IMPACT OF THE AMERICANS WITH DISABILITIES ACT ACcommodations Act ON SCHOOL-BASED FOOD ALLERGY MANAGEMENT

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I. INTRODUCTION

Although the cause remains unclear, research shows an increase over the past twenty years in the number of children suffering from food allergies. ¹ From 1997 to 2007 alone, the number of children with food allergies increased by 18%. ² According to the American Academy of Allergy, Asthma and Immunology, approximately 3 million school-aged children are now experiencing food allergies. ³ When school nurses were surveyed, 94% responded that their school(s) had at least one child with a food allergy, and 71% reported that it was burdensome to properly manage student food allergies. ⁴

With the rise of food allergies in school-aged children, the need for realistic, yet medically-adequate school-based food allergy management procedures has garnered substantial public attention. Numerous private organizations and public agencies have responded to the medical concern by developing model guidelines for schoolhouse allergy management, and federal and state governments have acted legislatively to address the schoolhouse health concerns of food-allergic students. ⁵

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² Id.
legislative change occurred in 2008 when Congress passed the Americans with Disabilities Act Amendments Act (“ADAAA”) to provide broader coverage under the ADA. The amendments added by the ADAAA have greatly strengthened the legal protections for food-allergic students, arguably ending the debate as to whether life-threatening food allergies qualify as a legally-protected disability.

Despite the enhanced legal protections and the proliferation of free, educational materials outlining the necessary elements of an effective allergy management plan, numerous recent studies indicate that school food allergy practices continue to be riddled with implementation gaps that undermine the effectiveness of accommodation attempts. In one study, 65% of school nurses admitted a lack of confidence in the school’s ability to effectively manage student food allergies.

The purpose of this paper is to discuss how the ADAAA strengthens disability protection for food-allergic students, identify common implementation gaps in school-based food allergy management practices, and review best practices for daily management of student food allergies. In order to provide a background for the discussion of student food allergies, Section II begins with an explanation of the cause, medical symptoms and treatment for food allergies. Section III reviews the educational rights provided by federal and state law, and includes analysis of how the ADAAA has increased the educational protections for food-allergic students. Section IV

2014). Two federal laws directly address the health concern of school-based food allergy management. See infra pp. 15-16.
7 A study of primary school teachers indicated that a majority of teachers were unaware of anaphylactic symptoms, 93.7% could not identify the appropriate drug for treating anaphylaxis, and approximately 75% were not willing to administer treatment to a student experiencing anaphylaxis. Hulya Ercan, et al., Primary School Teachers’ Knowledge About and Attitudes Toward Anaphylaxis, 23 PEDIATRIC ALLERGY & IMMUNOLOGY 428, 429 (2012). Survey results also indicate that schools continue to lack written food allergy management practices, and some schools do not have a stock of food allergy medication. Anna Nowak-Wegrzyn et al., Food-Allergic Reactions in Schools and Preschools, 155 ARCHIVES PEDIATRIC & ADOLESCENT MED. 790, 794 (2001). For those schools that do adopt food-allergy management plans, many of them are developed in-house and fail to incorporate important components including symptoms of anaphylaxis, instructions for medical treatment and emergency contact information. Jill Powers, Comparison of School Food Allergy Emergency Plans to the Food Allergy and Anaphylaxis Network’s Standard Plan, 23 J. SCH. NURSING 252, 255 (2007). One barrier to protecting student health is the existing administrative gap in proactively identifying which students suffer from school allergies. See Anne H. Sheetz et al., Guidelines for Managing Life-Threatening Food Allergies in Massachusetts Schools, 74 J. SCH. HEALTH 155, 156 (2004).
8 Patty Morris et al., Preparedness for Students and Staff with Anaphylaxis, 81 J. SCH. HEALTH 471, 474 (2011).
shifts focus from legal requirements of allergy management to the proper and practical aspects of providing a safe environment for food-allergic children.

II. FOOD ALLERGIES: A BRIEF OVERVIEW

Food allergies develop when the immune system misinterprets food as a harmful substance.\(^9\) Although eight foods (milk, eggs, peanuts, tree nuts, wheat, soy, fish and shellfish) are attributed with causing 90% of all food-allergic reactions,\(^10\) it is important for school personnel to understand that an individual can develop an allergy to any food item.\(^11\) Whenever the food allergen is ingested, the body releases chemicals to attack the food, causing the person to experience an allergic reaction. The severity of an allergic reaction can range from minor to a severe, life-threatening form of hypersensitivity called anaphylaxis.\(^12\) Symptoms of a minor reaction include itching, rashes, congestion or even watery eyes.\(^13\) Anaphylaxis, however, impacts multiple organ systems, occurs rapidly, often within minutes after allergen exposure,\(^14\) and can be fatal if treatment is delayed.\(^15\) Studies indicate that anaphylactic reactions, triggered by food allergies, cause approximately 150-200 deaths each year.\(^16\)

Because delayed treatment increases the risk of death, educators should be trained to quickly identify the physical signs that are indicative of an anaphylactic reaction. The organ systems most likely to be impacted by anaphylaxis are the skin, respiratory system, gastrointestinal system, cardiovascular system and central nervous system,\(^17\) manifesting physical

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9 See Scott H. Sicherer, Food Allergy, 78 MOUNT SINAI J. MED. 683 (2011);
10 S. Bailey et al., Restaurant Staff’s Knowledge of Anaphylaxis and Dietary Care of People with Allergies, 41 CLINICAL & EXPERIMENTAL ALLERGY, 713 (2011) (citing S.H. Sicherer & H.A. Sampson, Food Allergy, 125 J. ALLERGY & CLINICAL IMMUNOLOGY 116 (2010)).
14 Hugh A. Sampson, Anaphylaxis and Emergency Treatment, 111 PEDIATRICS 1601, 1602-04 (2003).
15 See Hugh A. Sampson et al., Fatal and Near-Fatal Anaphylactic Reactions to Food in Children and Adolescents, 327 NEW ENG. J. MED. 380, 383 (1992) (“No patient who died received epinephrine before severe respiratory symptoms developed, whereas all the patients with nonfatal reactions received epinephrine before or within five minutes of the development of severe symptoms.”).
16 Sampson, supra note 14, at 1602.
clues including hives, swelling of the mouth or throat, coughing and wheezing, lightheadedness, anxiety, vomiting, diarrhea, and/or cramping.18

Once an allergic reaction has been identified, treatment should be administered immediately.19 The common medical treatment is administration of antihistamine and/or an injection of adrenaline (i.e., epinephrine).20 Antihistamines may work well for treating minor reactions, but epinephrine is the suggested treatment for anaphylaxis.21 Studies show that death from anaphylaxis is attributed to non-treatment by epinephrine or to delay in administering epinephrine.22 Even when educators and students are trained in the signs and symptoms of anaphylaxis, it is common for each to delay acknowledgement of the symptoms and consequently postpone treatment until the student’s physical ailments are more pronounced.23

To ensure prompt injection of epinephrine, doctors often prescribe a small, individual auto-injector pen that contains a single dose of epinephrine, designed to be carried by the allergic individual at all times.24 Individuals self-administer the medication by injecting epinephrine directly into the thigh. To aid younger students, as well as older students who are too ill to self-administer the epinephrine, school nurses, staff and educators should be trained in the proper administration of auto-injector epinephrine pens.

As this section has explained, proper student food allergy management cannot be provided absent effective educator training on food allergies, including causes, avoidance techniques, symptoms and treatment. Before identifying best practices for food allergy training and effective school-based food allergy management, the next section will analyze whether federal law protects food allergies as a disability, and thus whether educators are even legally required to provide schoolhouse accommodations.

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18 Sampson, supra note 14, at 1603-04; Symptoms, supra note 13.
19 Id. at 1604-06; Simons, supra note 17, at 632.
20 See Simons, supra note 17, at 631-33.
22 Sampson, supra note 15, at 383-84; Sampson, supra note 14, at 1604; Hay, supra note 21.
23 Hay, supra note 21, at 479.
24 See Sampson, supra note 14, at 1605; see also Simons, supra note 17, at 631.
III. PASSAGE OF THE ADAAA STRENGTHENS DISABILITY PROTECTION FOR STUDENTS WITH LIFE-THREATENING FOOD ALLERGIES

A. Pre-ADAAA Disability Protection for Food-Allergic Students

As the prevalence of school-aged food allergies increased, a variety of stakeholders (parents, school administrators, medical profession and legal profession, to name a few) began questioning the educational institution’s legal obligations for accommodating food allergies. Among these questions are: Is a school required to offer a special menu to food-allergic students? Is the school required to create an allergen-free eating zone? Must schools go as far as ensuring an allergen-free school? Are teachers required to inject epinephrine into a student experiencing an anaphylactic reaction? These are just a few examples of issues debated by parents and school personnel.

If a legal accommodation obligation does in fact exist, it originates from Section 504 of the Rehabilitation Act of 1973 (“Section 504”),25 the Americans with Disabilities Act of 1990 (“ADA”),26 and/or the Individuals with Disabilities Education Act (“IDEA”).27 All three federal laws were passed with the purpose of providing children with equal access to a public education, focusing on reducing discrimination against children with physical or mental limitations.28 Section 504 and the ADA provide broader protection than the IDEA, with the latter being limited to physical and mental limitations that also negatively impair learning and require special

28 Section 504 and the ADA are both civil rights laws designed to provide equal access for disabled individuals, but they regulate different types of entities. Section 504 was passed before the ADA and applies only to government entities that receive federal financial assistance. 29 U.S.C. §794(a) (2012). The ADA was passed in 1990 to extend the reach of Section 504 to other government programs and specified private businesses. Shannon S. Taylor, Special Education, Private Schools, and Vouchers: Do All Students Get a Choice? 34 J. L. & EDUC. 1, 2 (2005). Title II of the ADA, which regulates state and local governments, prohibits public schools from discriminating against disabled students. 42 U.S.C. §§ 12131(1), 12132 (2012). Title III of the ADA prohibits discrimination by public accommodations and applies to non-religious child care centers and non-religious private schools. Id. at § 12181(7)(J) (public accommodations include “a nursery, elementary, secondary, undergraduate, or postgraduate private school, or other place of education”); id. at § 12181(7)(k) (public accommodations include day care centers). Religious private schools and religious day care centers are not governed by the ADA, but they are governed by Section 504 if they receive federal financial assistance. Id. at § 12187 (although Title III applies to private schools, an exemption is provided for “religious organizations or entities controlled by religious organizations, including places of worship”); see also Taylor, supra at 2.
education. Because a food allergy does not usually create a learning disability, the IDEA is generally unavailable as an accommodation tool. However, because Section 504 and the ADA focused on whether a mental/physical ailment impacts a major life activity (breathing, eating, walking, etc.), regardless of whether learning is also impaired, parents and a variety of support organizations began arguing that schools owed food-allergic children the accommodation protections implicated by both laws.

To qualify for the protections provided by Section 504 and the ADA, an individual must suffer from a disability as defined by each law. Both laws define disability as (1) “a physical or mental impairment that substantially limits one or more major life activities,” (2) having “a record of such an impairment,” or (3) as someone who is “regarded as having such an impairment.” An individual need only meet one of the three tests in order to be qualified as disabled, and this paper will focus only upon the first of the three definitions.

The answer to whether a food allergy qualifies as a physical or mental impairment that substantially limits one or more major life activities initially varied by source (judiciary, EEOC, Office of Civil Rights), making it difficult for parties to identify rights and responsibilities. In the 1990s, the Department of Justice (“DOJ”), enforcing the rights conferred by the ADA,
together with the Department of Education’s Office of Civil Rights (“OCR”),
with authority to enforce Section 504, began treating severe food allergies
as a disability, and drafted settlement agreements requiring youth-based
organizations to allow students to carry epinephrine, requiring staff to
administer epinephrine during allergic reactions, and forbidding covered
institutions from denying admission to food-allergic children. The
Department of Agriculture, which issues guidance to institutions that
participate in the Department’s food programs, promulgated an interpretative
rule clarifying that severe food allergies (i.e., food allergies that may cause
anaphylaxis) do qualify as a disability under Section 504, requiring
participating institutions to provide appropriate meal substitutions. During
the same time period, the judiciary and EEOC were adopting a quite different
approach to food allergies, generally ruling that they did not qualify as a
legally protected “disability.”

In the 1999 seminal case of Land v. Baptist Medical Center, the Eighth
Circuit ruled that a child’s peanut allergy was not a disability. Megan Land,
diagnosed with a peanut allergy, experienced several allergic reactions while
in attendance at Baptist Medical Center’s day care. Following Megan’s
second allergic reaction, Baptist Medical Center dismissed her from the

32 Goddard, supra note 29, at 506.
33 Settlement agreements have been entered into with a child care center, a private boys’
school, a private religious school, and a nationwide summer day camp. In 1997, the DOJ
settled with La Petite Academy, Inc., a child care center. La Petite previously refused to
administer epinephrine injections to children who suffered from severe food allergies. The
settlement agreement required La Petite to train staff about food allergies and to agree to
administer epinephrine when a child suffers an allergic reaction. See Settlement Agreement
Under the Americans with Disabilities Act Between the United States of America and La Petite
Military Institute entered into an agreement with the DOJ in which a food-allergic child was
determined to be a person with a disability. Settlement Agreement Under the Americans with
Disabilities Act Between the U.S. Department of Justice and Carson Long Military Institute,
http://www.ada.gov/carsonlg.htm (last visited June 5, 2014). As part of the settlement, Carson
Long agreed to modify its medication administration policies to allow disabled students to
self-medicate in cases of emergency. Id. Carson Long also agreed to develop policies and
procedures for training about administration of epinephrine in situations involving life-
threatening allergic reactions. Id. The DOJ has also settled a case with a nationwide summer
camp that refused to administer epinephrine to food-allergic students, but instead had a policy
that the parents would have to travel to the camp and administer the medication themselves.
Enforcing the ADA: A Status Report from the Department of Justice, April–June 2002, INFO.
& TECH. ASSISTANCE ON THE AMERICANS WITH DISABILITIES ACT,
34 Marie Plicka, Mr. Peanut Goes to Court: Accommodating an Individuals Peanut Allergy in
Schools and Day Care Centers Under the Americans with Disabilities Act, 14 J. L. & HEALTH
87, 101 (2000) (quoting a Department of Agriculture’s interpretative rule titled, “Meal
Substitutions for Medical or Other Special Dietary Reasons”).
program, prompting Megan’s mother to initiate a lawsuit that claimed violations of the ADA and the Arkansas Civil Rights Act. During litigation, Megan’s physician testified that she was “‘exquisitely sensitive’ to peanuts and peanut products,” that exposure to peanuts could cause her to die, and that she must practice “strict avoidance of peanuts and peanut products, and…have available at all times an epinephrine injection.”

When analyzing whether Megan’s peanut allergy qualified as a “physical or mental impairment substantially limiting one or more major life activities,” the court agreed that she suffered from a physical impairment, and also affirmed that several major life activities (eating and breathing) were impacted. The court continued, however, by noting that the “pivotal question” was whether Megan’s eating and breathing were substantially impaired, and ultimately concluded that this pivotal legal requirement did not exist.

Interestingly, when determining that her breathing was not substantially impacted, the court placed more emphasis on the quantity of breathing-impaired occurrences (two allergic reactions), rather than on the degree of breathing impairment that existed during an isolated allergic reaction. So, although a single allergic reaction could fatally impact breathing, the restriction was deemed not substantial because her reactions did not occur with enough frequency. When addressing the major life activity of eating, the court ruled she was not substantially impaired because she was not completely prohibited from eating. “Although Megan cannot eat foods containing peanuts or their derivatives, the record does not suggest that Megan suffers an allergic reaction when she consumes any other kind of food or that her physical ability to eat is in any way restricted.” Avoidance of peanut products requires substantial attention to food ingredients, including avoidance of cross-contamination with other students’ food and adult assistance, yet the court held that Megan’s act of “eating” was not significantly impaired in “the condition, manner, or duration…as compared to an average person in the general population” In all fairness, the Land majority opinion was representative of the judiciary’s cautionary approach to interpreting the ADA, one that was not limited to food allergy cases or the education/child care relationships.

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36 Id.
37 Id. at 426.
38 Id.
39 Id. at 424-25.
40 Id. at 425.
41 Id.
42 Id.
43 See, e.g., Sutton v. United Air Lines, 527 U.S. 471, 481 (1999) (holding that petitioners’ vision limitations must be examined after considering the remedying effects of mitigating
In 2008, in a legislative response designed to reverse course on a decade of conservative judicial and administrative ADA interpretation, Congress passed the ADAAA. The stated purpose of the ADAAA was to “reinstate a broad scope of protection” for disabled individuals to support “the ADA’s objectives of providing ‘a clear and comprehensive national mandate for the elimination of discrimination.’”

B. Post-ADAAA Disability Protection for Food-Allergic Students

The amendments introduced by the ADAAA have reduced the likelihood that severe food allergies will continue to receive the different degrees of legal protection that were identified in the previous subsection. Following passage of the ADAAA, students with life-threatening food allergies are almost certain to qualify as disabled under the ADA and Section 504. This subsection of the paper will identify the specific modifications introduced by the ADAAA and discuss how those modifications benefit food-allergic students.

It is important to note that the ADAAA did not change the three-part ADA definition of disability, but instead clarified the legal meaning of existing terms. Under the first prong of the definition (the focus of this paper), disability retains its original form, being described as a “physical or mental impairment that substantially limits one or more major life activities.” Congress enhanced disability protection by clarifying the meanings of “major life activities” and “substantially limits,” and by adding statutory rules of construction.

medical aids, and consequently ruling that petitioners’ severe myopia did not qualify as a disability); Toyota Motor Mfg., Ky. v. Williams, 534 U.S. 184, 200-01 (2002) (“When addressing the major life activity of performing manual tasks, the central inquiry must be whether the claimant is unable to perform the variety of tasks central to most people’s daily lives, not whether the claimant is unable to perform the tasks associated with her specific job…There is also no support in the Act…for…the idea that the question of whether an impairment constitutes a disability is to be answered solely by analyzing the effect of the impairment in the workplace.”).

46 Neither the ADA nor the ADAAA include a formal definition for “physical or mental impairment,” rather the courts will continue to use the definition adopted by the EEOC, DOJ and OCR prior to passage of the ADAAA. Emily A. Benfer, The ADA Amendments Act: An Overview of Recent Changes to the Americans with Disabilities Act, AM. CONSTITUTION SOC’Y FOR LAW AND POLICY 4 (2009), http://www.acslaw.org/files/Benfer%20ADAAA_0.pdf. “The phrase physical or mental impairment means — (i) Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following bodily systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genitourinary; hemic and lymphatic; skin; and endocrine; (ii) Any mental or psychological disorder such as mental retardation, organic brain
When passed in 1990, the ADA did not provide a definition of “major life activity,” so the OCR acted through regulation to adopt its own definition with a non-exhaustive list that included the tasks of caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.\(^47\) Congress strengthened the pre-ADAAA definition in four ways. First, the ADAAA adopted a statutory definition for major life activities, removing potential judicial arguments that the OCR regulations were not binding.\(^48\) Second, the ADAAA’s definition lengthened the OCR’s non-exhaustive list, an approach that may benefit food-allergic students because the task of eating is now one of the statutory examples.\(^49\) Third, and perhaps most importantly for disability rights, major life activity is no longer solely defined by one’s inability to complete functional tasks (i.e., walking, talking, eating). The ADAAA added a second definition that focuses on whether a person experiences an impairment to “major bodily functions” (i.e., digestive function, respiratory function, brain function) even when such impairment exists as a hidden disability that does not negatively impact daily activities.\(^50\) Food-allergic students can now satisfy the requirement of “major life activity” merely by showing that their digestive, respiratory, and immune system are impacted, with no further legal requirement to analyze whether the tasks of eating or breathing demonstrate any impairment. Finally, Congress legislatively clarified that a person is disabled even if only one major life activity is impaired, reversing the preexisting judicial precedents that often applied stringent requirements that multiple major life activities be implicated.\(^51\)

In addition to clarifying the meaning of major life activities, Congress also directly addressed the proper legal interpretation of the phrase syndrome, emotional or mental illness, and specific learning disabilities; (iii) The phrase physical or mental impairment includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism; (iv) The phrase physical or mental impairment does not include homosexuality or bisexuality.” \(\text{Id.}\) at n. 18 (citing 28 C.F.R. § 36.104).

\(^{47}\) 34 C.F.R. § 104.3(j)(2)(ii).

\(^{48}\) See Wendy F. Hensel, \textit{Rights Resurgence: The Impact of the ADA Amendments Act on Schools and Universities}, 25 GA. ST. U. L. REV. 641 (2009). “The Supreme Court…called the EEOC’s authority to promulgate such regulations into questions…because the definition of disability is located in the General Provisions section of the ADA rather than in any of the subsequent Titles. Because Congress gave no agency the authority to promulgate regulations relating to the General Provisions, the Court voiced skepticism that the regulations were entitled to any deference by the courts.” \(\text{Id.}\) at 644.


\(^{50}\) \(\text{Id.}\) at § 12102(2)(B).

\(^{51}\) \(\text{Id.}\) at § 12102(4)(C).
“substantially limits,” as that term is used in the statutory definition of disability. Neither the text of the ADA nor the ADAAA contains a definition for “substantially limits,” but the ADAAA adds rules of construction, several of which focuses solely on the term “substantially limits” and make clear that the phrase should receive a broad interpretation that favors classifying conditions as a legally-protected disability. Although it was quite plausible for food-allergic plaintiffs to convince the court that food allergies impacted a major life activity, the argumentative snag arose in trying to persuade the court that the existing impairment was substantial enough to warrant legal protection. The ADAAA rules of construction lowered the pre-existing exacting legal standard established by the Supreme Court. One of the stated purposes of the ADAAA was “to convey congressional intent that the standard created by the Supreme Court...has created an inappropriately high level of limitation necessary to obtain coverage under the ADA...and to convey that the question of whether an individual’s impairment is a disability under the ADA should not demand extensive analysis.”

First, the ADAAA nullifies the Supreme Court’s interpretation that the term “substantially” creates a “demanding standard for qualifying as a disability.” Second, Congress rejected Supreme Court precedent that required the impaired activities to be of “central importance” to people’s lives. Finally, the ADAAA shifts focus to the EEOC, which defined “substantially limits” as “significantly restricted,” stating that the EEOC’s standard was too high and requiring the EEOC to revise its standard to be consistent with the guidance provided by the ADAAA.

Two final rules of construction add extensive teeth to the food-allergic student’s claim of disability. When evaluating whether a food allergy “substantially impairs one or more major life activities,” the analysis must focus on the medical condition in an unprotected, non-medicated, non-accommodated state. The court (and school) must pretend that no medication (epinephrine) exists to treat a food allergic reaction, and must ignore any food allergy management practices (i.e., hand washing, checking...

52 Id. at § 12101(4)(A)-(B).
54 See id. at 424-25.
56 Id. at note (b)(4).
57 Id.
58 Id. at note (a)(8).
59 Id. at § 12102 (4)(E)(i). “The 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, medical supplies, equipment, or appliances, low-vision devices (which do not include ordinary eyeglasses or contact lenses), prosthetics including limbs and devices, hearing aids and cochlear implants or other implantable hearing devices, mobility devices, or oxygen therapy equipment and supplies.” Id.
food labels) that assist the child in avoiding allergic reactions. Consider the impact of this ADAAA amendment on the *Land* ruling. In *Land*, the majority opinion evaluated Megan’s condition after considering the ameliorative impact of managing ingestion of peanuts. The court stated that as long as she did not eat peanuts, her major life activities were not impaired and thus she did not have a disability. Under the ADAAA, the court must examine Megan’s major life activities ignoring the possibility of reading food labels and of removing allergens from her diet.

The second rule of construction requires that episodic conditions be evaluated only in regard to the impact that occurs during an active state. For food-allergic children, the school must evaluate the student’s impairment to major life activities only during an actual reaction, not in reference to the majority of the time period when no allergic reaction occurs. Again, the *Land* decision does not comply with the ADAAA because the court’s ruling, in part, is grounded in a quantitative analysis that conditions “substantiality” of impairment on the existence of a minimum number of allergic reactions. Under the ADAAA, the *Land* court may not consider the frequency of allergic reactions, but rather must limit its inquiry to how Megan’s major life activities are impaired during an actual allergic reaction.

To date, there is a paucity of case law applying the ADAAA to food allergies in the school setting. However, a 2012 settlement between the DOJ and Lesley University provides some insight on how food allergies will be analyzed pursuant to the ADAAA. The settlement agreement addressed a Lesley University policy that required all residential students to purchase a meal plan, regardless of whether the food-allergic students could safely eat the food being served. Ruling that severe food allergies can qualify as a disability under the ADA, the DOJ required Lesley University to offer allergen-free meal options, allow food-allergic students to pre-order allergen-free meals, display allergen notices on all university cafeterias, separate the allergen-free food preparation zone from the ordinary food preparation area, train food service staff and other university staff about food allergies, and make an effort to hire food vendors that offer allergen-free foods. Although university accommodation requirements may be evaluated differently than ADA accommodations in the K-12 setting, the settlement agreement clearly signals that severe food allergies qualify as an ADA disability.

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62 *Land*, 164 F.3d at 425.
A final, but important comment regarding the application of Section 504 to food allergies in the K-12 setting is the applicability of the OCR’s “extraordinary circumstances” rule. In the K-12 setting, an unsatisfied parent can file a complaint with the OCR and generally the OCR review will only evaluate whether the proper Section 504 due process procedures are satisfied, but typically does not evaluate the appropriateness of the accommodations provided in the Section 504 plan.64 For severe food allergy cases, the OCR is more likely to apply its “extraordinary circumstances” rule, which allows the OCR to conduct a substantive review of the 504 plan in circumstances where the school’s decision could result in death or illness to the student.65 Because improper food allergy management practices, or a school’s refusal to accommodate severe food allergies creates a risk of death for severely allergic children, it is quite possible for the OCR to recommend or even require substantive changes to a school’s food allergy management practices.

As primary and secondary educators continue to work diligently towards identifying successful food allergy management practices, they should be aware of additional federal and state food allergy legislation, particularly how these laws vary from or supplement Section 504 and the ADA.

C. Additional Federal and State Food-Allergy Laws: A Voluntary Approach to School Food-Allergy Management

Whereas Section 504 and the ADA impose mandatory accommodation requirements for food allergies that qualify as a disability, several other federal and state laws provide incentives and educational materials that can be voluntarily adopted by local school districts interested in adopting effective food allergy management practices.

Two federal laws focus specifically on food allergies, attempting to provide resources to schools managing student allergies. Through the Food Allergy and Anaphylaxis Management Act (FAAMA) of 2011,66 the U.S. Secretary of Health and Human Services developed the first national school-based food allergy management guidelines, which thoroughly identified the practical steps of daily food allergy management. The national food allergy guidelines are not mandatory practices, but voluntary information for school districts seeking guidance. In 2013, the President of the United States signed

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64 Perry A. Zirkel & Brooke L. McGuire, A Roadmap to Legal Dispute Resolution for Students with Disabilities, 23 J. SPECIAL EDUC. LEADERSHIP 100, 108 (2010).
65 Id.
into law the School Access to Emergency Epinephrine Act, providing financial incentives for states to begin requiring local districts to maintain a stock of epinephrine, the medication of choice for treating severe, life-threatening allergic reactions.

When examined from the perspective of legislative action, state efforts have focused more on protecting food-allergic students’ access to medication than on mandating specific food allergy management practices (which encompasses more than administering medication) to local school districts. Practically every state, plus the District of Columbia, has adopted legislation giving students the right to carry epinephrine during the school day. Only nine states require their local schools to maintain a stock of epinephrine, in addition to a student’s individually prescribed epinephrine. Maintaining a stock of epinephrine has proven necessary for a variety of reasons. While some parents fail to provide the school with epinephrine, other students experience their very first allergic reaction during the school day, before being diagnosed and prescribed medication.

Though medication-access is a necessary component of food allergy management, medical literature reinforces that allergen avoidance techniques are equally important. Allergic individuals have a daily goal of completely avoiding allergic reactions, because severe cases may prove fatal even with administration of epinephrine. Medication-access legislation addresses only the treatment component of allergy management. State legislation addressing allergen avoidance remains a minority trend (approximately 15 states), and when adopted provides voluntary guidance, very different from the absolute rights granted by the medical-access legislation. Despite recent legislative

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69 As of June 2, 2015, California, Nevada, Virginia, Maryland, Nebraska, New Mexico, Michigan, North Carolina and New Jersey are the only states that require schools to maintain a stock of epinephrine. See Stocking Epinephrine in Schools, ASTHMA AND ALLERGY FOUND. OF AM., http://www.cqrcengage.com/aafa/epinephrine (last visited August 14, 2015).
70 Anne Munoz-Furlong, Daily Coping Strategies for Patients and Their Families, 111 PEDIATRICS 1654 (2003).
71 A small group of states has independently developed statewide food allergy management guidelines, which incorporate both allergen avoidance planning and medical treatment protocol. Michael C. Young, Anne Munoz-Furlong & Scott H. Sicherer, Management of Food Allergies in Schools: A Perspective for Allergists, 124 J. ALLERGY CLINICAL IMMUNOLOGY 175, 180 (2009). According to Food Allergy Research and Education, a non-profit organization that works to protect individuals suffering from food allergies, only 15 states have adopted state level guides, and most, if not all of these are provided as voluntary resources to be adopted at the sole discretion of the school district. See School Guidelines, FOOD ALLERGY RESEARCH & EDUC., http://www.foodallergy.org/laws-and-
efforts to improve awareness of school-based food allergies and guidance on proper food allergy management, research and anecdotal evidence indicate that schools continue to experience gaps in best practices for allergen avoidance and treatment of allergic reactions.\textsuperscript{72}

The following section summarizes existing research identifying implementation gaps in school-based food allergy management practices, and identifies best practices. The discussion moves away from the legal analysis of Section 504 and the ADA, and focuses on the modifications to daily school management for those administrators and educators who wish to focus on the practices required to protect the health of food-allergic students.

\textbf{IV. SCHOOL PREPAREDNESS TO MANAGE FOOD ALLERGIES}

Experts have identified three critical areas that should be addressed by school-based food allergy management practices: (a) schools must have effective practices for identifying all students suffering from food allergies, (b) personnel should work collaboratively with parents and physicians to implement effective food allergen avoidance strategies, and (c) school personnel must be trained to properly diagnose and treat allergic reactions.\textsuperscript{73} Despite the robust availability of sample food allergy plans and free training resources, research shows that a number of schools continue to struggle with all three components of allergy management.\textsuperscript{74}

\textbf{A. Identification of Food Allergic Students}

Because proper food allergy management focuses as much on preventing reactions as treating them,\textsuperscript{75} successful allergy management requires far more than adding epinephrine education to in-service training. Prevention of allergic reactions requires a proactive, yet individualized approach: proactive, in the sense that educators will themselves anticipate the yearly need for allergen management and will lead efforts to identify preventative measures; individualized, in the sense that implemented

\begin{footnotesize}
\begin{enumerate}
\item See \textit{supra} note 7.
\item Sheetz et al., \textit{supra} note 7, at 157.
\item See \textit{discussion}, \textit{supra} note 7.
\item Nowark-Wegrzyn et al., \textit{supra} note 7, at 790 (“[T]he only available therapy for these children is strict avoidance of the offending foods…”).
\end{enumerate}
\end{footnotesize}
measures should be tailored to address the unique circumstances presented by each student. A “one-size, fits-all” approach does not protect students with food allergies.\footnote{See Jean A. Litarowsky, Susan O. Murphy, \& Daryl L. Canham, Evaluation of an Anaphylaxis Training Program for Unlicensed Assistive Personnel, 20 J. SCH. NURSING 279, 280 (2004) (noting that early identification of food-allergic students improves prevention of life-threatening reactions, and that individual student health needs and medical treatment protocols should be inventoried).}

To achieve proactive and individualized allergy management, school officials must be able to identify members of two critical groups: (1) students suffering from food allergies and (2) the core team of adults supervising students throughout the school day (“core team”).\footnote{See Ercan et al., supra note 7, at 431 (noting that a multidisciplinary approach is often recommended in school-based food allergy management guidelines). “The primary approach is aimed to organize all those who may have a supervisory role for a child at any time before, during, or after the school day to develop an individualized healthcare plan. Schools may establish a core team involving the school nurse, teacher, principal, school food service and nutrition manager/director, and a counselor to work with parents and the student to establish an action plan.” Id.} Unfortunately, research indicates that many food-allergic children remain unidentified by school staff. When public schools teachers were surveyed, only 23% of the respondents were able to identify the names of enrolled students diagnosed with food allergies.\footnote{Id. at 429.} In a study of food allergy practices in Massachusetts schools, it was discovered that many schools lacked a formal process for notifying school staff of a student’s food allergy.\footnote{Sheetz et al., supra note 7, at 156.}

Why do schools continue to struggle with the task of identifying students with food allergies? Research shows that many schools remain passive about allergy training, relying on parents to train the core team.\footnote{“A study of practices in Michigan schools found significant needs regarding staff education and policy development around the growing problem of life-threatening food allergies. Some schools did not offer food-allergy education for staff, or staff training in administering epinephrine for emergency treatment of anaphylaxis. Among schools that offered education, more than one-half relied on parents of children with food allergies to educate staff, and often no formal mechanism existed to provide school-wide education.” Sheetz et al, supra note 7, at 156.} I suggest that the passivity displayed towards training may also exist towards initial identification of food-allergic children. The following are several potential practices that may cause identification gaps, most of which coincide with a reactive, rather than proactive mentality towards food allergy management. In the first scenario, the school does not request food allergy information at the time of enrollment. Parents are forced to work outside the enrollment process to report the existence of a student food allergy, and self-identify to whom the information should be directed. Parents may notify the
student’s teacher about the allergy, but the teacher may neglect to notify other supervisory adults like extended day staff, bus drivers, coaches or cafeteria workers. A second scenario involves schools that do collect food allergy information at the time of enrollment, but lack follow-up processes. The information is administratively placed in the student file, but is never reported to teachers and staff. It is imperative that school employees comprehend the relevance of collecting food allergy information. Documenting food allergy history is not merely a bureaucratic exercise to be checked off the list and forgotten; a parental alert of an existing food allergy should immediately trigger an internal communication process. Parents will likely assume that if a school inquires about food allergy history or, in addition, requests medication and doctor’s treatment instructions, the school is preparing to act upon that information. In a third scenario are schools that do request food allergy information and properly follow-up by notifying the primary teacher, but overlook the need to identify and alert additional support staff about the student’s allergy.

The first two scenarios are reactive because the school does not take the initiative to be involved in communicating the information to the core team. Schools following these processes are more likely to find themselves treating allergy reactions because the communication gap prevented allergen avoidance planning. This passivity may be indicative that school administrators lack awareness that food allergy management is comprised of twin goals: allergen avoidance and medical treatment. A myopic focus on medical treatment increases the health risk for food-allergic students. The goal in allergy management is to prevent allergic reactions by strictly managing allergen exposure.

As indicated by scenario three, even when a school is aware of the dual requirements of prevention and treatment, identification gaps remain possible where the communication plan fails to include all members of the core team. Core team members include any adult who operates in a supervisory capacity over the student plus adults who participate in food preparation. Examples of potential core team members are teachers, bus drivers, before and after school program staff, school volunteers, coaches, cafeteria staff, and music teachers. Identification of core team members is an individualized process; each student’s unique daily routine will influence the membership of the core team. In support of a proactive approach to identification, the school should contemplate which employee has responsibility for identifying members of a core team and notifying them of the child’s allergy. Some food allergy plans appoint the school nurse as the “core team captain,” but any school employee, including the primary teacher, could serve in this capacity. Core team membership might change during the year, either permanently or temporarily; school personnel should remain alert that allergy identification
triggers may arise at any point during the semester. The introduction of a substitute teacher into the school day provides one common example of a temporary, yet immediate change in core team membership. Internal processes should accommodate these unanticipated events to ensure new core team members receive timely notification and training.

In summary, effective identification of food-allergic children is a necessary prerequisite to initiating the preventative planning for allergen avoidance. Schools that adopt a proactive approach to identifying food-allergic students and core team members are more likely to ensure early and effective planning. For those schools seeking to improve early identification of food-allergic students, the National School Boards Association food allergy guide recommends utilizing multiple approaches including registration forms, health history forms, and even newsletters. More importantly, the initial reporting of an allergy should automatically trigger the formation of the core team for purposes of collaborative planning and training.

**B. Allergen Avoidance: Preventative Strategies**

Allergen avoidance, the first of the twin goals in allergy management, is the only medical protocol for preventing an allergic reaction. The medical community emphasizes a preference for proactively preventing reactions, rather than reactively administering treatment. All too often, schools miss the opportunity to institutionalize broad based allergen avoidance measures. When allergen avoidance is addressed in isolated fashion (as it often is), the school-wide environment likely retains numerous risks for accidental allergen exposure (e.g. buses, athletic events, field trips, art projects). Missed opportunities may also be a result of an overly individualized definition of the student’s social existence in the school house; the student does not exist in a physical or social vacuum as he or she interacts with classmates, teachers, coaches, parents, visitors, etc. For this reason, care should be given to the student-in-relationship to the social structure of the school. Integrating

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82 Munoz-Furlong, supra note 70, at 1654.

the core team into the allergy planning process is intended to address this very issue.

Accidental allergen exposures have been linked to a number of factors including cross-contamination and student food sharing practices. Allergens may be introduced into the classroom through food-based art projects, classroom parties and community use of school facilities. Administrators have used a variety of approaches for managing classroom parties. Some teachers send a food allergy alert to all parents, requesting voluntary cooperation in providing allergen free foods. Alternatively, schools may adopt more prescriptive approaches whereby parents are instructed to provide specific food items (and brands). Finally, some administrators have opted for food-free celebrations.

In 2004, Congress passed the Food Allergen Labeling and Consumer Protection Act (FALCPA), which requires food labels to include an allergen warning identifying the existence of one or more of the eight most common food allergens (milk, eggs, fish, shellfish, tree nuts, peanuts, wheat or soybeans). School personnel should be trained that the only approved method for determining allergen contamination is by reading food labels. Visual examination of food will not adequately inform one about the existence of allergens. Even small traces of an allergen can be fatal for highly allergic individuals. Particularly for young children, school personnel should not ask the child to identify the existence of allergens. Young children may not have the ability to read food labels or may lack the maturity to interpret what they are reading.

Although some parents request administrators to implement complete allergen bans and transition the school into an allergen-free environment, others are critical of this approach primarily because “allergen-free” zones are almost impossible to obtain. Claiming that a school is “allergen-free” has the potential to instill an unrealistic and false sense of protection in both the student and school employees, and may lead to a relaxed disposition towards monitoring the student’s environment.

A more realistic approach is to establish “allergen-free” zones, such as peanut-free tables. When creating allergen-free tables, administrators are encouraged to avoid isolating allergic students. Other students (with allergen-free lunches) may dine alongside a food-allergic student. Some schools have worked towards confining food to the lunch room to improve the likelihood

84 Sheetz et al, supra note7, at 156.
85 Munoz-Furlong, supra note 70, at 1657.
87 Munoz-Furlong, supra note 70, at 1654-55.
88 Nowak-Wegrzyn et al., supra note 7, at 794.
that larger sections of the school, such as the classroom, library, auditorium, gym, and playground are allergen-free. Prohibitions against food swapping and utensil sharing limit the possibilities for accidental allergen exposure. Heightened health standards, including consistent hand-washing and cleansing of tables after meals, will help prevent reactions due to cross-contamination. Hand soap and sanitary wipes will generally be sufficient for removing food proteins from the skin, though hand sanitizers are generally not recommended. Although comprehensive allergen avoidance strategies decrease the opportunities for allergen exposure, no amount of preventative planning can completely eliminate the risk of allergic reaction.

C. Recognizing and Treating Allergic Reactions

In the event that an allergic reaction does occur, a student’s health depends on the ability of school personnel to (1) recognize the onset of an allergic reaction and (2) respond with proper treatment. Delayed diagnosis and treatment of anaphylaxis increases the risk of death. In a study of thirteen incidents of anaphylaxis caused by food allergies (in school settings), six of the reactions were fatal and seven were nearly fatal. Of the six fatalities, four did not receive epinephrine within one hour of onset of anaphylaxis. Of the seven children who survived, all but one received treatment within thirty minutes of exposure.

Although effective treatment of student anaphylaxis is highly dependent upon a school’s preparedness to diagnose and treat, much of the existing research on this issue indicates that school personnel lack the training necessary to safeguard student health. A 2012 study of school teachers found that only 13.2% of the public school teachers surveyed could identify all symptoms of an anaphylactic attack, and 26.4% of public school teachers were unable to identify even one symptom of anaphylaxis. The study indicated a lack of formal in-service training, with 71.7% of the teachers

89 See id.
90 Munoz-Furlong, supra note 70, at 1657.
91 Scott H. Sicherer, Todd Mahr & The Section on Allergy and Immunology, Management of Food Allergy in the School Setting, 126 PEDIATRICS 1232, 1236 (2010).
92 See Nowak-Wegrzyn et al., supra note 7, at 790. “While the only available therapy for these children is strict avoidance of the offending foods, accidental reactions are common and occur in up to 50% of food-allergic children despite their best efforts to avoid the offending foods.” Id.
93 Sampson et al., supra note 14, at 382.
94 Id.
95 See Sheetz et al., supra note 7, at 156.
96 Ercan et al., supra note 7, at 429.
responding that they had never been educated on the topic of anaphylaxis. Although nut allergies are the leading cause of food-allergy anaphylaxis, only 7.2% of the teachers identified nuts as a potential trigger of anaphylaxis.

On the issue of treatment, 93.7% of the teachers self-reported a lack of knowledge about the appropriate medication for treating anaphylaxis. The teachers who self-identified as competent to treat anaphylaxis improperly identified antihistamines as the appropriate medication for anaphylaxis. A disturbing revelation was that none of the surveyed teachers were able to identify epinephrine as the medication of choice for anaphylaxis.

Other factors impeding effective treatment include lack of awareness that epinephrine is injected with an auto-injector pen, lack of awareness of the location of an auto-injector pen, failed attempts to administer epinephrine, an adult’s personal preference to wait and allow parents to administer treatment, and even circumstances where the school was never provided with an auto-injector pen.

On the issue of diagnosis, school personnel should not assume students will self-diagnose their own reaction. Young students may not be mature enough to identify their physical condition as symptomatic of an allergic reaction. Rather than announcing that he is suffering from anaphylaxis, a six-year old is more likely to proclaim that he is sick at his stomach or that his mouth feels funny. Furthermore, research shows that up to 25% of food-allergic children experience their first allergic reaction at school, before being diagnosed and receiving training on their condition. To further complicate the diagnosis process, the symptoms and severity of an allergic reaction can vary from student to student, but may also vary by episode for a single student.

97 Id. at 429-30.
98 Id.
99 Id.
100 Id.
101 Id.
102 See id. at 429-31; Morris et al., supra note 8, at 471-72.
103 McIntrye et al., Administration of Epinephrine for Life-Threatening Allergic Reactions in School Settings, 116 PEDIATRICS 1134, 1138 (2005).
D. Diagnosis and Treatment: Key Recommendations for Training School Personnel

When designing a training program, administrators will need to address the following questions: Which school personnel should be designated as trainees? What content should be included in the training? Who should be designated or invited to lead the training session? At what point during the school year should training be provided?

The designated group of “trainees” should certainly include the core team members that were selected during the identification stage. Because some children can experience their first allergic reaction at school (before a core team is ever developed), a plausible argument exists for providing school-wide training. In fact, some administrators have elected to train the student’s classmates in order to strengthen allergen avoidance and improve the odds of diagnosing anaphylaxis.104

The content of the training program should include an overview of food allergies, including the cause and need for preventing allergen exposure; an explanation of the range of potential medical consequences of an allergic reaction, including the severity of anaphylaxis; a description of the symptoms of an allergic reaction, including the difference between a mild reaction and anaphylaxis; protocol for treating allergic reactions, including demonstration of auto-injector pens; the consequences of failing to promptly treat anaphylaxis; and, training on the school’s food allergy management documentation practices and medication storage locations.

Because concerns about personal legal liability might influence an employee’s willingness to administer treatment, the training could incorporate a review of relevant state and federal law on two issues: (a) the legal requirements for complying with the treatment protocol identified in the student’s food allergy plan, and (b) personal legal liability, along with any defenses, in those circumstances where medical treatment was ineffective or improperly administered.

Several studies show that parents have often shouldered the responsibility for training staff on both diagnosis and treatment.105 In a study of Massachusetts schools, one-half of the schools relied on parents for allergy training.106 In a separate study, parents used a variety of techniques to educate teachers and staff, with 35% of the parents distributing written materials and 15% personally training school personnel.107

104 Bugden et al., supra note 81, at 15.
105 See Sheetz et al., supra note 7, at 156.
106 Id.
107 Nowak-Wegrzyn, supra note 7, at 791.
Although active parental involvement aids in the successful management of a student’s food allergy, placing training responsibility on parents creates a potential for education gaps. If the school administrator does not sponsor a school-wide training program, the parents retain the burden of scheduling individual meetings with the core team (if the school has identified a core team). Parents may be tasked with visiting the school on multiple days to accommodate the core team members’ individual schedules and may face extreme burdens in contacting support staff like bus drivers. The more proactive the school acts towards scheduling the training, the less likely a training gap will result.

Even if the school administrator arranges the training session, some parents may lack the communication skills or medical background necessary to deliver an effective training. FARE offers free school-based training materials through its website, but a physician could also be invited to provide in-service training. Parents can supplement the formal training by notifying the core team of the child’s unique allergy history, in terms of previous symptoms and responsiveness to treatment. Finally, administrators should contemplate the timing of food allergy training. Ideally, the training should occur before school begins. Some schools choose to repeat the training at multiple points throughout the school year.

V. SUMMARY

The purpose of this paper was to identify the impact of the ADAAA on school-based food allergy management and to reinforce the need for effective school-based food allergy management practices. The prevalence of food allergy among school-aged children makes food allergy management a relevant concern for school administrators; as previously discussed, the life-threatening potential of student food allergies places a serious burden on all school personnel who may interact with and supervise these students. While numerous medical studies and agencies have made recommendations in this area, schools have been slow and/or reluctant to respond. It is hoped that the issues addressed in this paper will be taken into consideration by school administrators as they oversee the design and implementation of allergen management protocols.