

Approved by	FPPC	Policy owner	Emma Murphy Inclusion Officer
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Purpose

This policy sets out how we minimise exposure to allergens, support the health, safety and inclusion of everyone in School, and respond promptly to allergic reactions, in line with Department for Education (DfE) statutory guidance and Benedict's Law. It applies throughout the school day, school activities, visits and any breakfast or after school provision. Further information on this guidance can be found [here](#).

1. Introduction and Core Principles

- In line with Benedict's Law, we are committed to providing a safe, inclusive, and welcoming environment for all children, young people, staff, and visitors with allergies. Recognising the serious and potentially life-threatening risk posed by anaphylaxis, this dedicated policy establishes robust risk-mitigation measures and emergency response protocols.
- Allergy is a spectrum of different allergic diseases. Reactions occur when a susceptible person is exposed to something (an "allergen") they are allergic to. Asthma, food allergy, eczema and seasonal rhinitis (hay fever) are all forms of allergy.
- Anaphylactic reactions usually begin within minutes of being in contact with the allergen i.e. eating a trigger food, though can occur several hours later (i.e. allergy to Mammalian meat). Anaphylaxis involves difficulty in breathing and affects the heart rhythm. In extreme cases there could be a dramatic fall in blood pressure leading to collapse.
- Once started, anaphylaxis reactions progress quickly. Investigations into fatal anaphylaxis show that there is only a 20-30 minute window of opportunity during which steps can be taken to prevent death – therefore giving emergency adrenaline immediately and calling Emergency Services (999) is crucial. Anaphylaxis always requires an emergency response
- Anaphylaxis can occur without any other signs (such as a skin rash) being present. Always consider anaphylaxis in someone with a known food allergy who has sudden difficulty in breathing. Giving adrenaline in this context is very safe and may be lifesaving.
- The most common causes of "whole body" allergic reactions – including anaphylaxis – are:
 - foods (e.g. peanuts, tree nuts, cow's milk/dairy foods, egg, wheat, fish/shellfish and sesame);
 - insect stings (e.g. bee, wasp);
 - medication (e.g. antibiotics, pain medicines such as ibuprofen);
 - latex (e.g. rubber gloves, balloons, swimming caps).
- Even for food allergy, the vast majority of anaphylaxis reactions require the person to have eaten the food, although less serious allergic reactions can happen through skin or other contact. Anaphylaxis reactions due to skin contact are very rare. Students who have a skin reaction need monitoring for at least an hour.

- Thames View Infants has a whole school awareness approach, because it ensures all staff and children are aware of what allergies are, the importance of avoiding the individuals' allergens, the signs & symptoms, how to deal with allergic reactions and to ensure procedures are in place to minimise risk of exposure.
- Coeliac disease and food intolerance can present symptoms which are similar to those of food allergy; it is important that Coeliac disease and food intolerance is managed through dietary avoidance, but these conditions do not pose a risk of anaphylaxis and so they are not within this allergy safety policy.
- Eczema, asthma and allergies sometimes occur together – known as the atopic triad. It is important that these are managed well in order to keep the individual healthy. Asthma training is needed by all staff and an individual's asthma care plan needs to be included with their individual healthcare plan. These conditions are not included in this allergy safety policy.
- Thames View Infants understands that severe allergies are included in the Equality Act, 2010. The act considers a person disabled if they have a physical or mental impairment that has a substantial and long-term negative effect on their ability to carry out normal daily activities. Seasonal rhinitis (such as hay fever) is explicitly excluded from the definition of disability, unless it aggravates the effect of another health condition.

Our principles

- We share responsibility for allergy safety across teaching and support staff, the lunchtime team, catering staff, parents and carers, volunteers and visitors.
- We identify individual triggers and build practical precautions into everyday routines, curriculum activities, celebrations and visits.
- We work with parents, the School Nursing Team and relevant medical professionals to prepare individual Health Care Plans for children with diagnosed allergies.
- We train staff to recognise allergic reactions and anaphylaxis and to administer emergency adrenaline confidently.
- We keep emergency medication accessible and unlocked, including spare in-date adrenaline auto-injectors, and maintain clear emergency procedures.
- We support participation, dignity and wellbeing, and review this policy at least annually.

2. Roles and responsibilities

- Named senior leader accountable for allergy safety: Headteacher.
- Delegated operational allergy lead: Emma Murphy, Inclusion Officer.
- Named Director for allergies: Kelly Ager.
- Oversight: Board of Directors.
- All staff are to apply the policy consistently.
- This policy should be read alongside the [School's Policies](#) for managing medical conditions and medicines, safeguarding, behaviour and anti-bullying, health and safety, educational visits and data protection.

3. Recognising and responding to allergic reactions

Recognising a Reaction

- **What to look for:**
- Symptoms usually come on quickly, within minutes of exposure to the allergen.

- **Mild to moderate allergic reaction symptoms may include:**
- a red raised rash (known as hives or urticaria) anywhere on the body
- a tingling or itchy feeling in the mouth
- swelling of lips, face or eyes
- stomach pain or vomiting
- mild throat tightness
- sudden change in behaviour
- **These symptoms are treated with antihistamines.**

- **More serious symptoms are often referred to as the ABC symptoms and can include:**
- **AIRWAY** - swelling in the throat, tongue or upper airways (tightening of the throat, hoarse voice, difficulty swallowing).
- **BREATHING** - sudden onset wheezing, breathing difficulty, noisy breathing, persistent cough.
- **CIRCULATION** - dizziness, feeling faint, sudden sleepiness, tiredness, confusion, pale clammy skin, loss of consciousness.

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

- **Emergency action for suspected anaphylaxis:**
- As soon as anaphylaxis is suspected, adrenaline must be administered without delay.

- **1. Stay with the child and summon help.** Bring medication to them. Do not send or walk them to the office. Lay them flat with legs raised. If breathing is difficult, allow a supported position that helps breathing, with legs outstretched. Do not allow standing or walking, even if they improve. If unconscious but breathing normally, use the recovery position.
- **2. Give adrenaline immediately.** Use the child's prescribed AAI into the outer thigh, following the device instructions. Use a suitable spare device if their own is unavailable, fails, or the person has no prescribed device. Record the time. Do not delay treatment while seeking parental permission or waiting for an ambulance.
- **3. Call 999 immediately.** Say "ANAPHYLAXIS" and request an ambulance to Thames View Infants School, Bastable Avenue, IG11 0LG. Where another adult is available, they should call while adrenaline is given. Arrange for someone to meet the ambulance.
- **4. Give a second dose after five minutes if there is no improvement.** Use the second AAI, preferably in the opposite thigh, following training and emergency service instructions. Record the time.

- **5. Continue monitoring and follow 999 instructions.** If the child is unresponsive and not breathing normally, start CPR and use an AED if available, following training and the call handler's instructions.
- **6. Contact parents and hand over to paramedics.** Calling parents must not delay adrenaline or 999. Give paramedics the used devices and treatment times. Hospital assessment is required even if the child appears to recover.
- The same emergency principles apply to an adult or a child with no previously diagnosed allergy. Staff should follow their training and the relevant clinical action plan without delaying emergency treatment.

4. Roles and individual Health Care Plans

- **Leadership and staff**
 - The Headteacher is the named senior leader accountable for allergy safety and delegates operational responsibility to Emma Murphy, Inclusion Officer. Emma coordinates implementation, allergy records, Health Care Plans, training and spare AAls. She checks medication and expiry dates, follows up replacements with parents, liaises with the School Nursing Team and catering, and escalates concerns and incidents to the Headteacher. The Headteacher ensures suitable cover during her absence.
 - The Board of Directors monitors implementation, with Kelly Ager as the named Director for allergies. All staff must understand and apply the policy, know the children they support, follow their plans and report concerns, incidents and near misses promptly. Relevant allergy risks are included in the School's risk assessments and risk register.
 - Parents and carers provide accurate allergy information, clinical advice and prescribed medication, and notify School promptly of changes or reactions outside School. School works with families to resolve difficulties in obtaining medication or advice.
- **Identification and information sharing**
 - Allergy information is collected before admission wherever possible and updated when needs change. Necessary information must reach the staff and caterers responsible for the child before food or activities involving relevant risks are provided. Support must not be delayed solely because a diagnosis is awaited.
 - All known pupil allergies are entered on the School MIS and pinned at the top of the child's profile, accessible to office staff and teachers. Relevant information is shared securely with staff, supply staff and caterers who need it. Staff and regular volunteers are invited to disclose allergies. The visitor sign-in form asks about allergies, and visitors are also asked verbally. Visitors are also informed that all staff receive annual allergy awareness and emergency response training. Relevant needs are passed to the Inclusion Officer and host so suitable arrangements can be made. Visitors are told the School's food restrictions: food brought from home may only be eaten in the staff room, subject to the nut prohibition. The existing Office and Leadership Team exception for staff is set out below.
- **Health Care Plans and Clinical Action Plans**
 - Every child with a diagnosed allergy has an individual Health Care Plan (HCP), developed with parents or carers, the School Nursing Team and relevant medical professionals. An interim plan is used where an allergy is suspected and support is needed while assessment is awaited.
 - The HCP identifies allergens, symptoms, avoidance measures, medication and doses, emergency action, contacts, staff responsibilities and arrangements for meals, learning, visits and wider participation. It includes relevant asthma arrangements and any clinical Allergy Action Plan. Clinical prescribing and treatment instructions remain the responsibility of healthcare professionals.
 - Plans are reviewed annually and immediately when allergies, medication or clinical advice change, and following an incident or relevant near miss. Digital copies are kept in the child's inclusion folder; paper copies

are kept with the child's medication in their individual medical box. Staff must be familiar with the plans they may need to use. Relevant plans are shared securely during transition and ahead of transition visits.

5. Our arrangements for Food and Allergen Avoidance

- **Nuts and food brought from home**
- The School prohibits peanuts and tree nuts: nobody may bring them onto the site and the catering team does not use nut ingredients. The local risk-assessment rationale is to reduce the deliberate introduction of these allergens within an infant school, alongside the wider controls on food brought from home. The restriction does not replace controls for other allergens. DfE guidance favours an allergy-aware approach over claims of a nut-free environment. School cannot guarantee an environment free of nuts or other allergens; individual assessment, ingredient checks and emergency readiness remain essential. Precautionary "may contain" labels are considered against the child's clinical advice and agreed catering arrangements.
- Children may not bring packed lunches or snacks from home. Exceptions for significant food aversions or sensory needs are carefully agreed, managed and kept under continuous review. The arrangements must protect the child's access to food and other children's allergy safety, with individual controls recorded.
- Staff may bring food from home, subject to the nut prohibition. It may be eaten only in the staff room, except for the Office and Leadership Team because of their working patterns. These colleagues must not leave food from home unattended at their desks and must maintain appropriate cleaning and allergen precautions.
- Families may not bring food from home to family events or provide food for class parties or birthdays, whether homemade or shop-bought. Any School-provided food must be checked and managed through the School's allergy arrangements.
- **Olive Catering and identifying children**
- Olive Catering provides the lunchtime meal service. Every child with an identified medical allergy has a personalised menu. Most can access the main menu with adaptations managed by Olive. Arrangements are monitored at monthly meetings, and allergy changes are communicated promptly.
- Medical posters in classrooms, the office, staff room, corridors,, offices and the dining hall show each child's photograph, name, class, allergens and treatment. Children with allergies wear a red lanyard carrying a card with their photograph, name and allergens. Catering staff cross-check the card against the medical posters and the agreed menu before serving food.
- These identification arrangements must be accurate, current and used consistently. Lanyards must be suitable for young children, with safety-release fittings and activity-specific safety considered. Staff remain responsible where a card is missing or cannot safely be worn. Medical information is positioned and shared to support safety while limiting unnecessary disclosure. Children with allergens wear their lanyard all day, including at Breakfast Club and After School Provision.
- All members of the Senior Leadership Team are involved in lunch supervision. Meal checks are ongoing, with all staff trained and alert to allergy risks. A culture of speaking up and whistleblowing supports prompt challenge of unsafe practice. Concerns are raised immediately with the catering manager, with follow-up and recurring issues reviewed at monthly meetings. This supervision supports the required card, poster and agreed-menu cross-check for each child.
- Catering and staff providing food check ingredients and labels, prevent cross-contact and provide clear allergen information. Recipes and substitutions are checked before use. If safety cannot be established, the food must not be served and a safe alternative must be arranged.

6. Daily routines and inclusive participation

- **Handwashing and food sharing**
- Children wash their hands using soap and running water before lunch. Where they have played outside after washing, staff ensure hands are clean before eating. The existing additional use of hand sanitiser may continue for general hygiene, but it does not replace washing to remove food allergens. Staff supervise hand hygiene and clean eating surfaces and equipment appropriately.
- Food, snacks and drinks must not be shared. Children are taught, in an age-appropriate way, why this matters; utensils and food containers must not be shared either.

- **Fruit boxes and curriculum activities**
- Where a child has a significant allergy to a fruit or vegetable supplied in classroom fruit boxes, these snacks are eaten in class before children go out to play. Children must not take them into the playground, reducing the risk of dropped food being picked up by a child with an allergy.
- All curriculum ingredients are checked for allergens before purchase and again before use. Risk assessments cover cooking, food tasting, celebrations, craft materials, play dough and food packaging used in activities. Suitable alternatives and cleaning arrangements enable children with allergies to participate safely.

- **Non-food allergens**
- Risk assessments identify individual risks from animals, insect stings, latex, airborne or contact allergens and other environmental sources. Where School dogs pose a risk, controls include restricting access to designated areas, enhanced cleaning and handwashing after contact. Arrangements are adapted to the affected child's clinical advice and HCP.

- **Visits and additional provision**
- Allergy risks are considered in planning every educational visit, sporting activity and other off-site activity. Assessment covers food, transport, the venue, medication storage, trained staff and access to emergency help. The trip leader checks the child's plans and both prescribed AAIs, where prescribed, and other required medicines before departure.
- A named adult carries the child's medication and ensures it remains accessible throughout the visit. The Inclusion Officer and visit leader decide whether additional spare AAIs are needed, without leaving School without adequate spare provision. If medication is missing, leaders must resolve the risk promptly with the family and seek a safe arrangement, rather than impose an automatic exclusion.
- The same standards apply to breakfast and after school provision where offered. Any third-party provider must receive this policy and agree suitable information sharing, training and medication access arrangements.

- **Wellbeing and inclusion**
- Children receive age-appropriate allergy awareness teaching, including within assemblies. School plans meals, rewards and celebrations inclusively and addresses allergy-related anxiety sensitively. Deliberate exposure, threats and allergy-related bullying are taken seriously under safeguarding and behaviour procedures. Parents must not be required to attend routinely to administer medication or accompany a child on a visit as a condition of participation.

7. Medication and staff preparedness

- **Prescribed medicines and storage**
 - Where AAls are prescribed, each child has two in-date pens and antihistamine where relevant, supplied by parents. Brands and strengths vary between children. Staff use the strength prescribed for the individual child and recorded in their clinical action plan; the prescriber determines the appropriate dose using relevant clinical factors, including weight. Staff must not select or change a child's prescribed dose based on age, height or appearance. Infant-age children are not expected to manage emergency treatment independently.
 - Children's medication is kept in clearly labelled individual medical boxes in the office cupboard in the main school office. The cupboard is unlocked, readily accessible and clearly marked with a poster. Each box contains the child's HCP and relevant clinical action plan. Emergency spares are also kept in this cupboard and clearly marked. Devices must be brought to the child immediately in an emergency; access must be maintained whenever children are on site, including additional provision. Access arrangements are checked across the premises and adjusted where necessary to avoid delay.
 - Devices are stored according to manufacturer instructions, protected from excessive heat and direct sunlight. Safe access to medication must also be planned for evacuation and lockdown; staff must not re-enter an unsafe building to retrieve it.
- **Spare AAls and checks**
 - School holds central spare, back-up AAls. They supplement prescribed devices and may be used where a personal device is unavailable or fails, or for suspected anaphylaxis in someone without a prescribed device. In a life-threatening emergency, obtaining consent must not delay treatment. Advance parental consent is recorded through the care-planning process where possible.
 - Emma Murphy completes documented monthly medication checks using the form on the inside of the cupboard door. Checks cover expiry dates, device condition and solution clarity where visible; stock is also checked after use. She maintains the digital medication log and printed record and follows up replacements with parents. Parents are contacted by telephone and School Messenger at least one month before their child's medication expires. Replacements must be secured before expiry and promptly after use, including replenishing School's emergency spares.
 - Spare devices are clearly marked as emergency spares in the office medication cupboard. Staff follow their device-specific training and emergency guidance. Used AAls are handed to paramedics; expired or damaged devices are returned through an appropriate pharmacy or approved disposal route.
- **Training and practice**
 - All staff receive annual mandatory allergy awareness and emergency response training as part of safeguarding training. Allergy training is also part of induction for new staff, trainees and volunteers. School checks suitable training and briefing for supply and cover staff, catering and lunchtime staff, and any others supervising children.
 - Training covers individual plans, avoiding allergens and the risk-reduction measures noted in this policy, recognising reactions, locating and using the devices held in School, asthma overlap, reporting incidents and supporting wellbeing. It reinforces that hand sanitiser does not replace washing away allergens; adrenaline and 999 take priority; children must not stand or walk during suspected anaphylaxis; and hospital assessment follows treatment. Staff handling food receive instruction on labels and preventing cross-contact. School holds an annual emergency practice response and hands-on trainer-device practice during annual

safeguarding training, covering the different devices used in School. Training records are retained and practice is reviewed to identify improvements.

8. Incidents - Monitoring and Review

- **Recording and Learning**
 - All allergic reactions and near misses, including incorrect meals, labelling errors and accidental exposure without symptoms, must be reported promptly to the Inclusion Officer and Headteacher and recorded within the School's Safeguarding system, CPOMS. Emergency care always comes first.
 - Records should include the person affected, date and time, symptoms, possible exposure, food or product information, treatment and treatment times, staff involved and communication with parents and emergency services. Relevant packaging and food evidence should be retained safely where appropriate without exposing anyone to further risk.
 - The Headteacher and Inclusion Officer review what happened with relevant staff, the caterer and parents, seeking to learn and prevent recurrence. They share findings and actions with the family, update the HCP and risk assessments where necessary, and report significant matters to the Board. Learning should be open and constructive while maintaining appropriate accountability.
 - Leaders consider any required reporting to environmental health, the Health and Safety Executive or safeguarding services. Unsafe food supplied by School as a food business must be reported to the local authority environmental health team. Any RIDDOR reporting decision must reflect the applicable criteria. Concerns about a child being placed at risk are referred to the Designated Safeguarding Lead for assessment and proportionate action.
- **Unacceptable practice**
 - Staff must not delay or obstruct access to emergency medication, leave a child having a reaction alone, send a child with suspected anaphylaxis to the office, disregard clinical advice, assume children with the same allergy need identical support, or dismiss a suspected allergy because diagnosis is pending. Children must not face unnecessary barriers to participation or penalties for medically necessary absence.
- **Monitoring and publication**
 - The Inclusion Officer and named Director monitor care plans, training, medication readiness, meal identification and incident learning. The policy is published on the School website and reviewed at least annually, after significant incidents and when relevant guidance changes. Families can raise concerns with the Inclusion Officer or Headteacher and use the School's complaints procedure.

Sources informing this version

School source: 2026 Allergy Policy, written by Emma Murphy as the current account of practice.

Model source: Anaphylaxis UK, Allergy Safety Model Policy, July 2026, supplied by the Headteacher.

Current official reference checked on 28 September 2026: Department for Education, Allergy safety in schools, published 6 July 2026.

<https://www.gov.uk/government/publications/allergy-safety-in-schools>

<https://www.anaphylaxis.org.uk/education/benedicts-law/>