Date of Hearing: April 10, 2024

ASSEMBLY COMMITTEE ON EDUCATION
Al Muratsuchi, Chair
AB 2317 (Stephanie Nguyen) – As Amended March 20, 2024

[This bill was double referred to the Assembly Human Services Committee and was heard by that Committee as it relates to issues under its jurisdiction.]

SUBJECT: Child day care facilities: anaphylactic policy

SUMMARY: Requires by July 1, 2027, the State Department of Social Services (DSS) to establish an anaphylactic policy that sets guidelines and procedures to be followed by child daycare personnel to prevent a child from suffering from anaphylaxis and to be used during a medical emergency resulting from anaphylaxis, and authorizes a child daycare facility to implement the anaphylactic policy by January 1, 2028, and to notify the parent or guardian of a policy upon enrollment of their child. Specifically, **this bill**:

1) Requires the DSS to, on or before July 1, 2027, in consultation with the California Department of Education (CDE) to establish an anaphylactic policy that sets guidelines and procedures to be followed by childcare personnel to prevent a child from suffering anaphylaxis and to be used during a medical emergency caused by anaphylaxis.

2) Authorizes, but does not require, a childcare center to implement the anaphylactic policy developed by the DSS as of January 1, 2028.

3) Requires, if the childcare center has adopted an anaphylactic policy, the childcare provider to notify the parents or guardians of children upon their enrollment in the program and annually thereafter of the anaphylactic policy and include contact information for the parent or guardian to engage further with the provider to learn more about the policy.

4) Requires the policy to be developed by the DSS to include consultation with representatives of all of the following:

    a) Pediatric physicians and other health care providers with expertise in treating children with anaphylaxis;

    b) Parents of children with life-threatening allergies;

    c) Childcare center administrators and personnel; and

    d) Not-for-profit corporations that represent allergic individuals at risk for anaphylaxis.

5) Requires the DSS, in developing the policy, to consider existing requirements and current and best practices for childcare providers on allergies and anaphylaxis, as well as voluntary guidelines issued by the United States Department of Health and Human Services for managing food allergies in childcare facilities.

6) Requires the anaphylactic policy to include all of the following:

a) A process for childcare center providers to solicit volunteers among its employees to be trained to administer epinephrine auto-injectors to a child having an anaphylactic reaction and authorize volunteers to administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis at a childcare center during operating hours;

b) A procedure and treatment plan, including emergency protocols and responsibilities, for childcare personnel responding to a child suffering from anaphylaxis, and a requirement that personnel have access to an undesignated stock of an appropriate weight-based dosage of epinephrine auto-injector in a secure place at the site, and to carry and administer it to a child believed in good faith to be having an anaphylactic reaction;

c) A requirement that a parent or guardian sign a document acknowledging an understanding of the protections provided for individuals who provide emergency medical or nonmedical care without compensation and the Good Samaritan Law;

d) A training course for childcare center personnel to include all of the following:

   i) Techniques for preventing, recognizing the symptoms of, and responding to anaphylaxis;

   ii) Standards and procedures for the storage, restocking, and emergency use of epinephrine auto-injectors;

   iii) Emergency follow-up procedures, including calling the emergency 911 telephone number and contacting, if possible, the child's parent and health care provider; and

   iv) Written materials covering the information required by this subparagraph.

e) A requirement that the training course be provided at no cost to the employee during their working hours;

f) A requirement that DSS consider the feasibility of developing the training course in languages other than English, and whether the training may be effectively provided through online instruction to meet the needs of providers;

g) Appropriate guidelines for each childcare facility to develop an individual emergency health care plan for children with a food or other allergy that could result in anaphylaxis; and

h) A communications plan for discussion with children that have developed adequate verbal communication and comprehension skills, and the parents or guardians of all children, about foods that are safe and unsafe and strategies to avoid exposure to unsafe foods.

7) Requires the DSS to create informational materials in multiple languages as required by federal and state law, detailing the anaphylactic policy developed, and requires by September 1, 2027, the DSS and the CDE to post the informational materials on their respective websites.

8) Requires an anaphylactic policy for family childcare providers to be developed in consultation and coordination with the Joint Labor Management Committee established by the state and Child Care Providers United (CCPU) pursuant to the agreement between the state and the CCPU; requires that training on the policy be provided by the DSS's Community Care Licensing Division (CCLD) in consultation with CCPU for all family childcare providers who wish to participate regardless of union status; and requires the CCLD to review minimum standards of training for the administration of epinephrine auto-injectors; and requires that training be consistent with the most recent Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs published by the federal Centers for Disease Control and Prevention (CDC);

9) Prohibits these provisions from being construed to preempt, modify, or amend a childcare provider's requirement to comply with existing federal and state disability laws or the requirements of a child's individualized family service plan (IFSP) or individualized education program (IEP).

10) Defines the following terms for purposes of this measure:

    a) "Anaphylaxis" as a potentially life-threatening hypersensitivity to a substance;

    b) "Epinephrine auto-injector" as a disposable delivery device designed for the automatic injection of a premeasured dose of epinephrine into the human body to prevent or treat a life-threatening allergic reaction; and

    c) "Volunteer" or "trained personnel" as an employee who has volunteered to administer epinephrine auto-injectors to a person suffering, or reasonably believed to be suffering, from anaphylaxis, has been designated by a childcare center or family daycare home and has received training, as specified.

EXISTING LAW:

1) Requires the governing board of any school district to give diligent care to the health and physical development of pupils, which may include employing properly certified persons for the work. (Education Code (EC) Section 49400)

2) Establishes the "California Child Day Care Facilities Act," creating a separate licensing category for child daycare centers and family daycare homes within DSS's existing licensing structure. (Health and Safety Code (HSC) 1596.70)

3) Defines "child daycare facility" to mean a facility that provides nonmedical care to children under 18 years of age, as specified, including daycare centers, employer-sponsored childcare centers, and family daycare homes. (HSC 1596.750)

4) Requires child daycare centers to obtain a written medical assessment of the child within 30 calendar days following the enrollment of a child that cannot be older than one year. Further requires the medical assessment to provide the following:

    a) A record of any infectious or contagious disease that would preclude care of the child by the licensee;

b) Results of a test for tuberculosis;

c) Identification of the child's special problems and needs;

d) Identification of any prescribed medications being taken by the child;

e) Ambulatory status; and,

f) Health information, such as dietary restrictions and allergies, instructions for action to be taken in case the child's authorized representative, or the physician designated by the authorized representative, cannot be reached in an emergency; and a signed consent form for emergency medical treatment unless the child's authorized representative has signed a statement. (22 California Code of Regulations (CCR) 101221(b)(8); 22 (CCR) 101220; HSC 1597.05)

5) Requires a child not to be served any food to which the child's record indicates a known allergy. (22 CCR § 101227(a)(7)(B))

6) Requires a school district, county office of education (COE), and charter school to provide emergency epinephrine auto-injectors to school nurses or trained volunteers, and allows those individuals to utilize epinephrine auto-injectors to provide emergency medical aid to persons suffering from an anaphylactic reaction. (EC 49414)

7) Authorizes each public and private elementary and secondary school in the state to voluntarily determine, as specified, whether or not to make emergency epinephrine auto-injectors and trained personnel available at its school. (EC 49414)

8) Permits each public and private school to designate one or more volunteers to receive initial and annual refresher training, based on specified standards, regarding the storage and emergency use of an epinephrine auto-injector from the school nurse or other qualified person designated by an authorizing physician or surgeon. (EC 49414)

9) Requires a school nurse, or if the school does not have a school nurse or the school nurse is not onsite or available, a school administrator, to obtain from the school district physician, the medical director of the local health department, or the local emergency medical services director a prescription for epinephrine auto-injectors. (EC 49414)

10) Requires the Superintendent of Public Instruction (SPI) to review, every five years, or sooner, standards of training for the administration of epinephrine auto-injectors by consulting with organizations and providers with expertise in administering epinephrine auto-injectors and administering medication in a school environment. (EC 49414)

11) Sets minimum requirements for the training described above, requiring certain topics about anaphylaxis and procedures for rendering emergency treatment to be included in the training, and for the training to be consistent with guidelines of the CDC. (EC 49414)

12) Requires a school district, COE, or charter school to ensure that each employee who volunteers be provided defense and indemnification by the school district, COE, or charter school for any and all civil liability, as specified, and requires that this information be provided in writing and retained in the volunteer's personnel file. (EC 49414)

13) Defines "volunteer" and "trained personnel" for purposes of this section as an employee who has volunteered to administer epinephrine auto-injectors to a person suffering, or reasonably believed to be suffering, from anaphylaxis and who has been designated by a school and has received training. (EC 49414)

10) Requires the United States Secretary of Health and Human Services, in consultation with the United States Secretary of Education, to develop guidelines to be used on a voluntary basis to develop plans for individuals to manage the risk of food allergy and anaphylaxis in schools and early childhood education programs and make such guidelines available to LEAs, schools, early childhood education programs, and other interested entities and individuals, to be implemented on a voluntary basis only. (Section 112 of the Food and Drug Administration (FDA) Food Safety Modernization Act, 2011.12)

11) Requires school districts to provide a free appropriate public education to each qualified person with a disability who is in the school district's jurisdiction, regardless of the nature or severity of the person's disability, which includes reasonable accommodations required for the management of chronic medical conditions. (Section 504 of the Rehabilitation Act of 1973)

12) Prohibits discrimination by a daycare center or educational entity when admitting a child with disabilities into the program. (Title III of the Americans with Disabilities Act of 1990 (42 U.S.C. 12181 et seq.))

FISCAL EFFECT: Unknown

COMMENTS:

Need for the bill. According to the author, "AB 2317 will increase awareness for the signs and symptoms, among daycare settings, of this potentially life-threatening allergic reaction. Anaphylaxis is a concern in daycare settings as the rate of anaphylaxis is higher in children ages 0-to-4 than in any other age group. Furthermore, California health claims data points to a rise in anaphylaxis over the past 15 years (approximately 316%) which has led to an average of one in five children with a food allergy reporting one or more allergy-related emergency room visits in the previous year.

AB 2317 is otherwise known as Elijah's Law (passed in the state of New York in 2019) in tribute to Elijah Silvera who suffered with milk allergies and unfortunately lost his life due to anaphylaxis while under the care of daycare provider who fed him a cheese sandwich. Enacting Elijah's Law in California will help to ensure daycare providers are further equipped to: prevent possibly life-threatening allergic reactions due to food or venom allergies; recognize the signs and symptoms of anaphylaxis; and, treat anaphylaxis by utilizing an appropriate weight-based dosage of epinephrine.

To ensure the health and well-being of the 976,000 California children cared for in the approximately 13,000 daycare settings throughout the state, we should enact AB 2317."

What is anaphylaxis? According to the Mayo Clinic, allergies take place when an individual's immune system reacts to a foreign substance, produces antibodies to identify a particular allergen as harmful, and responds to the allergy, which can then manifest in the skin, digestive system, or airways. Anaphylaxis occurs when a person is exposed to something that they are allergic to, and

it causes a severe, potentially life-threatening reaction to the allergy. This type of reaction can cause an individual to go into shock, a sudden drop in blood pressure, and swelling of the airway, which blocks breathing. Anaphylaxis requires administration of epinephrine and a follow-up trip to the emergency room. The onset of symptoms usually occurs within minutes but can be delayed up to 30 minutes and, although rare, even hours after exposure. Nationally, pediatric emergency room visits for children with anaphylaxis increased from 5.7 to 11.7 per 10,000 visits from 2009 to 2013. (Farbman, 2016)

What is a food allergy? According to the CDC, a food allergy is defined as an adverse health effect arising from a specific immune response that occurs upon exposure to a given food. The immune response can be severe and life-threatening. Although the immune system normally protects people from germs, in people with food allergies, the immune system mistakenly responds to food as if it were harmful. One way that the immune system causes food allergies is by making a protein antibody called immunoglobulin E (IgE) in response to the ingested food. The substance in foods that causes this reaction is called a food allergen. When exposed to the food allergen, the IgE antibodies alert cells to release powerful substances, such as histamine, that cause symptoms that can affect the respiratory system, gastrointestinal tract, skin, or cardiovascular system and lead to a life-threatening reaction called anaphylaxis.

Incidence of severe food allergy among children and youth. According to the Asthma and Allergy Foundation of America, approximately 5.6 million children, or 7.6% have food allergies. In 2018, 4.8 million children under 18 years of age had food allergies over the previous 12 months. Foods are the leading cause of anaphylaxis in children. Milk is the most common allergen for children, followed by eggs and peanuts. (Gupta, 2018)

An international study of food allergies concluded that the best available evidence indicates that food allergies have increased in many westernized countries. (Tang, 2016) According to the CDC, food allergies among children increased by 50% between 1997 and 2011. Today, one in 13 children has food allergies, and nearly 40% of these children have already experienced a severe allergic reaction. Many of these reactions happen at school.

Anaphylaxis can develop in students with known allergies, but first-time reactions on school premises are possible as well. Safety measures at schools include allergen avoidance, staff training to identify the signs and symptoms of anaphylaxis, and availability of epinephrine auto-injectors to allow prompt initiation of treatment. Collaboration between the caregiver, physician, school staff, school nurse, and student is critical for effective care of those at risk for anaphylaxis in the school setting. (Ramsey, 2020)

Epinephrine auto-injectors. An epinephrine auto-injector (commonly called an "epi-pen" because its size and shape is similar to a writing pen) is a disposable medical drug delivery device that delivers a single measured dose of epinephrine, most frequently for the treatment of acute allergic reactions to avoid or treat the onset of anaphylactic shock. Anaphylactic shock can quickly cause death if untreated. Epinephrine auto-injectors can be obtained by prescription only.

California law has been amended to, among other things, permit school districts or COEs to provide emergency epinephrine auto-injectors to trained personnel, and to permit trained personnel to utilize the auto-injectors to provide emergency medical aid to persons suffering from an anaphylactic reaction.

California's childcare system. California has a multifaceted system of licensed childcare programs. The Early Childhood Development Act of 2020 authorized the transfer of most childcare programs to the DSS from the CDE effective July 1, 2021. The CDE continues to operate the California State Preschool Program (CSPP), which is administered through local educational agencies (LEAs), colleges, community-action agencies, and private nonprofit agencies. CSPP serves eligible children ages three and four for both part-day and full-day services and is the largest state-funded preschool program in the nation.

Under DSS, California offers multiple types of subsidized childcare and development programs: voucher-based childcare, direct contracts – Title 5 subsidized childcare, and the California Head State Collaboration Office. Childcare may be offered through these programs at a childcare center or in a family childcare home.

DSS's CCLD has the responsibility of licensing and monitoring the state's 12,768 daycare centers, which have a capacity to serve 663,454 children. There are an additional 2,201 licensed school-age daycare facilities with a capacity to serve 139,610 children.

Childcare Licensing Regulations on Anaphylaxis. Anaphylaxis poses a significant risk to children attending childcare facilities, particularly those with known allergies. State law and regulations provide guidance for anaphylaxis in K-12 schools, but not for childcare providers. Childcare centers are required to obtain a written medical assessment of the child within 30 calendar days after enrollment and cannot be older than one year. This assessment includes various health information, such as dietary restrictions and allergies, as well as instructions for handling emergencies when the child's authorized representative cannot be reached. Additionally, a signed consent form for emergency treatment must be included unless the child's authorized representative has signed a statement. One regulation in the CCR also requires that a child with a documented allergy must not be served any food known to trigger anaphylaxis. However, there are no further regulations regarding anaphylaxis prevention for both childcare centers and family daycare homes. This indicates each childcare facility adopts its own practices related to allergen identification, prevention strategies, emergency response procedures, and communication protocols with parents or guardians, further signifying a lack of consistency among childcare facilities. Based on current regulations, many childcare facilities may rely on ad hoc measures for children with unknown allergies and on individual plans for those who have known allergies rather than standardized policies endorsed by regulations or established best practices. ***The Committee may wish to consider that*** because this bill is permissive and allows childcare facilities to opt out of implementing the anaphylactic policy, ad hoc measures for treating anaphylactic reactions may persist.

Additionally, current regulations require at least one director or teacher at each childcare facility to have at least 15 hours of health and safety training and, if applicable, at least one additional hour of childhood nutrition training as part of the preventative health practices course. Topics in the training include pediatric first aid, pediatric cardiopulmonary resuscitation (CPR), and a preventative health practices course. This course includes instruction in identifying, managing, and preventing infectious disease, including immunizations, and preventing childhood injuries. Training may also include instruction in sanitary food handling, emergency preparedness and evacuation, and caring for children with special needs. However, the training does not include any topics addressing anaphylaxis prevention for both childcare centers and family daycare homes. Without appropriate policies and procedures in place, daycare personnel may lack the necessary training and resources to prevent and mitigate anaphylactic reactions effectively,

which can lead to delays in treatment, increased risk of adverse outcomes, and potential legal liabilities for daycare centers.

For childcare facilities that choose to adopt the anaphylactic policy, this bill requires a parent or guardian to demonstrate an understanding of the protections provided for individuals who provide emergency medical or nonmedical care without compensation by signing a document acknowledging the Good Samaritan law enumerated in statute.

Licensed childcare facilities are subject to federal and state disability laws. According to the DSS guidance, *Best practices related to the provision of incidental medical services (IMS) in childcare centers and family childcare homes,* posted on February 4th, 2022, licensed childcare centers and providers are places of public accommodation and are subject to federal and state disability laws including the Americans with Disabilities Act (ADA), the California Unruh Civil Rights Act, and the California Disabled Persons Act. Child daycare providers of children with disabilities who have an IEP for children 3 years of age and older, or an IFSP for children from birth to 36 months of age, are required to provide modifications for children with disabilities. Licensed childcare centers and providers are responsible for ensuring that each child's needs can be met when the child is admitted into their care and throughout their attendance at that facility. Childcare providers may be required to undertake an individualized assessment if the provider receives a request to provide IMS which is the administration of medication to a child, as an accommodation for a child with disabilities.

Section 504 of the 1973 Rehabilitation Act applies to schools and programs that receive federal money and entitles students to accommodations for a wide range of health conditions, including a life-threatening food allergy. The U.S. Department of Education's Office for Civil Rights lists allergy as an example of a hidden disability for the purpose of Section 504 and further explains how a food allergy, for many children, would be considered a disability under 504. Protections under Section 504 have been reinforced by the Americans with Disabilities Act of 1990 (ADA) and the ADA Amendments Act of 2008.

As stated in the DSS provider information notice, *Best practices*, state law permits IMS in childcare centers and family childcare homes in the case of emergency, including the administration of an epinephrine auto-injector to prevent or treat a life-threatening allergic reaction. Although DSS clearly states that childcare providers permits IMS in the case of administering an epinephrine auto-injector to treat an allergic reaction, it is not explicitly required in state law.

Arguments in support. The Elijah Alavi Foundation, sponsor of the bill writes, "Born in the wake of Elijah-Alavi Silvera's untimely passing due to an anaphylactic reaction, our foundation channels our profound loss into a fervent crusade for change. We are the vanguard of advocacy, relentlessly pushing for pivotal legislation that fortifies the defenses of childcare environments against the silent threat of food allergies. Through comprehensive education, we empower communities with the knowledge to identify, understand, and act against the risks associated with food allergies. Our hands-on training initiatives equip caregivers and institutions with the life-saving skills and protocols necessary to ensure no child's laughter is stifled by preventable tragedy. Supporting AB 2317 means you're not just voting for a bill; you're endorsing a shield that guards our little ones against a threat that can take them from us in a matter of minutes. You're helping providing peace of mind to parents who will rest a little easier, knowing their child is in safe hands."

Related legislation. AB 2714 (Wallis) of the 2023-24 Session would replace references to "emergency epinephrine auto-injectors" with "emergency epinephrine delivery systems" in referring to the authority of schools to store the medication, to have trained volunteers available to administer it to students suffering from anaphylaxis, and for students to carry and self-administer the medication.

AB 1651 (Sanchez) Chapter 588, Statutes of 2023, extends the definition of "volunteer" and "trained personnel" to include the holder of an Activity Supervisor Clearance Certificate (ASCC) who may administer an emergency epinephrine auto-injector, as specified, and requires an LEA, COE, and a charter school to store epinephrine auto-injectors in an accessible location upon the need for emergency use.

AB 2042 (Villapudua) of the 2021-22 Session would have required the DSS, in consultation with the CDE, to establish an anaphylactic policy that sets forth guidelines and procedures recommended for child daycare personnel to prevent a child from suffering from anaphylaxis and to be used during a medical emergency resulting from anaphylaxis. This bill was vetoed by the Governor with the following message:

> It is important for all children in a childcare setting to be cared for by staff who are trained to assist with their unique needs, including being able to recognize and respond to symptoms of anaphylaxis. While I appreciate the author's attention to this important matter, the bill before me creates a number of implementation concerns, including establishing multiple processes and expanding the memorandum of understanding between the State and the CCPU.
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> I encourage the Legislature to work with the Department of Social Services and the Emergency Medical Services Authority, who have the expertise to develop health and safety standards, on a workable alternative that is uniform and addresses these issues.

AB 2640 (Valladares) Chapter 794, Statutes of 2022 requires the CDE to create the "California Food Allergy Resource Guide" for voluntary use by LEAs to protect pupils with food allergies within schools and early education centers.

AB 3342 (Bauer-Kahan) of the 2019-20 Session would have required the DSS to authorize child daycare facilities to keep emergency epinephrine auto-injectors onsite to be administered by trained, volunteer personnel to provide emergency medical aid to a person who is suffering, or reasonably believed to be suffering, from an anaphylactic reaction; would also have required the DSS to develop a training program for the participating personnel, which would include components, including, but not limited to, techniques for recognizing symptoms of anaphylaxis and emergency follow-up procedures. This bill was held in the Assembly Human Services Committee.

AB 1386 (Low) Chapter 374, Statutes of 2016, permits a pharmacy to furnish epinephrine auto-injectors to an authorized entity if they are furnished exclusively for use at or in connection with an authorized entity; an authorized health care provider provides a prescription; and, the records are maintained by the authorized entity for three years. Specifies that authorized entities include, but are not limited to, daycare facilities, colleges and universities, summer and day camps, sports leagues, scout troops, before and after school programs, recreational parks and other places where children and adults could come into contact with potentially life-threatening allergens.

SB 738 (Huff) Chapter 132, Statutes of 2015, provides qualified immunity to physicians who issue prescriptions for epinephrine auto-injectors to school districts for emergency use on individuals afflicted with anaphylactic reaction.

SB 1266 (Huff) Chapter 321, Statutes of 2014, requires school districts, COEs, and charter schools to provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered. Authorizes school nurses or trained personnel to use the epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction.

REGISTERED SUPPORT / OPPOSITION:

Support

Association of Regional Center Agencies
Asthma and Allergy Foundation of America
California Society for Respiratory Care
Elijah-Alavi Foundation
Food Allergy and Research Education
Natalie Giorgi Sunshine Foundation
National Association of Pediatric Nurse Practitioner
No Nut Traveler
8 individuals

Opposition

None on file

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