Harbour Schools Partnership

A guiding light for education

Shirwell Community Primary School

Allergy Safety Policy

Date Adopted:	**Jul '26**
Reviewed on:	**Jul '26**
Author/owner:	**Trustees**
Anticipated Review:	**July 27**

Statutory status

This policy is issued to meet the duty on our schools to have, publish and keep under review an allergy safety policy — introduced by section 34 of the Children's Wellbeing and Schools Act 2026, which amends section 100 of the Children and Families Act 2014.

It has regard to the Department for Education's statutory guidance Allergy safety in schools (July 2026), which takes effect on 1 September 2026.

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How to use this policy

This is a shared policy. Harbour Support Services has written it once, on behalf of all our schools, so that thirty-four schools do not write thirty-four versions of the same document. It is ready to adopt as it stands. You do not need to redraft it, reword it, or run it past anyone before using it.

But a shared policy cannot do all the work. The statutory guidance is explicit that arrangements must reflect the circumstances of each school — its buildings, its pupils, its staffing, its day. A policy that told you where to put your adrenaline devices without having seen your site would be worse than useless: it would be wrong, and it would look compliant while being wrong. So, this policy does two things at once, and it is important to be clear about which is which.

What Harbour Support Services has set

Everything in sections 1 to 16 is set for all our schools. It is the shared position of our family of schools on identification, healthcare plans, allergen exposure, training, adrenaline, wellbeing, trips, incident reporting, information sharing and review. It is not a menu. It is not a starting point for local drafting. Adopt it unchanged.

If a section genuinely does not work for your school — not because it is inconvenient but because your circumstances make it unworkable — speak to Harbour Support Services rather than editing the text. Departures from the statutory guidance need a clear and justifiable reason, and that reason needs to be recorded somewhere it can be found later.

What you complete locally

Schedule A, at the end of this policy, is yours. It has five entries. One is a name; the other four are decisions only you can make, because only you can see your site, your rota and your children. Until Schedule A is complete, this policy is not finished and should not be published.

Schedule A entry	What you decide	Support available
A1 — Named allergy safety lead	Which member of your senior leadership team holds allergy safety. It cannot be your catering manager.	See section 4.
A2 — Individual Healthcare Plans	Which children need one, and the plans themselves.	Head guidance 1
A3 — Adrenaline device locations	Where prescribed and spare devices sit on your specific layout.	Head guidance 2
A4 — Training coverage	How you assure yourself trained staff are on site across the whole day.	Head guidance 3
A5 — Trips and visits	How the allergy check is built into your existing trip risk assessments.	Head guidance 4

> **A separate set of resources supports the four decisions**
>
> Sections A2 to A5 each have a short guidance resource written for you rather than for the policy file. They are not policy and they are not statutory text — they are practical support for getting the four decisions right, and they are deliberately held outside this document so that this document stays adoptable and publishable as it is.
>
> The guidance resources are not published on your website. This policy is.

What to do, in order

1. Read this policy through once. It is not long and it will tell you what you are being asked to assure.
2. Name your allergy safety lead (A1). Do this first — the other four entries need an owner.
3. Work through A2 to A5 with your lead, using the four guidance resources.
4. Publish the policy, including your completed Schedule A, on your website, and make it available in hard copy on request. You do not need anyone's approval to do this. The policy is already approved for all our schools, and Schedule A is yours to complete.
5. Tell staff, pupils and parents it exists and what it means for them.
6. Take your completed Schedule A to your local governing body — not for approval, but so they can see your arrangements and challenge them. Allergy risk is held on our risk register centrally; your local governing body monitors it as part of health and safety risk in your school.

> **What we already have running**
>
> Our schools already have allergy awareness training in place and existing arrangements for the supply of adrenaline auto-injectors. This policy formalises and documents what is already running rather than starting from zero. In most schools the work is evidencing and tightening what you do, not building it. Where the guidance asks for something genuinely new, it is flagged in the text.

1. PURPOSE AND STATUS

1.1 Allergy is a medical condition in which the body reacts to substances that are normally harmless — a food, an insect sting, a contact allergen such as nickel or latex, or an airborne allergen such as pollen. Many people with allergy to food or insect stings are at risk of anaphylaxis: a reaction affecting the airway, breathing or circulation, which progresses quickly and can kill.

1.2 Two facts shape everything that follows. Around one in five children and young people with allergy have their first allergic reaction while at their school or setting, which means arrangements built only around children we already know about will fail. And investigations into fatal anaphylaxis show a window of roughly twenty to thirty minutes in which action can prevent death, which means our arrangements have to work in minutes, not in principle.

1.3 This policy sets out how our schools identify people with allergy, reduce the risk of them meeting their allergens, respond when a reaction happens, and make sure that children with allergy are included in the whole of school life rather than managed at its edges.

1.4 Legal status

1.4.1 Section 100 of the Children and Families Act 2014 places a duty on governing bodies to make arrangements for supporting pupils with medical conditions. Section 34 of the Children's Wellbeing and Schools Act 2026 adds a further requirement to have an allergy safety policy, to publish it and to keep it under review, and to have regard to statutory guidance on allergy safety.

1.4.2 "Have regard to" means to take account of the guidance and consider it carefully. A decision not to comply must be supported by a clear or justifiable reason.

1.4.3 Other duties bear on this work: the duty to safeguard and promote welfare under sections 20 and 175 of the Education Act 2002; the employer's duty under section 2 of the Health and Safety at Work etc Act 1974; the Equality Act 2010, under which severe allergy can meet the definition of disability; and the common law duty of care.

1.5 Governance

1.5.1 The Board of Trustees is responsible for this policy in its capacity as the governing body of each of our academies. Under our scheme of delegation, allergy safety sits within the group of safeguarding policies covering support for pupils with medical conditions: Harbour Support Services develops the policy, the Education Standards Committee approves and monitors it, and headteachers implement it. Each school has a named allergy safety lead responsible for implementation in that school.

1.5.2 Our local governing bodies do not adopt this policy, and do not need to. Their role here is the one the scheme already gives them: to monitor health and safety risk in their school and to challenge the headteacher on it. Each local governing body sees its school's completed Schedule A and holds the headteacher to account for the arrangements it records. Oversight of allergy safety sits with the safeguarding link governor in each school and with the safeguarding link trustee at Board level, rather than through a separate allergy role.

1.5.3 Allergy risk is recorded on our risk register, maintained by the trust executive team and reviewed by the Audit and Risk Committee at each meeting. Serious incidents and near misses reach the Education Standards Committee through the termly safeguarding report.

1.6 Review

1.6.1 This policy is reviewed at least annually by Harbour Support Services. It is also reviewed following any serious incident or near miss in any of our schools, where that incident suggests the arrangements may leave someone at risk. Reviews take account of incidents and near misses reported to us and of the lessons drawn

from them. People with allergy — children, young people and staff — are involved in developing and reviewing these arrangements.

2. SCOPE

2.1 This policy covers everyone on our sites: children and young people, staff, and visitors. The measures that keep a child with allergy safe are equally relevant to an adult.

2.2 What is in scope

- Food allergy, including allergy to any of the fourteen regulated allergens and to foods outside that list — any food can cause a reaction.
- Anyone at risk of anaphylaxis, most commonly through allergy to food or to bee or wasp stings, and also to medication and latex.
- Asthma, which in children is usually allergic in nature and which sits alongside allergy throughout this policy. Every child who died of anaphylaxis in the national review period who had a known allergy also had asthma.
- Allergic rhinitis, allergic eye disease and eczema, where treatment or adaptation is needed in school.
- Allergy to animals, where avoidance measures are needed — for example around visits to farms or petting zoos, or animals brought into school.
- Medically recognised sensitivities and triggers which may not meet the clinical definition of allergy but can still cause serious or life-threatening reactions, such as mast cell disorders. Any known trigger with the potential to cause significant harm is identified and managed here.

2.3 What is out of scope

2.3.1 Coeliac disease and food intolerance are not allergy. Coeliac disease is an autoimmune condition, and intolerance is a non-immune reaction; neither can cause anaphylaxis, and neither should be treated as an allergic reaction. Both matter, and both need dietary avoidance and robust cross-contamination control — in the case of coeliac disease, control as strict as that needed for wheat allergy. But they are supported through our medical conditions policy, not this one.

> **Do not let the boundary become a gap**
> The distinction is a filing decision, not a signal that coeliac disease and intolerance matter less. If a child's coeliac disease is being managed as an afterthought because allergy has its own policy and coeliac does not, that is a failure of the arrangements. Check that your medical conditions policy is carrying the weight this policy is not.

3. CHILDREN IN OUR EARLY YEARS PROVISION

3.1 Every one of our schools has a Reception class, and several have nursery provision. This section applies to those children, and it matters because they sit under a different legal regime from the rest of the school.

3.2 The duty in section 100 of the Children and Families Act 2014 expressly excepts "young children" — those from birth until the first of September following their fifth birthday. Those children are covered instead by the statutory framework for the Early Years Foundation Stage. Everything else in this policy still represents how we work with them, and you should apply it. But where the EYFS framework sets a requirement, that requirement governs, and it is expressed as a duty rather than an expectation.

3.3 What the EYFS framework requires

3.3.1 These are requirements, not recommendations. They apply wherever babies and young children are being cared for, including a nursery or Reception class within one of our schools.

- Whenever young children are eating, a member of staff holding a valid paediatric first aid certificate — a full course meeting the criteria in Annex A of the EYFS framework — must be in the room. Not in the building, and not on call. In the room.
- Before a child is admitted, we must obtain information about any special dietary requirements, preferences, food allergies and intolerances, and any special health requirements.
- That information must be shared with all staff involved in preparing and handling food.
- At each mealtime and snack time, it must be clear who is responsible for checking that the food provided meets the requirements for each child.
- We must hold ongoing discussions with parents and, where appropriate, health professionals to develop Individual Healthcare Plans for managing any known allergy and intolerance. That information must be kept up to date and shared with all staff.
- All staff must be aware of the symptoms and treatment of allergy and anaphylaxis, the difference between allergy and intolerance, and the fact that children can develop allergies at any time — particularly during weaning.

3.3.2 Note the second and third of these carefully. For the rest of the school, gathering allergy information at admission is good practice and our own standard. In early years it is a requirement, it must happen before admission, and intolerance is included — even though intolerance is otherwise outside the scope of this policy.

3.4 Where early years differs from the rest of this policy

3.4.1 Two differences are worth naming, because both are easy to get wrong in opposite directions.

3.4.2 The regulations permitting schools to buy spare adrenaline auto-injectors without a prescription apply to schools and not to early years settings. Our nursery and Reception classes are part of our schools, so our spare devices cover those children in the same way as any other. A standalone early years setting could not do this; we can, and we do.

3.4.3 Intolerance is out of scope for this policy and handled through our medical conditions policy — but the EYFS requirement to gather and share information about intolerance before admission applies regardless of which policy the response is filed under. Gather it with the allergy information; act on it through the medical conditions policy.

> **The question worth asking this term**
>
> Take one week of your Reception and nursery timetable and check, for every occasion on which those children eat — snack, lunch, a birthday, a cooking activity — whether a paediatric-first-aid-qualified member of staff was in the room. This is a requirement, it is checkable, and it is the one in this section most likely to fail on a Wednesday when someone is off.

4. ROLES AND RESPONSIBILITIES

Who	What they are responsible for
Board of Trustees, as governing body	Holding this policy; ensuring each school has it, publishes it and reviews it; ensuring oversight arrangements are clear in our scheme of delegation.
Education Standards Committee	Approves this policy and monitors statutory compliance with it, consistent with our scheme of delegation, which places support for pupils with medical conditions among the safeguarding policies in its remit. Receives allergy incidents and near misses through the termly safeguarding report.
Local governing body	Monitors health and safety risk in the school, including allergy risk, and challenges the headteacher on it. Sees the school's completed Schedule A. Local governing bodies do not approve this policy. Under our scheme of delegation, they approve only the collective worship and RE policy and the behaviour policy. Oversight of allergy safety sits with the safeguarding link governor.
Harbour Support Services	Issuing and maintaining this policy; annual review; monitoring adoption, publication and Schedule A completion across our family of schools. Maintaining the arrangements for the supply of adrenaline auto-injectors and the allergy awareness training offer. Collating incidents and near misses across our schools and drawing shared lessons from them.
Headteacher	Completing Schedule A, publishing the policy, and taking Schedule A to the local governing body so they can see and challenge the arrangements. Deciding, in discussion with parents and any relevant healthcare professionals, whether a child's allergy needs an Individual Healthcare Plan or can be managed under our medical conditions policy. Assuring that arrangements work in practice, not just on paper.
Named allergy safety lead	A member of the senior leadership team in each school. Drives implementation of this policy and contributes to or leads its review. This responsibility must not sit with the catering manager. Catering is one part of allergy safety and cannot own the whole.
All staff	Completing annual allergy awareness training; knowing how to check whether someone is on the record of those with known allergy; knowing how to find and use an Allergy or Asthma Action Plan. Recognising anaphylaxis and responding to it. Reducing the risk of exposure in whatever they plan and run. Reporting incidents and near misses.
Catering staff	Providing allergen information; controlling cross-contamination; being available to meet parents to discuss allergen-safe meals; flagging menu substitutions.
Local governing body	Adopting the policy with Schedule A; receiving reports of serious incidents and near misses; holding the school to account for implementation.

Named governor

There is no requirement to have a named governor for allergy safety. Some schools do so as good practice. This is a decision for your local governing body, not something this policy imposes.

5. IDENTIFYING PEOPLE WITH ALLERGY

5.1 Our schools are active in seeking information about allergy rather than waiting for it to arrive. We ask children and young people, their parents, and their previous setting for relevant information: known allergens, whether medication has been prescribed, and copies of any Individual Healthcare Plan or Allergy Action Plan already in place. The child and their parents are always involved in decisions about sharing health information, and any sharing by healthcare professionals follows local data sharing agreements.

5.2 The record

5.2.1 Each school keeps a record of everyone with allergy — their known allergens, whether they carry medication such as an adrenaline device, and whether children and young people have an Individual Healthcare Plan or an Allergy Action Plan. This is held on the school's management information system and is the single point of truth.

5.2.2 It is good practice, and our expectation, that a list of people with known allergy — with current photographs and their known allergens — is kept wherever food is served or handled. That includes food technology, science, craft and art rooms as well as the kitchen and serving area. These lists are kept in areas that only staff can access.

5.3 Timescales

Situation	Arrangements in place by
Child or young person starting at the school	The start of the relevant term
Child or young person joining mid-term	Within two weeks, where it is appropriate for the school to do so
Member of staff	When they commence work
Visitor	Sought in advance of the visit wherever possible
Child already on roll who is newly diagnosed, develops allergy, or whose condition changes	As soon as the school becomes aware — existing arrangements are reviewed, not left to the next cycle

5.4 Staff and visitors

5.4.1 Our schools consider how staff and visitors with allergy are identified and supported. Visitors are asked whether they have an allergy we should know about, particularly if they are likely to be served food.

5.4 Where there is no diagnosis

5.4.1 A child does not need a formal diagnosis for us to act. Symptoms may be newly emerged, or diagnosis may still be under way, or a healthcare professional may have decided that accepting the symptoms is more

appropriate than proceeding to formal diagnosis. In all these cases our schools put arrangements in place based on the best assessment that can be made of the likely risk to the child's health, education and wellbeing, engaging closely with the child and their parents. Assuming a child does not have an allergy because they do not yet have a diagnosis is unacceptable practice.

5.4.2 The order matters. Put arrangements in place first, based on the best assessment you can make, and then seek further advice — not the other way round. Waiting for clinical advice before acting leaves the child unprotected in the meantime, and it is the child without a diagnosis who is most likely to react here for the first time.

5.4.3 Our staff are not expected to make clinical assessments or judgements and should not do so. Advice is sought from school nursing teams, or through the local authority's Designated Medical Officer or Designated Clinical Officer, who may be able to identify and engage relevant specialists. For rare, complex or multi-system conditions, seek advice from clinicians with relevant specialist knowledge. We take the advice of healthcare professionals at face value: it is not for us to insist on a letter from a consultant rather than a GP or a community nurse.

6. INDIVIDUAL HEALTHCARE PLANS

6.1 An Individual Healthcare Plan sets out what needs to be done to support a specific child with their allergy: how, when, and by whom, including in an emergency. It is developed in collaboration with the child and their parents, taking account of any advice from healthcare professionals.

6.2 Who needs one

6.2.1 A child should have an Individual Healthcare Plan if all three of the following apply:

- Their allergy has a functional impact on them in school; and
- They are at risk of harm as a result of their allergy; and
- They require arrangements which are additional to or different from those made generally.

6.2.2 Not every child with an allergy needs one. If the support a child needs would be available to anyone under our normal policies, or if they only needed non-prescription medication which our medical conditions policy would let them carry and take themselves, a plan may not be required. It is for the headteacher to decide, in discussion with parents and any relevant healthcare professionals, whether the allergy can be managed through our medical conditions policy or whether a plan is needed.

> **A quiet allergy still needs a plan**
> A child may need no specific support for long stretches of time. That does not make a plan unnecessary. If anaphylaxis is triggered, the plan is what points staff to the right clinical document and the right emergency response. Frequency of need is not the test; functional impact and risk of harm are.

6.3 What a plan is, and is not

6.3.1 An Individual Healthcare Plan is not a clinical document. It is our description of how the school will respond to the information and advice we have received. The school holds the pen, because the school is responsible for making the arrangements. This does not transfer responsibility for clinical judgement, and it does not make us responsible for healthcare activities that fall to the NHS.

6.3.2 Where a healthcare professional has issued an Allergy Action Plan or Asthma Action Plan, it is attached to the Individual Healthcare Plan — not summarised into it. Copying clinical instructions into our own document risks introducing errors and creating a substitute for the original. The plan refers to the attached document, names the health provider and the professional who issued it and records the review date.

6.3.3 Our schools take advice from healthcare professionals at face value. It is not for us to insist on a letter from a consultant rather than from a GP or community nurse.

6.4 One child, one plan

6.4.1 A single Individual Healthcare Plan covers all supportive arrangements for a child. A child should not have multiple plans covering different conditions.

6.5 Content

6.5.1 Plans use the template at Appendix 1, which follows the structure set out in the statutory guidance. The level of detail depends on the complexity of the child's condition and the support needed; two children with the same condition may need very different plans.

6.6 Review and transition

6.6.1 Plans are live documents, not records of a decision once made. They are reviewed at least annually, and additionally whenever the child's condition changes, whenever new advice or an updated Action Plan is issued by a healthcare professional, after any serious incident or near miss involving that child, and at any transition point within the school. The child and their parents are involved in the review, not only in the drafting.

6.6.2 A plan must always refer to the most recent care plan, action plan and prescribed medication, recording the date and the name of the responsible healthcare professional in each case. A plan pointing at a superseded document is worse than no plan, because it will be followed.

6.6.3 As children get older, they may take increasing responsibility for managing their allergy. Where that is safe, encourage it, involve the child in deciding how far they feel able to go and what support they still need, and amend the plan to match. Across a primary age range this changes more than once.

6.6.4 Where a child moves to a new school, a new plan is drawn up there; the previous plan is shared as part of transition and is a useful guide to the type of arrangements needed, but it is not simply carried across, because the arrangements have to reflect the new setting. Where a child returns from hospital education or alternative provision, including home tuition, work with the local authority and the education provider so that the plan identifies the support the child needs to reintegrate.

7. MINIMISING EXPOSURE TO KNOWN ALLERGENS

7.1 Our schools take reasonable steps to minimise the risk of anyone — child, young person, staff or visitor — coming into contact with their known allergens. This runs across four areas: food we provide, food others bring in, airborne and contact allergens, and the activities we plan.

7.2 We are allergy aware, not nut free

7.2.1 Our schools do not operate "nut free" policies. This is a deliberate position, and it follows the statutory guidance. Nut-free policies create a false sense of security: nuts are one of a number of allergens, all of which can have serious consequences; many foods carry precautionary "may contain" labelling which makes such policies difficult to implement in practice; and any food can cause a reaction. We are an allergy-aware environment. Schools may still discourage particular foods from being brought on site, but the important thing is to remain actively aware of the risk allergens pose, take steps to minimise exposure, and have robust emergency response plans.

7.3 Activities

7.3.1 Staff planning any activity consider the risk of exposure to allergens — in DT, outdoor-learning, science, music and cooking, and where activities involve animals. Children are not prevented from taking part alongside their peers simply because of a risk of contact with an allergen. Where an activity would involve

most children using a material that might contain an allergen affecting one of the group, an alternative is found for the whole group rather than an exclusion arranged for the individual.

7.3.2 Points that catch people out:

- Old food boxes and packaging may contain traces of allergens. Use non-food containers for craft where possible; where junk modelling makes that impossible, check the materials.
- Some products contain wheat flour, including play dough. Substitute wheat-free flour.
- Some glues contain milk, wheat or soya.
- Bird feed may contain nuts and sesame.

7.4 Food provision

7.4.1 Our schools are food businesses when they supply food, and the requirements apply to everything we provide — prepared on site or sourced from a third party, including through breakfast and after-school clubs.

- Food prepacked for direct sale must be labelled with the name of the food, a full ingredients list, and any of the fourteen regulated allergens clearly emphasised within it.
- Non-prepacked food must have information provided about the presence of the fourteen regulated allergens, clear, accurate and easily accessible to pupils and parents.
- Caterers provide allergen information to parents and make it available for the child to check independently. Catering staff are available to meet parents to discuss allergen-safe meals.
- Staff who handle food are taught to read labels for allergens and instructed in preventing cross-contamination: preparing food for children with allergy first, and cleaning preparation areas and utensils carefully with warm soapy water.
- Where menus are substituted at short notice, the needs of children with allergy and the statutory allergen requirements must still be met, and changes highlighted.
- Unlabelled food poses a greater risk than packaged food carrying precautionary labelling. This applies to food used in the classroom as much as food from the kitchen.
- Trading and sharing of food, utensils and containers is not permitted.
- Bottles, drinks and lunch boxes for children with food allergy are clearly labelled with the child's name.
- Where food is brought in by others — birthday treats, cake sales, cultural events — parental engagement and permission are sought in advance. Occasional provision of this kind is unlikely to fall within food information law, but clear allergen information should be provided as good practice.

7.5 Identification at mealtimes

7.5.1 Our schools use at least two robust methods of identifying children with known allergy at mealtimes. What those are depends on the size of the school and the age of the children — a member of staff who checks, coloured lanyards, or photographs with allergen details in the kitchen or serving area.

7.5.2 Children with food allergy are not segregated from their peers at mealtimes. They do not sit at a separate table. They eat alongside their friends with the risks managed around them. Balancing safety and inclusion is the point; a safe child eating alone is not a success.

7.6 Free school meals

7.6.1 Where a pupil is entitled to free school meals, our schools make reasonable adjustments to enable them to access that entitlement. We work with our caterer, the pupil and their family, and any other professionals

involved, to agree what is needed. Reasonable adjustments relating to food are captured through the child's Individual Healthcare Plan.

7.7 Air quality

7.7.1 Air pollutants indoors and outdoors trigger allergy and asthma. Clean air is a core asthma control measure, and every child in the national review period who died of asthma had been exposed to air pollution above World Health Organization guidelines. Our schools consider ventilation and air quality as part of their wider health and safety responsibilities.

8. ALLERGY AWARENESS TRAINING

8.1 All staff present at times when pupils are scheduled to be on site receive allergy awareness training at least annually. That means permanent staff, temporary staff, supply teachers, peripatetic staff, agency workers and regular volunteers. It includes catering staff and anyone who oversees children at breakfast or after-school clubs. It does not extend to contractors with no pupil-facing role — builders, electricians, maintenance personnel.

> **First aid training is not sufficient**
> A first aid qualification does not discharge this requirement. Allergy awareness and emergency response training is a distinct thing with distinct content, set out below.

8.2 Content

8.2 Training ensures all staff:

- Have an awareness of allergy, the risks it poses, how allergic reactions occur and how allergy is managed.
- Understand that allergy includes multiple conditions — food allergy, asthma, eczema, hay fever and others — which can co-exist.
- Understand the difference between food allergy, coeliac disease and food intolerance.
- Know where to find information on allergy triggers.
- Can identify the range of symptoms of allergic reactions.
- Understand and can recognise anaphylaxis.
- Know how to respond in an emergency: calling emergency services and informing parents; locating and administering emergency medication, whether adrenaline for anaphylaxis or a reliever inhaler for an asthma attack; and how to use the device itself, whether prescribed to a named person or one of the school's spare devices.
- Understand the impact allergy can have on a child's wellbeing.
- Understand this policy.
- Know how to check whether someone is on the record of those with known allergy, and how to use an Allergy or Asthma Action Plan.
- Understand their responsibilities in reducing the risk of people with known allergy coming into contact with their allergens.
- Understand how to report an allergic reaction or case of anaphylaxis, whether an incident or a near miss.

8.3 Refresh, induction and cover

8.3.1 Training is refreshed annually. Awareness of this policy forms part of that annual training. New staff receive allergy awareness training as part of induction, before they are responsible for children. Supply and cover staff must have received allergy awareness training; where a supply teacher arrives without it, the school provides a briefing covering recognition of anaphylaxis, the location of adrenaline devices, and how to raise the alarm, before that person takes a class.

8.3.2 Harbour Support Services maintains the training offer and holds the record of completion across our family of schools. Each school is responsible for assuring that its coverage is real — that trained staff are present across the whole of the day rather than in aggregate. Schedule A, entry A4, records how you assure this.

8.4 Drills

8.4.1 It is good practice, and our expectation, that schools run allergy safety drills in the same way as fire drills. A simulated case of anaphylaxis tests how staff actually respond, without risk to anyone. Results are recorded in the same way as an incident or near miss and used to inform review of this policy. Where it is appropriate to involve children — for example where a peer is at high risk of anaphylaxis — the child concerned is involved in planning the drill, so that it supports and reassures them rather than singling them out.

8.5 The limits of training

8.5.1 Training under this policy is allergy awareness and emergency response training. It does not replace separate clinical governance, competency or delegation arrangements where a child needs individual healthcare support beyond our allergy safety arrangements. Where support requires healthcare activity that falls under NHS responsibility, it is arranged through the appropriate legal, clinical governance, training, competency and accountability route.

9. PRESCRIBED ADRENALINE DEVICES

9.1 People at risk of anaphylaxis are usually prescribed adrenaline for self-administration. Two types of device are licensed: the adrenaline auto-injector and a non-injectable nasal adrenaline device. Clinical advice is that people at risk carry two devices at all times, whichever type, because two doses may be needed.

9.2 Access

9.2.1 Our schools ensure children who are prescribed adrenaline devices have rapid access to them at all times — travelling to and from school, in the lunch area, in the playground, on sports fields, and on visits and trips.

- Children are encouraged to keep their devices with them in their school bags, including in primary school, so that they have access when travelling to and from school.
- Where a child cannot keep their devices with them, because of age or other considerations, the devices are stored in an appropriate central location that is unlocked and accessible at all times.
- In anaphylaxis, adrenaline must be administered within five minutes. If a child does not have their own devices on them, the devices must be close enough to be brought to them and used within five minutes. If that cannot be achieved, spare devices are used instead.
- Where a child is prescribed a nasal adrenaline device, but it is not available, the school's spare auto-injectors may be used.
- A copy of the child's Allergy Action Plan is kept with their medication, since it carries the instructions for using it in an emergency.

9.3 Records and routines

9.3.1 Each school records which children have been provided with prescribed adrenaline and an Allergy Action Plan and has arrangements for children and parents to take individually prescribed devices home — for example at the end of the day for the journey home — and for checking that they remain in date.

9.4 Storage

9.4.1 All adrenaline devices, prescribed and spare, are stored at room temperature in line with the manufacturer's guidelines. They are not refrigerated, not left in direct sunlight, and not exposed to extremes of heat. They are not locked away and not kept in an office where access is restricted. Where a school judges that devices pose a risk to children, because auto-injectors contain needles, they are stored out of reach of children — which is not the same as locked away.

9.5 Disposal

9.5.1 A used auto-injector cannot be reused and must be disposed of according to the manufacturer's guidelines. Auto-injectors contain needles and must be separated from general and clinical waste. Used devices can be given to ambulance paramedics on arrival, taken to a pharmacy, or disposed of in a pre-ordered sharps bin for collection by the local council. Devices that expire without being used are disposed of the same way.

10. SPARE ADRENALINE DEVICES

10.1 All our schools stock spare adrenaline auto-injectors of the correct dosage for their pupils. This is not optional in our family of schools. Anaphylaxis is unpredictable, and up to one in five anaphylaxis reactions in schools happen in children with no pre-existing diagnosis of allergy — so spare stock is not a backup for known children, it is the arrangement that covers the child nobody knew about.

10.2 The legal position

10.2.1 The Human Medicines (Amendment) Regulations 2017 permit schools in England to purchase spare auto-injectors without a prescription for emergency use to treat anaphylaxis. The Regulations apply to schools only — not to early years settings or colleges. Currently only auto-injectors may be purchased as spare devices; nasal adrenaline devices may be prescribed to individuals but cannot be stocked as spares.

10.2.2 A spare device is never a replacement for a child's own. Children at risk of anaphylaxis should have their prescribed devices with them and should have access to both of their two prescribed devices at all times.

10.3 What we stock

10.3.1 Harbour Support Services maintains the supply arrangement for our family of schools. Purchase requires a request signed by the headteacher, on headed paper, stating the school's name, the quantity needed, and confirming that the supply is for administering to pupils at the school in an emergency.

School type	Under 6 years (150 micrograms)	Over 6 years (300 micrograms)
Primary school	One pair	One pair
Special school	One pair	One pair
Secondary school	—	One or two pairs — two where the site is large enough that one pair cannot reach everywhere within five minutes

10.3.2 Spare devices are always stocked and stored in pairs, so that if a second dose is needed it is to hand rather than fetched from elsewhere. Where a school operates across more than one site, spare devices of the appropriate dosage are held on each site. Larger sites may need more than one set — for example one near the dining area and another near the playground.

10.4 The five-minute rule

This is the design constraint for your whole site

In anaphylaxis, adrenaline should be administered as soon as possible, and in practice within five minutes. Adrenaline devices must be no more than five minutes away from anywhere they might be needed — measured as the time to bring the device to the person, not the time for the person to reach the device.

Never let someone having anaphylaxis stand or walk. Always bring help and medicine to them.

10.5 Storage and stock control

- Spare devices are readily accessible and not locked away. Accessible at all times, in a safe and central location — reception, the school office or the staff room.
- Stored in pairs.
- Clearly labelled, to avoid confusion with devices prescribed to a named person. Many schools use a clearly marked emergency anaphylaxis kit holding the spare devices, the emergency asthma reliever inhaler and spacer, and instructions for use.
- Checked for expiry on a defined routine, with a named person responsible. Replaced when used or when out of date, with used auto-injectors disposed of safely as sharps.

10.6 Spare asthma inhalers

10.6.1 The Human Medicines Regulations 2012 permit schools to buy an emergency salbutamol reliever inhaler and spacer without a prescription. The legal position differs from spare adrenaline in an important way: an emergency inhaler may only be used for a child who has been prescribed a reliever inhaler, but whose own inhaler is not available, and only where written consent has been obtained. Our schools keep emergency asthma reliever inhalers alongside their spare adrenaline devices.

10.7 Using spare devices

10.7.1 The Regulations permit spare devices to be used for the purpose of saving a life — for example a child presenting for the first time with anaphylaxis due to an unrecognised allergy. Consent is not required for a spare device to be used in an emergency. Our schools obtain advance consent from parents or the young person as good practice, so that consent can be assumed to be in place. But in an emergency, anyone may take reasonable action to save a life without checking whether prior consent has been given, and no one should delay treatment to look.

Staff acting in an emergency are protected

Anyone — staff, volunteer or bystander — may take reasonable action to save a life. The law recognises that rescuers act under extreme pressure, and people who attempt to save a life in good faith are protected even if injury occurs while giving emergency care. This includes administering adrenaline in anaphylaxis.

Mistakes, hesitation and imperfect technique do not amount to serious and wilful misconduct. The expectation is that staff act reasonably to the best of their ability. Staff in our schools should be told this, and told it more than once — hesitation kills, and hesitation is usually about fear of getting it wrong.

11. RECOGNISING AND RESPONDING TO A REACTION

11.1 Mild to moderate reaction

11.1.1 Symptoms not involving airway, breathing or circulation include swollen lips, face or eyes; an itchy or tingling mouth; mild throat tightness; hives or an itchy skin rash; abdominal pain or vomiting; and a sudden change in behaviour.

11.1.2 These can be treated with a non-drowsy oral antihistamine. Telephone the child's parent or emergency contact. Do not leave the child unattended. The child does not normally need to be sent home or to receive urgent medical attention. Observe them in a safe place for at least sixty minutes, because mild reactions can develop into anaphylaxis.

11.2 Anaphylaxis

11.2.1 Anaphylaxis affects airway, breathing or circulation:

	Signs
A — Airway	Swelling in the throat, tongue or upper airways; tightening in the throat; hoarse voice; difficulty swallowing
B — Breathing	Sudden onset wheezing; breathing difficulty; persistent cough; noisy breathing
C — Circulation	Dizziness; feeling faint; sudden sleepiness; tiredness; confusion; pale clammy skin; loss of consciousness

11.2.2 Anaphylaxis can occur without a skin rash or any other mild sign being present. Always consider anaphylaxis in someone with a known food allergy who has sudden difficulty breathing. Giving adrenaline in that situation is very safe and may be lifesaving.

11.2.3 What to do

- Place the person flat with their legs raised. Never let them stand or walk.
- Bring the adrenaline to them — their own prescribed device first, or a spare if theirs is unavailable or misfires.
- Give adrenaline as soon as possible, within five minutes. Do not wait to contact emergency services before administering it.
- Dial 999 and request an ambulance. The operator can give advice over the telephone.
- If there is no improvement after five minutes, give a second dose.
- Follow the child's Allergy Action Plan if they have one.
- Stay with them for at least one hour.
- If in doubt whether the reaction is anaphylaxis, treat for anaphylaxis.

11.3 Food allergy and asthma together

11.3.1 Many food-allergic children also have asthma, and wheeze is a symptom of both asthma and food-induced anaphylaxis. An Allergy Action Plan may instruct staff to give a reliever inhaler after a dose of adrenaline if the person is still wheezing. Never give a reliever inhaler instead of adrenaline to treat anaphylaxis.

11.4 Travel

11.4.1 Children may be at risk of anaphylaxis while travelling to and from school. Where they have been prescribed adrenaline devices, they should carry them at all times, including on the journey.

12. WELLBEING, INCLUSION AND BULLYING

12.1. Many children with allergy become anxious about the risk of exposure and the possibility of anaphylaxis, and that anxiety can be compounded by difficult-to-control asthma or eczema. Our schools are active in providing support — both reassurance that we are taking steps to minimise exposure and reassurance that robust measures are in place if anaphylaxis happens. Being told the arrangements is itself part of the support.

12.2 Bullying

12.2.1 Allergy-related bullying ranges from excluding peers from activities by deliberately using known allergens, to denigrating or mocking the need to avoid them, to threats to force-feed a known allergen. It contributes to higher anxiety among children who may already feel singled out by the very arrangements that keep them safe. Our schools take active measures to prevent it and respond to it and treat it under the school's anti-bullying arrangements as well as this policy.

12.3 Good practice

- Regular communication to children, parents and staff about allergy, sustaining awareness of the severity of the risks.
- Proactive engagement with new joiners with known allergy, setting out our arrangements and the support available.
- Inviting new joiners with allergy to tour the kitchen and canteen and meet the staff, which reduces anxiety and helps catering staff recognise them in the dining hall.
- Allergy champion roles for staff and pupils, and not only within the catering team — a point of contact who can share feedback and support new or anxious children.

12.4 Self-management

12.4.1 Our schools help children understand how to manage their allergy and, in time, take responsibility for it themselves. They are allowed and encouraged to carry their own medication and adrenaline devices where appropriate, or to know where to find them. A child who can self-manage may still need supervision and support.

12.4.2 Decisions about self-management are made individually, in discussion with the child, their parents and, where appropriate, healthcare professionals, taking account of the child's competence, their understanding of their allergy, the level of risk, and safeguarding considerations. The child's safety and best interests come first.

12.5 Peer awareness

12.5.1 Where a child is prescribed adrenaline devices, it may be appropriate for their friends to know how to seek help in an emergency. Any wider awareness or training is considered carefully and discussed with the child and their parents first. It never replaces staff emergency response arrangements — the responsibility stays with adults.

13. TRIPS AND VISITS

13.1 Children with allergy participate in visits and trips. Preventing them from taking part or creating unnecessary barriers to their participation — including by requiring a parent to accompany them — is unacceptable practice.

13.2 Our schools conduct a risk assessment for any child at risk of anaphylaxis taking part in a trip off the premises. This is not a separate document: the allergy check is built into the school's existing trip risk assessment, using the addendum at Appendix 3. Schedule A, entry A5, records how you have done this.

13.2 Requirements for every trip

- Children at risk of anaphylaxis have their own adrenaline devices with them — both of them.
- Staff trained to administer adrenaline are on the trip, and the trip leader knows who they are.
- The Individual Healthcare Plan and any Allergy Action Plan travel with the group.
- Catering requirements and emergency planning are considered early in planning, not in the week before — particularly for sporting events, restaurant or food processing visits, outings and camps.
- Emergency contact details and a plan for summoning help travel with the group.

13.3 Taking spare devices

13.3.1 Schools may consider taking spare adrenaline devices on some trips. This must not leave the school's own premises short of spare devices while pupils are on site. Where a trip would deplete site stock, obtain additional stock rather than choosing between the trip and the school.

14. SERIOUS INCIDENTS AND NEAR MISSES

14.1 Failure to learn lessons from serious incidents and near misses has contributed directly to the deaths of children in schools. This section is the mechanism by which we do not do that.

> **We approach these without blame**
>
> Serious incidents and near misses are approached in a no-blame spirit, seeking to learn lessons and address what the incident exposed. Carelessness, inadvertence or a simple mistake do not amount to serious and wilful misconduct. However good our arrangements, they can never remove the risk: a child with no prior history may react for the first time here. What matters then is the response.
>
> This matters practically. A form that people are frightened of is a form that does not get filled in, and the near miss nobody reported is the incident that happens next term.

14.2 What counts

14.2.1 The distinction matters because it drives what happens next, and both over-reporting and under-reporting cost us.

	Definition	Example
Serious incident	Any event relating directly to allergy in which a person with allergy is harmed or placed at immediate and significant risk of harm — including any situation requiring emergency medication, urgent clinical intervention or attendance by emergency services.	A child suffers anaphylaxis, is given adrenaline as set out in their Allergy Action Plan and is taken to hospital.

	Definition	Example
Near miss	An event relating directly to allergy that did not result in harm but had clear potential to do so — where an error, omission or system failure could reasonably have led to a serious incident had circumstances been only slightly different.	A child is served food containing a known allergen. She queries it. Catering staff confirm the allergen is present and provide an alternative.
Neither	An event which is not a serious incident or a near miss, but from which lessons may still be learned.	A child is exposed to a known allergen through cross-contamination from another child's food and has a mild reaction.

14.2.2 Near misses are as important as incidents. They expose weaknesses in policy, procedure, training or communication without anyone being harmed — which is the only free warning we get.

14.3 Recording

14.3.1 Record as soon as is feasible, using the form at Appendix 2, and record the incident in the school's accident book. The report sets out who was affected; what happened, when and where; why it occurred, so far as is known; how staff and children responded, what was done to support the person, and whether emergency services were called; and how the incident concluded. Reports do not need to be long. Capturing the key facts quickly, while they are fresh, matters more than polish.

14.4 Who the report goes to

14.4.1 The report always goes to your named allergy safety lead. They decide what is to be learned and whether this policy or the child's Individual Healthcare Plan needs to change, and nothing else in this section works if they do not have it.

14.4.2 Parents of a child under sixteen are notified as soon as possible. The report is shared with them, and they are given the opportunity to discuss what happened and to contribute their views to the review of what is learned. The school then tells them what it has learned and what it is doing as a result. This is not a courtesy: parents who are told an incident happened but never told what changed are the parents who complain, and they are right to.

14.4.3 Learning is shared with staff so they can act on it. Records and lessons are shared with Harbour Support Services so that learning travels across our family of schools rather than staying in one building. The Education Standards Committee receives allergy incidents and near misses periodically, through the termly safeguarding report, rather than case by case.

14.5 Reporting is not limited to staff

14.5.1 The impact of exposure to an allergen at school may be delayed and only recognised once the child is home — in some cases days later. Incident reporting therefore cannot rely on staff alone. Children, parents and others such as healthcare professionals may need to report that an incident has happened, and our schools make it clear how they can do so and take what they report seriously.

14.6 Reporting beyond the school

14.6.1 Three external routes may apply, and they are commonly confused.

Route	When it applies	The trap
The healthcare professional	Where the incident or near miss related to the delivery of a care plan or action plan issued by a healthcare professional. Notify them or their team and provide a copy of the report; they may issue further instructions or review the plan.	Being forgotten. The clinician who wrote the plan is often the only person who can tell you the plan was wrong.
Local authority environmental health	Where we act as a food business and there is reason to believe unsafe food — for example food containing an undeclared allergen — has left our immediate control and may pose a risk to consumers.	Isolated, contained events usually need no notification. Food correctly labelled as containing an allergen is not unsafe food. Record and review it as an incident or near miss regardless. If unsure, contact HSS before deciding not to notify.
RIDDOR — the Health and Safety Executive	Only where the incident arose out of or in connection with a work activity and resulted in death, or the person being taken directly to hospital for treatment. The clearest case: a child was given their allergen by a member of staff and suffered harm.	Both directions. Hospital purely as a precaution, with no apparent injury, is not reportable. Nor is a child taken to hospital because of the condition itself — an asthma attack or a seizure — since that did not arise from a work activity. But where we caused the harm, it is reportable, and that is exactly the case people miss.

14.7 Allergy and safeguarding

14.7.1 An incident relating to the management of a child's allergy does not, in itself, warrant a referral to safeguarding partners. Treating every allergy incident as a safeguarding matter is not caution; it is a misuse of a process other children need.

14.7.2 A referral is needed where an incident raises concern that a child may be at increased risk of neglect, abuse or exploitation because of their condition. Two patterns are named in the statutory guidance: where relevant information about a child's allergy is not provided to the school, and where a child is repeatedly sent in without essential medication. Both put the child at risk, and both are about the adults around them rather than the allergy itself. If you are seeing either, that is a conversation with your designated safeguarding lead.

14.8 Wellbeing after an incident

14.8.1 An incident with the potential to put a child's life at risk affects the child, their family, the staff who responded, and the children who witnessed it. Review what happened with the child and their parents, who may reasonably fear the place is not safe, and involve them in reviewing the arrangements made for them. Support the staff involved — give them time to reflect, constructively. Consider how the incident is communicated internally: it is a chance to remind everyone why this policy exists, but the privacy of the child involved comes first.

14.9 Learning

14.9.1 The lead and the staff involved work through the same questions each time.

- Could we reasonably have foreseen an incident of this nature?
- Might it have been avoided through reasonable preventative steps? Which ones?

- Were the circumstances covered by a policy or a plan — this policy, the medical conditions policy, an Individual Healthcare Plan, or a care or action plan?
- If so, was it followed? If it was not, are there training, capability or disciplinary issues to consider?
- Was the policy or plan adequate? If not, what needs to change?
- Should our policies change as a result?

14.9.2 The lead also considers whether the incident indicates that any statutory duty may have been breached, or be at significant risk of breach, and whether there were weaknesses in the design or the delivery of the relevant policy or plan. Where a care plan was involved, the healthcare professional is part of that review. The child and their parents are part of it too.

14.9.3 Not every incident requires a policy to be rewritten. Where the arrangements are sound and were followed, say so and record why. Where a near miss suggests our shared arrangements are wrong, Harbour Support Services reviews this policy rather than waiting for the annual cycle. When the policy is reviewed, all recent incidents and near misses are considered together.

14.10 If a child dies

14.10.1 The death of a child with a medical condition at school is rare and catastrophic, and nobody manages it well from first principles. Two things need to be known in advance.

14.10.2 An unexplained death may be subject to police investigation and a Coroner's inquest. Materials such as residues of food consumed or handled, or samples of fluids, may constitute evidence and may need to be seized and retained. The instinct in that moment is to clear up. Do not. Secure the area and wait to be told.

14.10.3 Contact Harbour Support Services and the CEO immediately; the CEO holds emergency decision-making authority for our schools. Beyond the immediate response, consider how you support the children, the staff, the family and in particular any siblings. Child death reviews are covered by Working together to safeguard children and by the child death review statutory and operational guidance. Child Bereavement UK and the Child Death Helpline can help.

15. INFORMATION SHARING

15.1 Information about a child's allergy is health information, and health information is special category data under UK GDPR. It is highly sensitive and carries additional legal protections. Our schools have a lawful basis to hold, use and share it where necessary to keep a child safe and included in education.

15.2 Necessity is the test in both directions. Staff who need to act must have the information; a plan nobody can find is not a plan. But unnecessary sharing reduces children's confidence in the adults around them and can be embarrassing for children who do not want to be singled out. The lists of children with known allergy kept where food is handled are held in areas accessible to staff only, for this reason.

15.3 Where a parent or child raises confidentiality concerns, the individuals to be entrusted with information about the condition are specified on the Individual Healthcare Plan. The child and their parents are always involved in decisions about sharing health information.

16. UNACCEPTABLE PRACTICE, AWARENESS AND PUBLICATION

16.1 Unacceptable practice

16.1.1 This policy is explicit about what is not acceptable in our schools. The following are unacceptable practice:

- Preventing children from easily accessing their medication, including prescribed adrenaline devices.

- Ignoring the views of the child or their parents or carer.
- Ignoring medical evidence or the opinion and advice of healthcare professionals.
- Assuming that every child with allergy requires the same support.
- Assuming that older children do not require support, even where they are able to take increasing responsibility.
- Assuming that a child does not have an allergy because they do not yet have a diagnosis, for example while medical investigation is under way.
- Sending children home frequently for reasons associated with their allergy or preventing them from staying for normal or extracurricular activities including lunch.
- Sending a child who becomes unwell to the office or medical room without suitable supervision. In an allergic emergency, help must come to the child rather than the other way round.
- Penalising children for an attendance record affected by allergy — including excluding them from rewards for full attendance where absence results from a medical condition or allergy. This is reflected in our attendance arrangements.
- Requiring parents or carers to attend, or making them feel obliged to attend, to administer medication or provide medical support to their child.
- Allowing parents' work or other responsibilities to be affected because the school is failing to support their child's allergy.
- Preventing children from participating, or creating unnecessary barriers to participation, in any aspect of school life including visits and trips — for example by requiring parents to accompany them.

16.2 Awareness

16.2.1 Each school raises awareness of this policy with staff, pupils and parents. All staff are aware of and understand the policy as part of their annual allergy awareness training. Our schools also consider how to raise awareness of allergy safety among children themselves, which matters particularly for countering the risk of bullying.

16.3 Publication

16.3.1 Each school publishes this policy, with its completed Schedule A, on its own website, and makes it available in hard copy on request. It must be readily accessible to parents and staff.

16.4 Inspection

16.4.1 Inspectors will consider allergy safety policies and how well they are implemented. In gathering evidence about the management of safeguarding, inspectors may consider the extent to which leaders have made arrangements to support pupils with medical conditions and have a dedicated allergy safety policy. The phrase that matters there is "how well they are implemented". An adopted policy with an empty Schedule A is not evidence of anything.

16.5 Sources of support

16.5.1 Harbour Support Services is the first point of contact. Beyond us, the British Society for Allergy and Clinical Immunology maintains spareadrenalineinschools.uk with advice for schools, teachers, parents and young people, together with Allergy Action Plans and other resources. The Department of Health and Social Care has published guidance on using emergency adrenaline auto-injectors in schools and on emergency asthma inhalers for use in schools. The Food Standards Agency publishes allergen guidance for food businesses and an allergen checklist widely used in education catering.

SCHEDULE A — LOCAL COMPLETION

This schedule is completed by each school. The policy is not finished and must not be published until it is complete. Head guidance resources 1 to 4 support entries A2 to A5.

School details

School	Shirwell Community Primary School
Headteacher	Miss Kelly McKeague
Date shared with LGB	Sept 2026
Date published on school website	Sept 2026
Date allergy risk added to risk register	
Next review date	Sept 2027

A1 — Named allergy safety lead

A member of the senior leadership team. This must not be the catering manager.

Name	Miss Kelly McKeague
Role	Headteacher
Date appointed	Sept 2026
Named governor, if any	*Optional — not required*

A2 — Individual Healthcare Plans

See Head guidance 1.

Number of children with a plan in place	0
Number of children with allergy without a plan, and why	0
Who completes plans	Lead Administrator
Where plans are held, and how staff access them in an emergency	In the office
Review cycle and next review date	Sept 2027

A3 — Adrenaline device locations

See Head guidance 2. Attach your annotated site plan.

Spare device locations	Main office
Quantity and dosage held at each location	2x 0.15mg and 2x 0.3mg

Where prescribed devices are held for children who cannot carry their own	Main office
Emergency asthma inhaler location	Main office
Who checks expiry dates, and how often	Lead Administrator
Five-minute test: furthest point on site, and time taken	1 minute 3 seconds 03.09.2026
Confirmation that no device is behind a lock, key or code	Confirmed

A4 — Training coverage

See Head guidance 3.

Date of last whole-staff annual training	3rd September 2026
Next refresh due	3rd September 2027
Staff outstanding, and by when	
How breakfast club coverage is assured	N/A
How after-school club coverage is assured	N/A
How supply and cover staff are assured	Supply and cover staff are briefed when they first enter the school – this links with our safeguarding briefing
Date of last allergy safety drill, and what it showed	3rd September 2026

A5 — Trips and visits

See Head guidance 4.

Where the allergy check sits in your existing trip risk assessment	Emergency arrangements Incidents of injuries being exacerbated by absence of First Aid and emergency arrangements
Who signs off the allergy section	Miss Kelly McKeague
How trained staff are confirmed on every trip	Via Evolve
Arrangements for taking spare devices without depleting site stock	Order another device 3rd Sept 2026

Signed — Headteacher	
Signed — Chair of local governing body	
Date	3rd September 2026

APPENDIX 1 — INDIVIDUAL HEALTHCARE PLAN FOR ALLERGY

> **Before you complete this**
>
> This is not a clinical document. Do not summarise or copy across clinical instructions from an Allergy Action Plan or Asthma Action Plan — attach the original and refer to it. Copying introduces errors and creates a substitute for the document that matters.
>
> Complete this with the child and their parents, not for them.

Key information

Name	
Date of birth	
Class / year group	
Photograph	*Attach a current photograph*
Parent / carer names	
Emergency contact details	*In priority order*
Second emergency contact	
Who needs to be aware of this allergy and the support required	
Where confidentiality has been raised: who is entrusted with this information	

The allergy

What allergies does the child have	
Known allergens	*List each one*
Is the child likely to be aware they are having a reaction	
Can they alert others	
Is this a diagnosed or suspected allergy	*A diagnosis is not required for this plan to exist*

Managing the allergy

Care or action plans issued by healthcare professionals	*Attach at Annex B / C*
Prescribed medication	*Record at Annex A*
Can the condition be managed through adjustments to practice	

How far can the child take responsibility for managing their allergy	
Do they require support or monitoring, and what kind	

Impact

Potential impact on health	*What harm might come if the allergy is not managed properly*
Potential impact on learning	
Potential impact on wellbeing	
Any interaction between allergy and SEN	

Arrangements for support

Support or adaptations the school will put in place	
How the risk of exposure to known allergens will be managed	
How food allergy will be managed at meal and snack times	
How the two methods of identification at mealtimes apply to this child	
How educational progress will be maintained where absence or missed learning occurs	*How missed work is communicated and supported; catch-up assistance; expectations about workload on return; support on return, which may include flexibility or part-time attendance*

Visits and trips

Arrangements or adjustments needed to ensure participation	
What must be considered in the trip risk assessment	*Cross-refer to Appendix 3*
Who carries this child's devices off site	

Emergency response

Action Plan issued by a healthcare professional	*Refer to and attach. Do not summarise it here.*
Where no Action Plan exists signs and symptoms indicating an emergency	
What should happen in an emergency	
Who should be contacted	
Where the child's prescribed devices are located	
Where spare adrenaline devices are located	

Review

Issued on	
Issued by	
Last discussed with the child and their parents	
Next review due	

Annex A — Medication

Non-prescription medication

Non-prescription medication the child may need — for example an oral antihistamine	
Is this emergency medication	
Where is it stored	
How and when may the child need access	
Parental consent to administer it	*Yes / No — date given*

Prescription medication

Medication prescribed	
Prescribed by, and when	
Is this emergency medication	

Where is it stored	
How and when may the child need access	
Parental consent to administer this medication	*Yes / No — date given*
Consent to administer adrenaline, including a spare device, in an emergency	*Yes / No — date given*
Consent to use a spare salbutamol reliever inhaler	*Yes / No — date given. Written consent is required for this.*

Annex B — Action plans

Attach any Allergy Action Plan or Asthma Action Plan issued by a healthcare professional.

Plan attached	
Issued by — name and role	
Health provider	
Date issued	
Review date	

Annex C — Care plans

Care plan	
Where the plan can be found	
What staff are responsible for delivering or supporting	
Issued by — name and role	
Date issued	

Signatures

Child or young person	*Where appropriate to their age and understanding*
Parent / carer	
Allergy safety lead	
Headteacher	
Date	

APPENDIX 2 — ALLERGY INCIDENT AND NEAR MISS REPORT

> **Use this form for near misses too**
>
> A near miss is anything that could have caused a reaction but did not — a mislabelled meal caught before it was served, a device found out of date, a child who reached the dining hall without their lanyard. Near misses are free information about where the arrangements are weak. A school reporting no near misses is not a safe school; it is a school that is not looking.
>
> Reports may also come from children, parents or healthcare professionals, not only staff. Some reactions are only recognised once the child is home.

Section 1 — The report

School	
Reference number	
Reported by — name and role	
Is the reporter staff, parent, child, or healthcare professional	
Date and time of report	

Section 2 — The person affected

Name	
Class / year group, or role if staff or visitor	
Known allergies	
Do they have an Individual Healthcare Plan	*Yes / No*
Do they have an Allergy Action Plan	*Yes / No*

Section 3 — What happened

Serious incident, near miss, or neither	*See section 14.1. If neither, still complete this form — there may be lessons.*
Recorded in the accident book	*Yes / No — required*
Date and time	
Location	
Who was present	
Allergen involved, or suspected	
Route of exposure	*Eaten / skin contact / airborne / sting / unknown*

What happened — narrative account	

Section 4 — Response

Symptoms observed	
Did the reaction involve airway, breathing or circulation	*Yes / No*
Was adrenaline given	*Yes / No*
If yes: whose device — prescribed or spare	
Time from first symptom to adrenaline	*The number that matters most on this form*
Was a second dose given	
Was 999 called, and at what time	
Was the person kept flat and still	
Was the person observed for at least 60 minutes	
Was an antihistamine given	
Was a reliever inhaler used	
Outcome	

Section 5 — Notification

Allergy safety lead informed	*Required, always. They decide what is learned and what changes.*
Parents informed — by whom, when, how	*Required, as soon as possible*
Report shared with parents, and opportunity given to discuss it and contribute to the review	*Required*
Parents told what was learned and what is changing	*Required, once the review concludes*
Harbour Support Services informed	*Required*
Healthcare professional informed, with a copy of the report	*Required where the incident related to delivery of a care or action plan*

Food safety notification — considered	*Where we act as a food business and unsafe food may have left our control and could pose a wider risk. Correctly labelled allergen is not unsafe food. If unsure, contact HSS before deciding not to notify.*
RIDDOR — considered	*Reportable only if it arose from a work activity AND caused death or direct hospital treatment. Precautionary hospital visits and reactions caused by the condition itself are not reportable.*
Safeguarding — considered	*Not automatic. Refer only if the incident suggests increased risk of neglect or abuse — e.g. allergy information withheld from us, or a child repeatedly sent in without essential medication.*
Goes into the termly safeguarding report	*Required*

Section 6 — Wellbeing

Support for the person affected	
Support for their family	
Support for children who witnessed it	
Support for staff who responded	

Section 7 — Investigation and learning

Completed by the allergy safety lead with the staff involved, and with the child and their parents. No blame: the purpose is to find what was weak, not who was.

Could we reasonably have foreseen an incident of this nature	
Might it have been avoided by reasonable preventative steps — which	
Were the circumstances covered by a policy or plan — which	
Was it followed	*If not: are there training, capability or disciplinary issues to consider*
Was the policy or plan adequate — if not, what changes	
Should our policies change as a result	*Not every incident needs a policy rewrite. If the arrangements were sound and were followed, say so.*
May any statutory duty have been breached, or be at significant risk of breach	

Views of the child and their parents on the arrangements	
Does the Individual Healthcare Plan need to change	
Does this policy need to change	*If yes, notify Harbour Support Services — this may need review across our family of schools*
Actions, owners and dates	
Date actions reviewed	

Completed by	
Reviewed by — allergy safety lead	
Reviewed by — headteacher	
Date	

APPENDIX 3 — TRIP RISK ASSESSMENT: ALLERGY ADDENDUM

> **This attaches to your existing trip risk assessment**
>
> It is not a standalone document, and it does not replace anything you already do. Attach it to the risk assessment you already complete and sign it off through the same route.
>
> Complete it for any trip where a child at risk of anaphylaxis is taking part. Where no child on the trip is at risk of anaphylaxis, record that fact and the check that established it — that is the whole of your obligation.

Trip details

School	
Trip / visit	
Date	
Destination	
Trip leader	
Number of pupils	
Residential	*Yes / No*

Section 1 — Who is at risk

Has the record of people with known allergy been checked against the participant list	*Yes / No — date checked, by whom*
Children with allergy on this trip	*Name each*
Of those, children at risk of anaphylaxis	*Name each*
Individual Healthcare Plans reviewed for trip-specific arrangements	*Yes / No*
Staff on the trip with allergy	

Section 2 — The destination

Food provided at the destination	*By whom; allergen information obtained in advance*
Allergen information requested and received in writing	*Yes / No / Not applicable*
Eating arrangements	*Where; how allergen-safe food is identified; two methods of identification applied*
Animals, plants or environments posing a risk	*Farms, petting zoos, pollen, insects, latex*

Activities involving food or allergens	*Cooking, craft, science, food processing*
Alternatives arranged for the whole group where needed	*Not an exclusion for the individual*
Distance and time to nearest emergency medical care	
Mobile signal at the destination	*If none, what is the alternative means of calling 999*

Section 3 — What is carried

Each at-risk child's two prescribed devices	*Yes / No — checked in date on the day of departure*
Who physically carries them	*Named person, or the child themselves*
Individual Healthcare Plans and Allergy Action Plans	*Carried with the group*
Prescribed inhalers	
Antihistamine	
Spare adrenaline devices taken	*Yes / No. If yes, confirm site stock is not depleted while pupils are on site — obtain additional stock rather than choosing.*
Emergency contact details for each child	
Devices kept at room temperature in transit	*Not in a hold, not in direct sun, not in a hot coach*

Section 4 — People

Staff on the trip trained in allergy awareness and emergency response	*Name each*
Staff trained to administer adrenaline	*Name each. There must be more than one.*
Does the trip leader know who they are	*Yes / No*
Do all adults on the trip, including volunteers, know which children are at risk	*Consistent with the confidentiality arrangements on the plan*
Coach or transport staff briefed where relevant	

Section 5 — Emergency plan off site

Who administers adrenaline	*Primary and backup*
Who calls 999	
How the location is given to the ambulance service	*Address, grid reference or what3words — established before departure*
Who stays with the child	*For at least one hour*
Who supervises the rest of the group	
Who contacts parents	
Who contacts the school	
Where the second dose is	
Residential only: overnight arrangements and device location	
Residential only: who holds devices at night	

Section 6 — Sign-off

Completed by — trip leader	
Reviewed by — allergy safety lead	*Required*
Approved by — headteacher	*Required where any child on the trip is at risk of anaphylaxis*
Date approved	
Attached to trip risk assessment reference	

> **After the trip**
> If anything went wrong, or nearly went wrong, complete Appendix 2. Trips are where arrangements that work in a building stop working, and that is exactly the learning worth capturing.