. *Id.* at 79-80.

23. For instance, parents of a child with a peanut allergy can exclude all peanut products and foods that may be contaminated with peanuts from their home.

24. C. Lynne McIntyre, Anne H. Sheetz, Constance R. Carroll & Michael C. Young, *Administration of Epinephrine for Life-Threatening Allergic Reactions in School Settings*, 116 PEDIATRICS 1134,

eaters and often fail to wash their hands thoroughly with soap and water after eating. The residue from one child's peanut butter sandwich can easily find its way onto the desk or clothes of a child with a peanut allergy.²⁵ Such threats to children's health are not limited to the cafeteria. School projects may also contain hidden allergens, such as peanut butter.²⁶

Small children, with or without food allergies, should not be expected to understand the consequences of exposing allergic individuals to certain foods. The safety of children in the classroom depends on school personnel being appropriately trained in what substances can cause allergic reactions and what to do when there is an emergency. However, school personnel may not be familiar with the signs of anaphylactic shock. They may view a child struggling to breathe as having an asthma attack and attempt to get the child to use an inhaler.²⁷ Or they may not know how to properly administer epinephrine. Moreover, parents who do not have children with food allergies may resist restrictions on what their non-allergic children are allowed to eat and where they are allowed to eat it.²⁸

The combination of the severity of food allergy reactions and the practical difficulties in managing allergies places a significant burden on allergic children and their parents, especially in public school settings. Consequently, children with food allergies and their parents should be able to rely on the government to provide a safe environment in public schools.

II. FEDERAL LAWS

Several well-established federal laws impact how schools must accommodate children with disabilities. They include the Rehabilitation Act,²⁹ the Americans with Disabilities Act (ADA),³⁰ and the Individuals with Disabilities Education Act (IDEA).³¹ However, these laws were written and enacted before the recent rise of food allergies and do not specifically include food allergies as a disability.

Unlike many physical and mental disabilities, food allergies do not present obvious hardships. When one sees a child using a wheelchair or

1139 (2005) (allergic reactions can be "triggered by contact with a known allergen through cross-contamination or exposure to a food that contained the offending allergen as a hidden ingredient.").

25. *Id.* (food-related allergic reactions can occur outside of lunch periods).

26. *Id.* (allergic reactions have been triggered, for example, by class projects containing peanut butter).

27. *See, e.g.,* Federico v. Order of Saint Benedict, 64 F.3d 1, 2-3 (1st Cir. 1995).

28. *See* Editorial, *Peanut-Free is Nutty*, DES MOINES REGISTER, Sept. 3, 2004, at 12A.

29. 29 U.S.C. § 794 (2008).

30. 42 U.S.C. §§ 12101–12213 (2008).

31. 20 U.S.C. §§ 1400–1483 (2008).

interacts with a child who has an IQ of fifty, those children's disabilities are clearly apparent. However, food allergies are subtle. As their incidence is relatively new, poorly understood, and subtle, food allergy sufferers have yet to receive the sympathy or appreciation accorded to those who are disabled in a more traditional sense.

Congress has just begun to address the specific issues related to food allergies. The Food Allergen Labeling and Consumer Protection Act of 2004 (FALCPA) is directed to improving food labeling standards.³² However, it does not address food allergy management in public schools. The Food Allergy and Anaphylaxis Management Act of 2008 (FAAMA),³³ currently pending in Congress, does address this issue. However, it would provide only for the development of optional guidelines for public schools.³⁴ Below, I discuss each of these enacted and proposed laws and how they may be applied to individuals with food allergies.

A. *Rehabilitation Act*

The Rehabilitation Act prohibits all programs that receive federal funding, including public schools,³⁵ from discriminating against individuals with disabilities.³⁶ According to the Act, a disabled person "(i) has a physical or mental impairment which substantially limits one or more of such person's major life activities; (ii) has a record of such an impairment; or (iii) is regarded as having such an impairment."³⁷ Major life activities include "caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."³⁸

Court interpretation of the Rehabilitation Act has been largely in lock-step with court interpretation of the ADA because of the parallel structure of the two laws. In particular, Congress amended the Rehabilitation Act in 1992 to echo the principles espoused by the ADA.³⁹ In doing so, Congress

32. FALCPA was enacted in Title II of Pub. L. No. 108-282, 118 Stat. 891 (2004) and codified in various sections of 21 U.S.C. The most relevant sections of the United States Code for purposes of this article are 21 U.S.C. § 321(qq) (defining "major food allergens") and 21 U.S.C. § 343(w) (defining labeling requirements for major food allergens). FALCPA is also available at <http://www.cfsan.fda.gov/~dms/algact.html>.

33. H.R. 2063, 110th Cong. (2008).

34. *Id.* § 4(a)(1).

35. 29 U.S.C. § 794(b)(2) (2008).

36. *Id.* § 794(a) ("No . . . individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity . . .").

37. 29 U.S.C. § 705(20)(B) (2008).

38. 45 C.F.R. § 84.3(j)(2)(ii) (2008).

39. S. Rep. No. 102-357, at 1 (1992) (Amendments to the Rehabilitation Act were made "to

harmonized not only the language of the acts, but also the standards used to determine violations of the acts.⁴⁰ However, whether an individual with food allergies is considered disabled under the Rehabilitation Act is still unsettled.⁴¹

Given the similarities between the Rehabilitation Act and the ADA, and because the ADA is the more recent law and benefits from more voluminous statutory interpretation,⁴² it is helpful to turn to the ADA in order to further understand the applicability of the Rehabilitation Act to children with food allergies in public schools.

B. *Americans with Disabilities Act*

The ADA extends the principles of the Rehabilitation Act to the private sector, and is primarily focused on requiring that private employers not discriminate against disabled individuals.⁴³ The stated goal of the ADA was to “mandate the elimination of discrimination against individuals with disabilities,”⁴⁴ and the ADA defines a disabled person using the same language as the Rehabilitation Act.⁴⁵ The Equal Employment Opportunity Commission (EEOC), the body responsible for regulations associated with the ADA, adopted the Rehabilitation Act’s definition of “major life activities” and its definition of the term “substantially limits.”⁴⁶ The EEOC provides guidelines for determining when a major life activity is substantially

ensure that the precepts and values embedded in the Americans with Disabilities Act are reflected in the Rehabilitation Act.”).

40. 29 U.S.C. § 791(g) (2008) (“The standards used to determine whether this section [of the Rehabilitation Act] has been violated in a complaint alleging nonaffirmative action employment discrimination under this section shall be the standards applied under title I of the Americans with Disabilities Act of 1990”).

41. CONN. STATE DEP’T OF EDUC., MANAGING LIFE THREATENING FOOD ALLERGIES IN CONN. SCH. 16 (2006), available at http://www.sde.ct.gov/sde/lib/sde/PDF/deps/child/health/Food_Allergies.pdf (“There are substantial differences across the country in legal interpretations and school district practices regarding [the Rehabilitation Act], its definition of a qualified person with a disability, and the eligibility of students with life-threatening food allergies.”).

42. See, e.g., Allison v. Dep’t of Corr., 94 F.3d 494, 497 (8th Cir. 1996) (“Because the same basic standards and definitions are used under both [the Rehabilitation Act and the ADA], cases interpreting either are applicable and interchangeable for purposes of our discussion.”); Vande Zande v. Wis. Dep’t of Admin., 44 F.3d 538, 542 (7th Cir. 1995) (“[T]he employment provisions of the [ADA] merely generalize to the economy as a whole the duties, including that of reasonable accommodation, that the regulations under the Rehabilitation Act imposed on federal agencies and federal contractors.”).

43. See 42 U.S.C. § 12101 (2008).

44. *Id.* § 12101(b)(1).

45. Compare 42 U.S.C. § 12102(2) with 29 U.S.C. § 705(20)(B).

46. 29 C.F.R. § 1630.2(i)–(j) (2008) (“The term substantially limits means: (i) Unable to perform a major life activity that the average person in the general population can perform; or (ii) Significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform that same major life activity.”).

limited.⁴⁷

The ADA also requires that entities covered by the ADA provide a disabled person with “reasonable accommodation” for his or her disability unless such accommodation would “impose an undue hardship” on the entity.⁴⁸ While the ADA defines “reasonable accommodation” in terms of the entity being an employer,⁴⁹ courts have applied the “reasonable accommodation” standard to Rehabilitation Act claims brought against public schools and universities.⁵⁰ However, there is no hard and fast definition of what “reasonable accommodation” requires in these contexts.⁵¹

The Supreme Court narrowed the scope of the ADA in a pair of cases. In *Sutton v. United Airlines*, the Court found that the determination of whether an individual is disabled under the ADA should consider the individual in light of any corrective measures (such as eyeglasses or contact lenses for one whose vision is impaired) the individual might make to mitigate the individual’s impairments.⁵² In *Toyota v. Williams*, the Court construed the term “substantially limits” in 29 C.F.R. § 1630.2(i)–(j) to “preclude impairments that interfere only in a minor way with the performance of manual tasks from qualifying as disabilities.”⁵³ The Court also held that “major life activities” are “those activities that are of central importance to daily life.”⁵⁴ Combined, these holdings limited the ADA to apply only to individuals with a permanent or long-term impairment “that prevents or severely restricts the individual from doing activities that are of central importance to most people’s daily lives.”⁵⁵

47. *Id.* § 1630.2(j) (factors include “(i) The nature and severity of the impairment; (ii) The duration or expected duration of the impairment; and (iii) The permanent or long term impact, or the expected permanent or long term impact of or resulting from the impairment.”).

48. 42 U.S.C. § 12111(8)–(10).

49. The discussion of “reasonable accommodation” falls within the ADA’s Subchapter I on employment. *See id.* § 12111(9).

50. *See, e.g., Stern v. Univ. of Osteopathic Med. & Health Sci.*, 220 F.3d 906, 907-08 (8th Cir. 2000); *Zukle v. Regents of the Univ. of Cal.*, 166 F.3d 1041, 1046 (9th Cir. 1999); *Nathanson v. Med. Coll. of Pa.*, 926 F.2d 1368, 1383 (3rd Cir. 1991); *Southeastern Cmty. Coll. v. Davis*, 442 U.S. 397, 408 (4th Cir. 1979). In doing so, the courts have looked to the language of 29 U.S.C. § 794(a) and 29 U.S.C. § 701(a)(4).

51. One hint can be found in 7 CFR § 210.10(g)(1), a U.S. Department of Agriculture regulation on school lunches, which states that schools “must make substitutions in lunches and afterschool snacks for students who are considered to have a disability . . . and whose disability restricts their diet.” This regulation also states that schools “may make substitutions for students without disabilities who cannot consume the regular lunch or afterschool snack because of medical or other special dietary needs.” (emphasis added).

52. 527 U.S. 471, 482 (1999) (“[T]he approach adopted by [EEOC] guidelines—that persons are to be evaluated in their hypothetical uncorrected state—is an impermissible interpretation of the ADA.”).

53. 534 U.S. 184, 197 (2002).

54. *Id.*

55. *Id.* at 198.

While the Supreme Court has not decided any cases substantially related to food allergies, there have been a small number of federal appellate decisions that addressed whether an individual with food allergies or severe dietary restrictions is “disabled” under the ADA.⁵⁶ In *Land v. Baptist Medical Center*, decided before the *Sutton* and *Toyota* cases, the Eighth Circuit held that a child with a peanut allergy was not “substantially limited” in her ability to eat and breathe, despite the child having a record of suffering from allergic reactions when she ingested peanuts.⁵⁷ The majority read the EEOC definition of “substantially limits” not to include the child’s allergy because she could safely eat foods not containing peanuts; her ability to breathe was not impacted as long as she avoided peanuts.⁵⁸ Consequently, the panel found that the child was not disabled under the ADA⁵⁹ and did not address what would be “reasonable accommodation” in a school setting for a child with a peanut allergy.

The *Land* opinion has been criticized as misunderstanding the seriousness of food allergy reactions.⁶⁰ While a food allergy sufferer may not be “disabled” under the ADA in the normal course of daily life, even a minute exposure to an allergen could cause a deadly reaction.⁶¹ The majority discounted the burden of constant vigilance that is required on the part of the child, parents, caregivers, and school employees.⁶² However, in the *Land* dissent, Judge Arnold wrote that if the child “has a severe reaction that is not promptly treated, she may go into anaphylactic shock or, worse, die. The risk, therefore, that Megan may accidentally ingest peanuts . . . must be understood in light of the potential for serious injury.”⁶³

No other federal appellate court has directly addressed the issue of food allergies as a disability. Nevertheless, the Ninth Circuit appears to be

56. See, e.g., *Fraser v. Goodale*, 342 F.3d 1032 (9th Cir. 2003); *Land v. Baptist Med. Ctr.*, 164 F.3d 423 (8th Cir. 1999).

57. *Land*, 164 F.3d at 425.

58. *Id.* (“[T]he record does not suggest that Megan suffers an allergic reaction when she consumes [food without peanuts] or that her physical ability to eat is in any way restricted . . . Megan’s ability to breathe is generally unrestricted, except for the limitations she experienced during her two allergic reactions.”).

59. *Id.*

60. *Bridges*, *supra* note 11, at 1285 (“The proposition that life-threatening food allergies do not substantially limit an individual’s ability to eat seems preposterous.”).

61. See, e.g., *Plicka*, *supra* note 15, at 89 (“It has now become a question of whether an individual’s food allergy . . . can ever rise to a high enough level of severity that a court will recognize it as a disability . . .”).

62. *Bridges*, *supra* note 11, at 1285 (“Megan (or her mother) must be painstakingly cautious in reading every ingredient on every food label, in quizzing every waiter at every restaurant, in educating every caregiver and every babysitter. They must remain prepared, at any meal or snack, to head for the nearest hospital emergency room for treatment.”).

63. *Land*, 164 F.3d at 426 (Arnold, J., dissenting).

ready to entertain an approach similar to Judge Arnold's approach to addressing the risk of severe allergic reactions. In *Fraser v. Goodale*, the court wrote in dicta:

If a person is impaired only from eating chocolate cake, he is not limited in a major life activity because eating chocolate cake is not a major life activity. On the other hand, peanut allergies might present a unique situation because so many seemingly innocent foods contain trace amounts of peanuts that could cause severely adverse reactions.⁶⁴

At the federal trial court level, many complaints directed to food allergies have been filed. However, most appear to be from prisoners who contend, without an adequate factual basis, that they suffer from food allergies.⁶⁵ The majority of recent prisoner food allergy cases have been dismissed.⁶⁶ If anything, these prisoner cases desensitize the courts to legitimate claims of inadequate accommodation from food allergy sufferers.

While there are few federal court opinions applying the ADA to food allergy sufferers, there are a number of cases addressing the ADA's applicability to individuals with strict dietary requirements due to severe diabetes. To the extent that diabetes sufferers must carefully monitor their diets, their challenges are analogous to those of food allergy sufferers.

In *Fraser*, the plaintiff, who suffered from severe Type I insulin-dependent diabetes, worked at a bank.⁶⁷ Her condition required that she constantly monitor her blood sugar levels and adjust them as needed with insulin, food, or glucagon.⁶⁸ However, her supervisor prohibited her from eating at her desk, which resulted in her passing out from low blood sugar while on the job.⁶⁹ She subsequently filed a complaint against her supervisor.⁷⁰ Soon after, the bank terminated her employment, and she filed an ADA claim against the bank.⁷¹ On appeal from the district court's grant of the bank's motion for summary judgment, the Ninth Circuit found that an individual is likely disabled under the ADA when the individual establishes

64. 342 F.3d 1032, 1040 (9th Cir. 2003). *Fraser* addresses whether an individual with a case of life-threatening diabetes was "disabled" under the ADA. The opinion does not discuss food allergies further.

65. See, e.g., *Tate v. Bell*, No. 2:06-cv-00627, 2007 U.S. Dist. LEXIS 48300, at *2 (S.D. Ohio July 3, 2007); *Ybarra v. Thomas*, No. H-07-1956, 2007 U.S. Dist. LEXIS 45091, at *16-17 (S.D. Tex. June 21, 2007); *Lawson v. Wollenhaupt*, No. 3:02cv1097, 2004 U.S. Dist. LEXIS 3832, at *20-21 (D. Conn. Feb. 23, 2004). These prisoners may be using the malady of "food allergies" to attempt to escape what they believe to be the poor quality of prison food.

66. In a survey of such cases decided over the last several years, I found none in which a prisoner prevailed.

67. *Fraser*, 342 F.3d at 1034-35.

68. *Id.* at 1035.

69. *Id.*

70. *Id.*

71. *Id.*

that her diabetic regimen requires her to monitor her food intake, insulin levels, and physical activity with extreme care.⁷²

Similarly, in *Lawson v. CSX Transportation, Inc.*, the Seventh Circuit reviewed a case in which the plaintiff suffered from a comparable case of diabetes.⁷³ The plaintiff filed an ADA claim asserting that a railroad company denied him employment because of his diabetes.⁷⁴ In reversing the district court's granting of summary judgment to the railroad company, the Seventh Circuit found that the severity of the plaintiff's diabetes potentially rose to the level of a disability under the ADA.⁷⁵ On the other hand, when an individual fails to establish that his condition is severe, a court is more likely to find that his major life activities are not impacted and, therefore, that the individual is not disabled under the ADA.⁷⁶

When construing the ADA, the Supreme Court has focused on the language of Section 12101(a)(1), which states that "some 43,000,000 Americans have one or more physical or mental disabilities . . ."⁷⁷ The Court has used this language to conclude that the ADA should have a relatively narrow scope.⁷⁸ In particular, it seems as if the Court has tried to avoid holding that individuals with certain manageable afflictions were per se disabled, and instead required them to prove that their afflictions impacted major life activities.⁷⁹ Although the ADA does not clearly define "disabilities," some commentators have found that the Court's view of the ADA in this regard was overly literal, could lead to absurd results, and ran

72. *Id.* at 1041, 1045 (the diabetes sufferer "must constantly, faithfully, and precisely monitor her eating, exercise, blood sugar, and other health factors, and even this is no guarantee of success.").

73. 245 F.3d 916, 918 (7th Cir. 2001).

74. *Id.* at 922.

75. *Id.* at 924-26 ("It is the severity of these limitations on his ability to eat that distinguishes Mr. Lawson's situation from that of other individuals who must follow the simple 'dietary restrictions' that medical conditions sometimes entail.").

76. *See, e.g.,* Walker v. City of Vicksburg, Civil Action No. 5:06cv60-DCB-JMR, 2007 U.S. Dist. LEXIS 83974, at *23 (S.D. Miss. Nov. 1, 2007) (a food allergy in general is not a disability until the sufferer proves that a major life activity is impacted).

77. 42 U.S.C. § 12101(a)(1) (2008).

78. *See, e.g.,* Toyota v. Williams, 534 U.S. 184, 197 (2002) ("If Congress intended everyone with a physical impairment that precluded the performance of some isolated, unimportant, or particularly difficult manual task to qualify as disabled, the number of disabled Americans would surely have been much higher."); Sutton v. United Airlines, Inc., 527 U.S. 471, 487 (1999) ("Because it is included in the ADA's text, the finding that 43 million individuals are disabled gives content to the ADA's terms, specifically the term 'disability.'").

79. Apparently courts did not place as much focus on the "substantially limits" language when interpreting the Rehabilitation Act. *See* Chai R. Feldblum, *Definition of Disability Under Federal Anti-Discrimination Law: What Happened? Why? And What Can We Do About It?*, 21 BERKELEY J. EMP. & LAB. L. 91, 147 (2000) ("In cases brought under the Rehabilitation Act, courts rarely considered what it meant for an impairment to substantially limit a major life activity, and rarely considered what made a life activity sufficiently major.").

against the intent of the ADA drafters.⁸⁰

Considering how the Court might apply the ADA to an individual with food allergies, there are two grounds on which to find that a food allergy is not a disability. First, using reasoning similar to the Eighth Circuit's in *Land*, the Court could assert that a food allergy does not substantially limit a major life activity.⁸¹ Second, and more dangerously, the Court may take the view that "corrective measures" have been taken.⁸² For instance, the Court could evaluate a food allergy sufferer in light of her ability to avoid food with allergens (e.g., by reading labels) and the availability of epinephrine.

The latter evaluation would have to involve weighing the effectiveness and accuracy of food labeling⁸³ as well as the efficacy of epinephrine. In particular, epinephrine is not a "corrective measure" for food allergies.⁸⁴ It is a treatment for the anaphylactic shock that accompanies severe allergic reactions, and use of epinephrine is not guaranteed to prevent death.⁸⁵ Also, allergic reactions to foods can become increasingly severe with exposure. In children with peanut allergies who suffered multiple reactions, more than forty percent of the subsequent reactions were more severe than the initial reaction.⁸⁶ Furthermore, one study suggested that most anaphylactic reactions to food allergens in children occur where the child has no prior history of reactions to those allergens.⁸⁷

Thus, while there appears to be a reasonable basis for concluding that children with food allergies warrant protection under the ADA, the Court's penchant for viewing the ADA through a restrictive lens may render these arguments futile. However, recent legislation from Congress may force the Court to appreciate the broad purpose of the ADA.

80. Jill C. Anderson, *Just Semantics: The Lost Readings of the Americans with Disabilities Act*, 117 YALE L.J. 992, 996 (2008) ("In interpreting 'impairment' and 'major life activities' narrowly, courts have held that conditions the ADA drafters assumed would be covered as actual disabilities under the Act are not, in fact, disabling."); Cheryl L. Anderson, "*Deserving Disabilities*": *Why the Definition of Disability Under the Americans with Disabilities Act Should Be Revised to Eliminate the Substantial Limitation Requirement*, 65 MO. L. REV. 83, 107 (2000) ("Congress's reference to 43 million individuals with disabilities should be seen as a signal of inclusion, not exclusion.").

81. *Land v. Baptist Med. Ctr.*, 164 F.3d 423, 426 (8th Cir. 1999).

82. *Sutton*, 527 U.S. at 487 ("[T]he ADA's coverage is restricted to only those whose impairments are not mitigated by corrective measures.").

83. *See infra* Section I.D.

84. *See Plicka, supra* note 15, at 91.

85. S. Allan Bock et al., *Fatalities Due to Anaphylactic Reactions to Foods*, 107 J. OF ALLERGY AND CLINICAL IMMUNOLOGY 191, 193 (2001) (reported cases of individuals apparently receiving epinephrine in a timely fashion, yet still dying), available at <http://www.jacionline.org/article/S0091-6749%2801%2914683-X/>.

86. Kagan, *supra* note 9, at 224.

87. Dibs, *supra* note 10, at e7.

Effective January 1, 2009, the ADA Amendments Act of 2008 was Congress's repudiation of the *Sutton* and *Toyota* decisions.⁸⁸ These amendments also apply to the Rehabilitation Act.⁸⁹ While the 2008 amendments do not specifically address food allergies, they do update the definition of disability: "[a]n impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active."⁹⁰ Allergic reactions are "episodic" in that they occur at irregular intervals—when an allergy sufferer is exposed to an allergen. Furthermore, the 2008 amendments include eating as a major life activity.⁹¹

Moreover, the 2008 amendments state that "[t]he determination of whether an impairment substantially limits a major life activity shall be made without regard to the ameliorative effects of mitigating measures such as . . . medication [or] medical supplies . . ."⁹² Thus, courts should not consider the mitigating aspects of food labeling or epinephrine when determining whether a food allergy is substantially limiting.

It seems likely the Supreme Court and lower courts will construe the amended ADA more in favor of sufferers of severe food allergies than they had construed the previous version of the ADA.⁹³ However, it may be several years before we know for sure. In the interim, parents and children must wait and hope that Congress's broadening of the ADA works to protect allergy sufferers in public schools.

C. *Individuals with Disabilities Education Act*

IDEA funds public schools to provide free appropriate public education to all eligible children with a disability in the least restrictive environment appropriate to their needs.⁹⁴ For each such child, the public school must develop an appropriate Individualized Education Program (IEP).⁹⁵ Each child's IEP includes statements of the child's disabilities, current

88. ADA Amendments Act of 2008, Pub. L. No. 110-325, § 2(a), 122 Stat. 3553 (2008) (the purpose of the amendments was to reject the Supreme Court's limiting interpretation of the ADA as recited in the *Sutton* and *Toyota* decisions).

89. *Id.* § 7.

90. *Id.* § 4(a).

91. *Id.*

92. *Id.*

93. The Ninth Circuit has already recognized that the ADA, as amended, "significantly expands the scope of the term 'disability' . . ." See *Rohr v. Salt River Agric. Improvement and Power Dist.*, 555 F.3d 850, 861 (9th Cir. 2009). Interestingly, the plaintiff in *Rohr* was severely diabetic, like the plaintiffs in *Fraser* and *Lawson*. The Ninth Circuit found that the plaintiff's condition overcame a district court's summary judgment ruling, even under the un-amended ADA.

94. 20 U.S.C. § 1412(a)(1) (2008); 20 U.S.C. § 1412(a)(4)–(5) (2008).

95. 20 U.S.C. § 1414(d)(1)(A) (2008).

academic level, academic goals for the coming year, and accommodation that should be made for the child.⁹⁶ IEPs are developed, and a child's progress is tracked, by a team including at least one of the child's parents, the child's regular teacher, special education teachers, and a representative of the local educational agency.⁹⁷ Each IEP is reviewed annually.⁹⁸

Like the ADA, it is not clear whether a food allergy is a disability under IDEA. There have been only three cases that specifically applied IDEA to a child with food allergies.⁹⁹ However, in each case, the child or children in question suffered from other conditions as well.¹⁰⁰ Thus, it appears that such an application of IDEA has not been tested in the specific circumstances of food allergies.

IDEA provides administrative procedures for seeking remedies before the filing of a civil action under the statute. These remedies include an impartial due process hearing,¹⁰¹ and, if necessary, an appeal.¹⁰² However, IDEA also requires that anyone who has a claim that can be brought under the ADA or the Rehabilitation Act, but can also be brought under IDEA, must first exhaust these IDEA administrative procedures.¹⁰³

Some states have responded to the ambiguity in federal law with respect to food allergies by developing their own laws and regulations similar to the provisions of IDEA. For example, Connecticut and New Jersey have passed laws that provide for the development and maintenance of the equivalent of an IEP for children with food allergies, regardless of whether the child would be considered disabled under the Rehabilitation Act, the ADA, or the IDEA.¹⁰⁴ The New Jersey Department of Education has taken a further step of publishing guidelines requiring individualized care plans for children with food allergies.¹⁰⁵

96. *Id.*

97. *Id.* § 1414(d)(1)(B).

98. *Id.* § 1414(d)(4)(A)(i).

99. *Kropp ex rel. S.K. v. Me. Sch. Admin. Union # 44*, Civil No. 06-81-P-S, 2007 U.S. Dist. LEXIS 11648 (D. Me. Feb. 16, 2007); *Schuylkill Haven Area Sch. Dist. v. Rhett P.*, 857 A.2d 226 (Pa. Commw. Ct. Sept. 8, 2004); *Reed v. Lincoln-Way Cmty. High Sch. Dist. No. 210*, No. 98 C 4934, 2000 U.S. Dist. LEXIS 7402 (N.D. Ill. May 30, 2000).

100. *Kropp*, 2007 U.S. Dist. LEXIS 11648 at *14; *Schuylkill*, 857 A.2d at 227; *Reed*, 2000 U.S. Dist. LEXIS 7402 at *4.

101. 20 U.S.C. § 1415(f) (2008).

102. *Id.* § 1415(g).

103. *Id.* § 1415(l) (“[B]efore the filing of a civil action . . . seeking relief that is also available under this part, the procedures under subsections (f) and (g) shall be exhausted to the same extent as would be required had the action been brought under this part.”).

104. CONN. GEN. STAT. § 10-212c (2008); N.J. ADMIN. CODE § 6A:16-2.3(b)5xii (2009).

105. LUCILLE E. DAVY, BARBARA GANTWERK, & SUSAN MARTZ, GUIDELINES FOR THE MANAGEMENT OF LIFE-THREATENING FOOD ALLERGIES IN SCHOOLS (2008), available at <http://www.nj.gov/education/students/safety/health/allergies.pdf>.

D. Food Allergen Labeling and Consumer Protection Act

On January 1, 2006, the Food Allergen Labeling and Consumer Protection Act of 2004 (FALCPA), the first federal law calling for food allergen labeling, went into effect.¹⁰⁶ FALCPA requires that food products containing wheat, milk, soy, peanuts and tree nuts, fish and shellfish, and eggs be clearly labeled as containing these ingredients.¹⁰⁷ The allergens can be labeled in one of two ways.¹⁰⁸ They can be identified with the word “‘Contains,’ followed by the name of the food source from which the major food allergen is derived, . . . printed immediately after or . . . adjacent to the list of ingredients” or “the common or usual name of the major food allergen in the list of ingredients . . . followed in parentheses by the name of the food source from which the major food allergen is derived . . .”¹⁰⁹ For example, a food product label may state that the food “Contains Wheat, Milk, and Soy,” or it could state that the food product’s ingredients include “flour (wheat), whey (milk), and lecithin (soy).”

Nonetheless, FALCPA allows certain exemptions from labeling (e.g., raw agricultural products and highly refined oils) and provides little regulation for food prepared in restaurants.¹¹⁰ Thus, it has been criticized as being under-inclusive.¹¹¹ However, FALCPA may be over-inclusive as well. Food manufacturers use a variety of phrases to indicate that a food product *may* contain an allergen.¹¹² They probably take this risk-averse approach to avoid potential litigation or fines, instead of developing their facilities and processes to make foods truly allergen-free. Thus, food allergy sufferers may be forced to avoid certain foods that might actually be safe.¹¹³

106. See, e.g., 21 U.S.C. § 321(qq) (2008); 21 U.S.C. § 343(w) (2008).

107. 21 U.S.C. § 321(qq) (2008); 21 U.S.C. § 343(w) (2008).

108. 21 U.S.C. § 343(w)(1) (2008).

109. *Id.*

110. Neal D. Fortin, *The Food Allergen Labeling and Consumer Protection Act: The Requirements Enacted, Challenges Presented, and Strategies Fathomed*, 10 MICH. ST. U. J. MED. & L. 125, 135 (2006); See Derr, *supra* note 16, at 153–154. Similarly, store bakeries are not regulated by FALCPA.

111. Fortin, *supra* note 110, at 137 (2006) (“A major issue [with FALCPA] is how to handle the countless foods that may contain a trace of a food defined as a major food allergen, but which are not typically believed to pose a health risk.”). Concerns include a lack of threshold levels of allergens that would trigger labeling, as well as the risk of excessive use of allergen warnings. See Derr, *supra* note 16, at 151.

112. See, e.g., Food Allergen Labeling and Consumer Protection Act of 2004, Pub. L. No. 108-282, § 204(3)(A), 118 Stat. 891 (2004). Some of the language currently used includes phrases such as “may contain,” “may contain traces of,” “produced in a plant that processes,” and “produced on shared facilities that processes.”

113. Fortin, *supra* note 110, at 140.

E. Food Allergy and Anaphylaxis Management Act

The 2008 Food Allergy and Anaphylaxis Management Act (FAAMA) would require the Department of Health and Human Services, in conjunction with the Department of Education, to prepare a set of guidelines for public schools including guidelines for individual health care plans for children with food allergies, communications with emergency medical personnel, dissemination of food allergy information to parents, food allergy training for school staff, and parental obligations.¹¹⁴ FAAMA passed the U.S. House of Representatives, but died in the Senate.¹¹⁵ In February 2009 FAAMA was reintroduced in the Senate, co-sponsored by thirty-seven senators, but it has not made significant progress.¹¹⁶

However, even if enacted, FAAMA compliance would be voluntary, and the Act is specifically designed not to interfere with any state law regarding food allergies.¹¹⁷ The non-mandatory nature of FAAMA prevents it from hindering laws and regulations developed in states that have recognized the dangers of food allergies in public schools. But FAAMA does little to help those in states that have not recognized these problems. Furthermore, by making compliance voluntary, Congress may be signaling that more comprehensive food allergy legislation belongs at the state level rather than at the federal level.

III. STATE SURVEY OF FOOD ALLERGY MANAGEMENT

The current status of federal law addressing the specific dangers to children with food allergies is inadequate and allows for significant inconsistency in public school management of food allergy issues. In order to protect sufficiently the growing ranks of children who suffer from food allergies, there is a need for a minimum, standard set of mandatory regulations regarding food allergy management in public schools. In order to better understand the landscape of state food allergy law, I surveyed food allergy legislation across all fifty states and the District of Columbia.¹¹⁸ A

114. S. 456, 111th Cong. § 3(a) (2009).

115. H.R. 2063, 110th Cong. (2008); S. 1232, 110th Cong. (2008). The 2008 Senate adjourned before taking up FAAMA, but the bill was reintroduced in February 2009.

116. S. 456, 111th Cong. (2009); *see also* Govtrack.us, S. 456: Food Allergy and Anaphylaxis Management Act of 2009, <http://www.govtrack.us/congress/bill.xpd?bill=s111-456>.

117. S. 456, 111th Cong. §§ 3(a)(1), 3(c).

118. For each state, I accessed its respective LexisNexis state statute database. Within each database I ran a “terms and connectors” search with the phrase “food AND allergy.” In the resulting list of statutes, I manually searched for any instance of the words “allergy” or “allergic,” and determined from there whether the section of the statute was directed to food allergies. I followed a similar process for the search phrases “epinephrine,” and “anaphylaxis,” and “care plan.” For each state with substantive

summary of the results follows.

A. *Laws, Regulations, and Guidelines*

Most states have enacted at least some laws or regulations, or published some guidelines, directed at protecting children with food allergies.¹¹⁹ This legislation typically addresses possession and administration of epinephrine and development of food allergy guidelines for schools. State statutes rarely contain detailed procedures for implementing such guidelines. Instead, they typically mandate that a state's department of education write the guidelines.

So far only ten states have published such guidelines.¹²⁰ While conformance with some of these guidelines is mandatory, conformance with others is optional.¹²¹ Like FAAMA, these guidelines may be followed in whole, in part, or not at all.¹²²

Since food allergy legislation is spread across laws, regulations, and guidelines, it can be difficult for a parent, teacher, or other school personnel to determine what exactly a school is legally bound to do to protect children with food allergies. In states where there are no statewide guidelines, some local school districts have written their own guidelines.¹²³ Consequently, school food allergy policies may vary dramatically not only from state to state, but also from district to district within states.

laws addressing food allergies, I also searched the LexisNexis state administrative database for further regulations regarding these laws. Finally, when a state's laws or regulations indicated that statewide guidelines on food allergy management in schools were to be or had been written, I searched the Internet for those guidelines.

119. Notably, those that did not included Alabama, Georgia, Iowa, Louisiana, Nebraska, New Mexico, South Carolina, South Dakota, and Texas.

120. Food Allergy and Anaphylaxis Network, Schools, <http://foodallergy.org/page/statewide-guidelines-for-schools> (last visited March 21, 2010) (state guidelines to help schools manage risks associated with food allergies have been published in Arizona, Connecticut, Maryland, Massachusetts, Mississippi, New Jersey, New York, Tennessee, Vermont, Washington, and West Virginia).

121. See, e.g., ARIZONA DEPT. OF HEALTH SERVICES, ARIZONA RESOURCE GUIDE FOR SUPPORTING CHILDREN WITH LIFE-THREATENING FOOD ALLERGIES 12 (2007), available at www.azdhs.gov/phs/oh/fses/pdf/allergies1007.pdf ("To achieve this goal, teachers are asked to consider these guidelines . . .") (emphasis added). The section following the quoted material goes on to suggest a number of ways that a teacher can protect a child with a food allergy in the classroom. This sort of wishy-washy language is prevalent throughout all published state guidelines.

122. Nonetheless, the fact that states are beginning to acknowledge the importance of addressing food allergies in schools is a reasonable first step, even if these guidelines have little or no legal consequences.

123. See, e.g., ALEXANDRIA CITY PUBLIC SCHOOLS, FOOD ALLERGY GUIDELINES (2006), available at www.acps.k12.va.us/fns/food_allergy_guidelines.pdf; ANN ARBOR PUBLIC SCHOOLS, GUIDELINES & PRACTICES: MANAGING LIFE THREATENING FOOD ALLERGIES IN ELEMENTARY SCHOOL CHILDREN (2005), available at <http://www.aaps.k12.mi.us/aaps.forparents/files/foodallergyhandbook.pdf>.

B. *Legislation Topics*

The vast majority of food allergy legislation at the state level is directed at permitting children to carry epinephrine in schools, permitting school personnel to administer epinephrine to a child, and providing a safe harbor to protect schools and school personnel from liability when a child has an allergic reaction in spite of his or her access to epinephrine. Other common legislation directs schools to develop, at parents' request, IEPs or IEP equivalents for allergic children.

Aside from these major common provisions, state laws have a few outliers. For instance, Rhode Island laws permit peanut-free classrooms and posted warnings about peanut allergies.¹²⁴ However, most states have not mandated such measures. Accordingly, the discussion below focuses on epinephrine but also summarizes the content of the published state guidelines.

C. *Epinephrine in Schools*

Given the immediate and extreme danger of anaphylactic shock caused by food allergies, it is critical for a child to receive the appropriate dosage of epinephrine as quickly as possible.¹²⁵ Consequently, most states have enacted legislation that allows children to carry and use epinephrine while on school property.¹²⁶ States have also enacted legislation to provide for training of school personnel in the administration of epinephrine to children and to allow school personnel to administer epinephrine to children having an allergic reaction.

It is important to note that in states that have not passed such laws, children are not necessarily prevented from self-administering epinephrine, nor are school personnel necessarily prevented from administering the drug. However, without proper training, the likelihood of delayed admini-

124. R.I. GEN. LAWS § 16-21-32(a) (2009) (“Depending upon the nature and extent of the child’s peanut/tree nut allergy, the measures . . . may include the posting of signs at school, the prohibition of the sale of particular food items in the school, the designation of special tables in the cafeteria, the prohibition of particular food items in certain classrooms, and the complete prohibition of particular food items from a school or school grounds.”).

125. Stephen F. Kemp, Richard F. Lockey, & F. Estelle R Simons, *Epinephrine: The Drug of Choice for Anaphylaxis—A Statement of the World Allergy Organization*, 1 WORLD ALLERGY ORG. J. S19 (2008) (“[A]ny symptoms of anaphylaxis . . . should be treated immediately and as necessary with appropriate intramuscular doses of epinephrine in an attempt to prevent more severe anaphylaxis from occurring.”).

126. According to the Food Allergy and Anaphylaxis Network web site, as of January 2010, 44 states and the District of Columbia have passed laws or regulations regarding this issue. See The Food Allergy & Anaphylaxis Network, Legislation (Jan. 15, 2010), <http://foodallergy.org/page/legislation>.

stration or misadministration of epinephrine is increased.¹²⁷ Furthermore, such acts by children or school personnel could potentially subject the school personnel to liability.

Schools should permit the self-administration of epinephrine and the administration of epinephrine by school personnel. The former is a prudent approach to food allergy management that can reduce the delay between the first indications of a reaction and the use of epinephrine. However, it is not a reasonable approach for all children or all situations. Thus, as a safeguard, the latter approach is needed as well.

1. Possession and Self-Administration of Epinephrine by Children

Most states that explicitly allow children to possess and self-administer epinephrine first require written approval from the children's parents and health care providers. In particular, a child's health care provider typically must provide written certification that the child needs epinephrine and is capable of self-administration.¹²⁸ The certification of the child's self-administration capability may require stating that the child has received proper training in the self-administration of epinephrine and has demonstrated a level of skill necessary to self-administer epinephrine.¹²⁹ Alternatively, some states allow children to demonstrate their self-administration proficiency to the school nurse and/or require that the school nurse evaluate the appropriateness of allowing each child to self-administer epinephrine.¹³⁰

Such laws seem to be written with older children (perhaps high school age) in mind. It is unlikely that all elementary school children, especially those five to nine years old, can demonstrate the appropriate level of skill to inject themselves with epinephrine. Children at this age, or even teenagers, may not be able to detect symptoms of anaphylaxis in themselves, or they may panic if they find themselves unable to breathe or feeling suddenly ill.¹³¹ Furthermore, given the pain associated with shots and injec-

127. See, e.g., McIntyre, *supra* note 24, at 1138–39 (recommending that school nurses, teachers, and field trip chaperones be trained to recognize the symptoms of anaphylaxis and to respond appropriately).

128. See, e.g., ARK. CODE ANN. § 6-18-707(c)(2) (2008); NEV. REV. STAT. ANN. § 392.425(2)(a) (2008).

129. See, e.g., MO. REV. STAT. § 167.627(2) (2008); N.J. STAT. ANN. § 18A:40-12.3(a)(2) (West 2008).

130. See, e.g., CONN. AGENCIES REGS. § 10-212a-4(e) (2008); 14-600 DEL. CODE REGS. 3.11 (Weil 2008).

131. CANADIAN SCHOOL BOARDS ASSOCIATION, ANAPHYLAXIS: A HANDBOOK FOR SCHOOL BOARDS 3 (2001) (“A severe allergic reaction may be so incapacitating as to inhibit the ability to self-administer, regardless of age.”).

tions, it is unlikely that most small children would be willing to self-administer the drug.

Even if a small child is willing and able to inject himself or herself with epinephrine, the child and his or her parents may not be aware that he or she has any allergies, and therefore the child may not be carrying an epinephrine auto-injector.¹³² Thus, providing a reasonable level of protection to children with food allergies requires the presence of suitably trained school personnel who will take the appropriate action in an emergency,¹³³ as well as a readily available non-student-specific supply of epinephrine.

For older children, such as high school children, self-administration of epinephrine is a more reasonable option. These children typically move between classrooms and do not have the same teachers throughout the day. They are far more independent than elementary school children and can be expected to take some responsibility in the management of their allergies. However, because anaphylactic reactions may disable individuals and prevent them from self-administering epinephrine, school personnel still should be trained to recognize the symptoms of anaphylaxis and to know how to administer epinephrine.¹³⁴

Allowing children to carry epinephrine has apparently raised the issue of improper use of auto-injector needles in some quarters. For example, Hawaii allows a school to confiscate a child's epinephrine if the child endangers others with it.¹³⁵ This could lead to situations where a child could be separated from his or her epinephrine, unnecessarily placing the child's health at risk. A more appropriate approach would be to discipline the child for his behavior just as any other misbehavior would be disciplined, but to do so in such a way that the child is not separated from his epinephrine.¹³⁶

132. Dibs, *supra* note 10, at e7 (allergic reactions in children can occur even when the child has no previous history of allergies).

133. The fact that anaphylaxis can be a first-time allergic reaction suggests that schools should maintain a non-child-specific supply of epinephrine injections. This supply could also be used as a backup injection if a child's epinephrine cannot be rapidly located or if a child suffering a reaction requires a second injection.

134. See, e.g., DAVY ET AL., *supra* note 105, at 7 ("Although teenage students will more than likely be permitted to carry and self-administer emergency medications, those students should not be expected to have complete responsibility for the administration of epinephrine. A severe allergic reaction can completely incapacitate a child and inhibit the ability to self-administer emergency medication.").

135. HAW. REV. STAT. § 302A-1164(f) (2008).

136. See, e.g., ALASKA STAT. § 14.30.141(d) (2008) ("The imposed disciplinary action may not limit or restrict the child's immediate access to the child's prescribed medication."); D.C. CODE § 38-650(b) (2008) ("[D]isciplinary action shall not limit or restrict the access of a child to his or her prescribed medication.").

2. Administration of Epinephrine by School Personnel

In order properly to protect the safety of children who are not capable of carrying or authorized to carry epinephrine or to self-administer epinephrine, a two-prong approach is needed.¹³⁷ First, the child's epinephrine should be in close proximity to the child at all times during the school day. This includes times when the child is in the classroom, at a "special" class,¹³⁸ in the lunchroom, at recess, on a school bus, on field trips, or participating in school activities outside of normal school hours. Second, there must be a responsible party in close proximity to the child who is trained to recognize signs of an allergic reaction and to administer epinephrine to the child in case of such an emergency.

Only two states currently have "close proximity" laws,¹³⁹ but in both cases the laws only explicitly apply to the epinephrine, not both epinephrine and school personnel trained to administer epinephrine. Minnesota law provides that "if the parent and prescribing medical professional determine the child is unable to possess the epinephrine, [the child should] have immediate access to nonsyringe injectors of epinephrine in close proximity to the child at all times during the instructional day."¹⁴⁰ Similarly, Rhode Island law states that "[t]he policies, rules, and regulations shall . . . authorize the school department to administer the epinephrine [to children] in case of an emergency and ensures that the epinephrine is kept in a conspicuous place, readily available . . ."¹⁴¹ Neither law explicitly addresses management of food allergies during after-school activities, on school buses, or on field trips.¹⁴²

Another critical component of proper administration of epinephrine is the appropriate training of school personnel. The laws of Washington D.C., Massachusetts, and New Jersey, for example, mandate training of school

137. It is important to note that segregation of children with food allergies is not recommended. Children with severe food allergies, like most children, benefit from participation in a regular classroom. *See, e.g.*, 20 U.S.C. § 1400(c)(5) ("Almost 30 years of research and experience has demonstrated that the education of children with disabilities can be made more effective by . . . having high expectations for such children and ensuring their access to the general education curriculum in the regular classroom, to the maximum extent possible . . .").

138. "Specials" include music, art, gym, speech, reading, and enrichment.

139. Other states suggest or imply in published guidelines that epinephrine should be kept in close proximity to children with food allergies. *See, e.g.*, DAVY ET AL., *supra* note 105, at 6 (New Jersey guidelines state that schools must "[e]nsure that epinephrine is quickly and readily accessible in the event of an emergency.").

140. MINN. STAT. § 121A.2205(a)(2) (2007). A nonsyringe injector is another name for an autoinjector, such as an EpiPen.

141. R.I. GEN. LAWS § 16-21-22(a) (2008).

142. Again, published guidelines may address some of these concerns. *See, e.g.*, DAVY ET AL., *supra* note 105, at 5-6.

personnel by a health care professional.¹⁴³ Washington D.C. issues a certification, valid for three years, to trained school employees,¹⁴⁴ while Massachusetts requires annual retraining.¹⁴⁵ New Jersey laws do not specify the frequency of re-training, but New Jersey guidelines provide for annual retraining.¹⁴⁶ In contrast, Missouri only provides for a school nurse to administer epinephrine to children, and only the nurse is trained.¹⁴⁷

3. Safe Harbor Laws

Many states with laws that permit the administration of epinephrine at public schools also have safe harbor laws protecting the school districts and school personnel from liability associated with the administration. These safe harbor laws can be divided into those that (1) protect the affirmative acts of school personnel, (2) protect both the affirmative acts and omissions of school personnel, and (3) protect school personnel who prevent a child from self-administering epinephrine.

Typically, laws that protect the affirmative acts of school personnel immunize the school and its personnel from liability stemming from a child's being injured by self-administration of epinephrine. For example, an Arkansas statute provides that "[n]o school district, school district employee, or agent of a school district shall be liable for injury to a student caused by his or her use of a prescription inhaler or self-administration of medication."¹⁴⁸

On the other hand, Illinois requires that "[t]he parents or guardians of the pupil must sign a statement acknowledging that the school district or nonpublic school is to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by the pupil"¹⁴⁹ Thus, Illinois requires that parents explicitly agree not to hold the school liable for any injury to the child before the child can bring epinephrine to the

143. D.C. CODE § 38-644(a) (2008); 105 MASS. CODE REGS. 210.007(A) (2008); N.J. REV. STAT. § 18A:40-12.6a (2008). It should also be noted that D.C. CODE section 38-646(a) mandates that school personnel not administer epinephrine to a child, even in an emergency, unless they have been trained. Laws such as this one exemplify a tradeoff of potentially under-reacting versus over-reacting. School personnel who are not trained to administer epinephrine are more likely to mis-administer it. However, any delay associated with school personnel needing to locate a trained individual may be fatal to a child suffering a reaction.

144. D.C. CODE § 38-644(c) (2008).

145. 105 MASS. CODE REGS. 210.007(F) (2008).

146. See DAVY, GANTWERK, & MARTZ, *supra* note 105, at 2.

147. MO. REV. STAT. § 167.630(3) (2008).

148. ARK. CODE ANN. § 6-18-707(d) (2008).

149. 105 ILL. COMP. STAT. 5/22-30(c) (2009).

school. However, liability still exists in situations where the school or its personnel have engaged in reckless conduct with respect to the child's self-administration of epinephrine.

Other states' safe harbor clauses protect the school and its personnel from both affirmative acts and omissions. For example, a Colorado law states that "a school, school district, school district director, or school or school district employee or volunteer . . . shall not be liable in a suit for damages as a result of an act or omission related to a student's own use of the student's epinephrine auto-injector . . ." ¹⁵⁰ Similarly, in Florida, "[a] school district . . . their employees and volunteers shall be indemnified by the parent of a child authorized to carry an epinephrine auto-injector for any and all liability with respect to the child's use of an epinephrine auto-injector . . ." ¹⁵¹ It is not clear what omissions the Colorado and Florida laws are anticipating, since both statutes are limited to a child's use of an epinephrine auto-injector. Neither state has laws addressing school personnel's administering epinephrine to a child.

In contrast to the Colorado and Florida laws, Connecticut law does provide for school personnel to administer epinephrine to a child, and the school and school personnel and certain other individuals are immune from liability due to their acts or omissions. ¹⁵² Connecticut specifies that this immunity includes acts of ordinary negligence but not reckless behavior. ¹⁵³

While safe harbor laws such as these are designed to protect schools and school personnel from liability, they also may place the burden of epinephrine use and management squarely on the shoulders of parents and their children. As discussed earlier, such a burden may be appropriate to place on older children, but younger children may not have the capacity to properly self-administer epinephrine.

Safe harbor laws also may serve to encourage school personnel to assist a child suffering from an anaphylactic reaction. Similar to well-established "Good Samaritan" laws, ¹⁵⁴ these safe harbor laws may prevent situations where school personnel are reluctant to administer epinephrine to a child. Knowing they are protected from liability if the child is injured in some way due to an epinephrine injection or if a child fails to recover from

150. COLO. REV. STAT. 22-1-119.5(6) (2009).

151. FLA. STAT. § 1002.20(3)(i) (2009).

152. CONN. GEN. STAT. § 10-212a(a)(1) (2008) ("No such school [employee] administering medication . . . shall be liable to such child or a parent or guardian of such child for civil damages for any personal injuries that result from acts or omissions of such [employee] administering medication . . .").

153. *Id.*

154. *See, e.g.*, MD. CODE ANN., CTS. & JUD. PROC. § 5-603(c) (West 2008); VA. CODE ANN. § 8.01-225(A) (2008).

the reaction despite the epinephrine, school personnel will be less likely to waste valuable time deciding whether to administer the drug.

At least one state goes too far with a law that provides a safe harbor for school personnel who prevent a child from self-administering epinephrine. Michigan Compiled Law § 380.1179 provides that school districts, school employees, and certain other individuals are

not liable for damages in a civil action for injury, death, or loss to person or property allegedly arising from a pupil being prohibited by an employee of the school or school district from using an inhaler or epinephrine auto-injector because of the employee's reasonable belief formed after a reasonable and ordinary inquiry that the conditions prescribed in subsection (2) had not been satisfied.¹⁵⁵

Subsection (2) of the statute requires that the child has written approval from the child's parents and health care provider to use the epinephrine auto-injector and that the school's principal has received a copy of the written approval.¹⁵⁶

Strict adherence to such a law could result in school personnel preventing a child from self-administering epinephrine until the personnel have confirmed that the written authorization exists. Given the need to administer epinephrine within a few minutes of the onset of an anaphylactic reaction, this law may place children under an unnecessary and easily avoidable risk of death.¹⁵⁷

D. Guideline Topics

Ten states have published guidelines for managing food allergies in public schools.¹⁵⁸ In many instances these guidelines provide details that are missing from the states' laws and regulations. While the guidelines vary in substance and depth, they are more uniform than state laws. In particular, these guidelines include or focus on the following areas:

- Development of IEPs similar to those permitted by the Rehabilitation Act
- Procedures for rapidly notifying emergency responders in the event a child experiences anaphylactic shock or needs to be treated with epinephrine
- Food allergy awareness training for all school personnel
- Procedures for training bus drivers about food allergies and for

155. MICH. COMP. LAWS § 380.1179(3) (2009).

156. *Id.* § 380.1179(2).

157. Dibs, *supra* note 10, at e7.

158. Food Allergy and Anaphylaxis Network, *supra* note 120.

handling anaphylactic emergencies on school buses

- Special food preparation training for cafeteria food service personnel
- Special cleaning directions for custodians and maintenance workers
- Allergen-safe tables in the school cafeteria
- Procedures to alert substitute teachers of children with food allergies in their classrooms
- Designation of a responsible delegate on field trips to monitor children with food allergies and to be able to administer epinephrine if necessary
- Procedures for ensuring the safety of children with food allergies in after-school activities
- Defining the expectations placed on children, their parents, and schools with respect to food allergy management

These guidelines are more comprehensive and arguably do more to protect children with food allergies in school than some state laws.¹⁵⁹ Accordingly, it is recommended that the authors of the FAAMA guidelines look to these state guidelines for suggestions and example provisions.

IV. PROPOSED MODEL LAWS

The federal government or each state should develop a comprehensive set of statutes and/or regulations that sufficiently mitigate the risk of attending public school for children with food allergies. The goal of these laws should be to put the safety of the children first, but to do so without placing an undue burden on schools, parents, or medical professionals. Each proposed model law in the following subsections is based on the best practices developed by states, as discussed above.¹⁶⁰

159. Albeit, the non-mandatory nature of most of these guidelines may limit their effectiveness.

160. One inevitable question that will arise in response to any proposal to further regulate schools is “who will pay for all this?” Questions of this sort tend to arise from local taxpayers. First, the cost of taking the preventative measures recommended herein is relatively low, especially when compared to the potential consequences of not properly addressing food allergies in schools. These measures mostly consist of training and education for school personnel that can be performed by a school nurse, as well as maintaining a nominal amount of epinephrine at the school. Second, the development of IEPs is already funded by the federal government per IDEA. *See* 20 U.S.C. § 1412(a). If a food allergy is determined to be a disability, then the costs of these proposals may be paid for, in part or in their entirety, by the federal government.

A. Definitions

The model code shall provide the following definitions. These definitions apply across all sections of the model code unless otherwise noted.

Definitions:

- (a) “Close proximity” means an appropriate physical distance between a child and his or her epinephrine. This distance shall be determined on a case by case basis and may take into account factors such as general safety standards for handling and storage of medications, developmental stage and competence of the child, size of the school building, availability of a full time school nurse in the school building, availability of communication devices between teachers and paraprofessionals who are inside the building or on the playground and the school nurse, school nurse response time from the health office to the classroom, preferences and other responsibilities of the teacher, preferences of the parent, preferences of the child (as applicable), and movement of the child within the building.
- (b) “Epinephrine auto-injector” means a prefilled device designed to inject epinephrine into a person.
- (c) “School nurse” means a nurse practicing in a school setting, who is:
 - (i) a graduate of an approved school for professional nursing; and
 - (ii) currently licensed as a registered nurse pursuant to state law.¹⁶¹
- (d) “School personnel” means all administrators, teachers, nurses, aides, and staff, including bus drivers.

B. A food allergy is a disability.

The model code should view a food allergy as a disability and afford the protection of the Rehabilitation Act and the ADA to children with food

161. This requirement may raise issues of the availability of registered nurses, as well as school nurses, regardless of registration, in rural areas. For example, Arkansas requires that there can be as few as one full-time school nurse per 750 students in each school district. ARK. CODE ANN. § 6-18-706(c)(1) (2008). Also of note is the current nursing shortage in the U.S. See, e.g., Kristin M. Mannino, Note, *The Nursing Shortage: Contributing Factors, Risk Implications, and Legislative Efforts to Combat the Shortage*, 15 LOY. CONSUMER L. REV. 143, 144 (2003). However, as described in Section IV.D, *infra*, a registered nurse need only train school personnel once per year. So trained, the school personnel would be able to take preventative measures to lower the risk of an allergic child’s exposure to allergens as well as to respond properly to anaphylactic emergencies.

allergies. This will allow children with food allergies the opportunity to have written IEPs that serve as legally binding contracts between families (parents and allergic children) and the school district. The following is an example of IEP requirements.

Individualized Education Plans (IEPs):

- (a) A school shall, at the request of the parents of a child with food allergies, work with the parents to develop an IEP for the child.
 - (i) An IEP should be developed by a team including the child's teacher(s), the school nurse, and the child's parents. Other individuals may be included as necessary or desired.
 - (ii) Each child's IEP must be reviewed annually and updated as necessary.
- (b) An IEP should include, but not be limited to including, the following information:
 - (i) the child's name and other identifying information;
 - (ii) a photograph of the child taken within the past year;
 - (iii) a description of the child's allergies and allergy history;
 - (iv) a list of medications to be administered in the event of the child being exposed to an allergen or the child suffering an allergic reaction;
 - (v) the name of the person who will administer epinephrine (self-administration or school personnel);
 - (vi) post-administration procedures, including contacting emergency medical services and parents;
 - (vii) special accommodations for the child, such as an allergen-free lunch table in the cafeteria, special cleaning procedures for the child's classroom, allergens that should not be brought into the child's classroom or in the child's presence, hand-washing for all children in the child's class before and after eating; and
 - (viii) procedures for managing the child's allergies while on the school bus, during after-school activities, and on field trips.

C. Children shall be allowed to self-administer epinephrine.

This section provides for children to carry and self-administer epinephrine while on school grounds, on the school bus, or on field trips.

Self-administration of epinephrine:

- (a) A parent or guardian of a child who suffers from a life-threatening allergy shall notify the school of the potential need for the child to self-administer epinephrine by:

- (i) providing a written certification from the child's health care professional indicating that the child has a life-threatening allergy and may require self-administration of epinephrine while at the school; and
 - (ii) providing a written authorization that the child may self-administer epinephrine.
- (b) When the requirements of Section (a) of this statute are met, the school nurse shall determine whether the child has been properly trained in the self-administration of epinephrine and whether the child possesses the appropriate level of skill to self-administer epinephrine.
 - (c) When the requirements of Section (b) of this statute are met, the child shall be allowed to possess and carry an epinephrine auto-injector on the child's person at all times while in school, traveling to or from school, and on field trips.
 - (d) Upon request, the child shall be allowed to store a backup epinephrine auto-injector in a safe, conspicuous and unlocked location known to the school nurse.
 - (e) Nothing in this statute shall prevent school personnel from administering epinephrine to the child if the child appears to be incapable of self-administering the epinephrine. The school personnel need not be a designated party to administer epinephrine to a child.
 - (f) If the school determines that a child has endangered another child or school personnel with the child's epinephrine auto-injector, the school may commence disciplinary proceedings against the child. However, the child shall always remain within close proximity to the child's epinephrine even if the epinephrine has been confiscated by the school.
 - (g) The school and its personnel shall not be held liable for any criminal or civil penalty due to a child's self-administration of epinephrine according to this statute. This immunity from liability does not apply to acts or omissions constituting gross negligence or willful or wanton conduct.

D. School personnel shall be allowed to administer epinephrine.

This section provides for school personnel to be able to administer epinephrine to a child, even if the administration of epinephrine is not specifically addressed in the child's IEP, or even if the child has no IEP.

Administration of epinephrine to a child by school personnel:

- (a) All school personnel shall be trained annually to:
 - (i) understand the consequences and severity of anaphylactic shock;
 - (ii) know how to limit the risk of exposing children to life-threatening allergens;
 - (iii) recognize the signs of anaphylactic shock;
 - (iv) know the locations of the appropriate epinephrine auto-injectors;
 - (v) administer epinephrine to a person in anaphylactic shock; and
 - (vi) know the post-administration process for summoning emergency medical professionals and reporting the incident.
- (b) A parent or guardian of a child who suffers from a life-threatening allergy shall notify the school of the potential need for the school to provide administration of epinephrine by:
 - (i) providing a written certification from the child's health care professional indicating that the child has a life-threatening allergy and may require administration of epinephrine while at the school; and
 - (ii) providing a written authorization that the school may administer epinephrine to the child.
- (c) Epinephrine must always be in close proximity to the child, so that in the event of an anaphylactic reaction, the epinephrine can be administered in a timely fashion.
- (d) The school shall maintain a reasonable supply of epinephrine auto-injectors for use when either the epinephrine auto-injector of a child with an epinephrine auto-injector cannot be located, the epinephrine auto-injector of a child with an epinephrine auto-injector has been used and school personnel determine that the child requires another dosage, or a child without an epinephrine auto-injector appears to be having an anaphylactic reaction. These epinephrine auto-injectors shall be kept in a conspicuous and unlocked location.
- (e) There must always be at least one designated party, who has been trained pursuant to Section (a) of this statute, in close proximity to the child. The designated party is responsible for recognizing signs of anaphylactic shock in the child, administering epinephrine to the child if necessary, summoning emergency service professionals, and reporting the incident.
- (f) The school, its personnel and any designated party shall not be held

liable for any criminal or civil penalty due to the administering of epinephrine according to this statute. This immunity from liability does not apply to acts or omissions constituting gross negligence or willful or wanton conduct.

CONCLUSION

Baseline federal regulation is not necessary or even desirable for all matters. The leeway that our system of government affords the several states allows for regional diversity and the representation of local views. But the safety of all children in the United States is a powerful enough concern to change that equation. Food allergies can result in severe and even deadly reactions. While in schools, children with food allergies are outside of the care of their parents. These children cannot be expected to properly care for themselves in such an environment.

Until federal courts are called upon to apply the recent ADA amendments to individuals with food allergies, the law will remain unsettled as to whether these individuals are afforded the protections of the disabled. In the interim, to address a special case and to avoid further tragedies, states should adopt a set of model laws, such as those presented here, to protect children with food allergies in public schools.