Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HUMAN SERVICES
Alex Lee, Chair
AB 2317 (Stephanie Nguyen) – As Amended March 20, 2024

SUBJECT: Child day care facilities: anaphylactic policy

SUMMARY: Requires the California Department of Social Services (CDSS), in consultation with the California Department of Education (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. Specifically, **this bill**:

1) Requires CDSS, on or before July 1, 2027, and in consultation with 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.

2) Permits a child daycare facility to implement the anaphylactic policy developed by CDSS on or before January 1, 2028.

3) Upon enrollment of a child at a child daycare facility, requires the child daycare provider on and after January 1, 2028, and annually thereafter, to notify the parent or guardian of the anaphylactic policy if the facility has adopted a policy. Requires the notice to include contact information for a parent or guardian to engage further with the child daycare provider to learn more about the policy.

4) Requires the policy to be developed in consultation with representatives from all of the following:

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

    b) Parents of children with life-threatening allergies;

    c) Child daycare administrators and personnel, including local educational agency employees employed in childcare programs, and the labor organizations representing those employees; and,

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

5) In developing the policy, requires CDSS to consider existing requirements and current and best practices for child daycare providers on allergies and anaphylaxis. Further requires CDSS to consider any voluntary guidelines issued by the United States Department of Health and Human Services for managing food allergies in child daycare facilities.

6) Requires an anaphylactic policy for family childcare providers to be developed in consultation and coordination with the Joint Labor Management Committee (JLMC)

established by the state and Child Care Providers United - California (CCPU) pursuant to the agreement effective July 26, 2021, to July 1, 2023, between the state and CCPU.

7) Requires training on the anaphylactic policy be provided by CDSS' Community Care Licensing Division (CCLD) in consultation with CCPU pursuant to that agreement, and any extension or renewal of that agreement, for all family childcare providers who wish to participate, regardless of union status.

8) Requires CDSS' CCLD to review minimum standards of training for the administration of epinephrine auto-injectors, as necessary. Requires training to 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) Requires the anaphylactic policy to include all of the following:

    a) A process for a child daycare facility to solicit volunteers among its employees to be trained and to administer epinephrine auto-injectors to a child having an anaphylactic reaction. Permits a volunteer to administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis at a child daycare facility during operating hours. Requires the process to solicit volunteers to include a statement that there shall be no retaliation against any employee who chooses not to volunteer or who rescinds their offer to volunteer, including after receiving training;

    b) A procedure and treatment plan, including emergency protocols and responsibilities, for child daycare personnel responding to a child suffering from anaphylaxis;

    c) Requires the procedure and treatment plan to include the capacity for trained personnel to have access to an undesignated stock of an appropriate weight-based dosage epinephrine auto-injector in a secured place at the site and to carry and administer it to a child believed in good faith to be having an anaphylactic reaction;

    d) 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 existing law;

    e) Requires a training course for child daycare 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 healthcare provider; and,

        iv) Written materials covering the information required under this subdivision.

f) Requires the training course to be provided at no cost to the employee during their regular working hours. Further requires CDSS to consider the feasibility of developing the training course in languages other than English to meet the needs of providers and to consider whether the training may be effectively provided through online instruction;

g) Appropriate guidelines for each child daycare facility to develop an individual emergency healthcare plan for children with a food or other allergy that could result in anaphylaxis;

h) A communication plan for dissemination of information by CDSS regarding children with food or other allergy that could result in anaphylaxis, including a discussion of methods, treatments, and therapies to reduce the risk of allergic reactions;

i) Strategies for the reduction of the risk of exposure to children of anaphylactic causative agents, including food and other allergens; and,

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

10) Requires CDSS to create informational materials, in multiple languages, pursuant to federal and state law, detailing the anaphylactic policy. Requires CDSS and CDE to post the informational materials on each of the departments' internet websites on or before September 1, 2027.

11) Requires the anaphylactic policy to be updated by CDSS as necessary.

12) Provides that 1) to 11) above shall not be construed to preempt, modify, or amend a child daycare provider's requirement to comply with existing federal and state disability laws, or the requirements related to a child's individualized family service plan or individualized education program.

13) Defines the following terms:

a) "Anaphylaxis" as a potentially life-threatening hypersensitivity to a substance. Symptoms include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itching, swelling, shock, or asthma. Causes of anaphylaxis may include, but are not limited to, an insect sting, food allergy, drug reaction, and exercise.

b) "Epinephrine auto-injector" is 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.

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

EXISTING LAW:

1) Establishes the "Child Care and Development Services Act" to provide childcare and development services as part of a coordinated, comprehensive, and cost-effective system serving children from birth to 13 years of age and their parents including a full range of supervision, health, and support services through full- and part-time programs. (Welfare & Institutions Code [WIC] § 10207 *et seq.*)

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

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 (TB);

    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 school districts, county offices of education, and charter schools to provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered to provide emergency medical aid to persons suffering or reasonably believed to be suffering from an anaphylactic reaction. Further provides guidelines for implementing these provisions. (Education Code [EDC] § 49414)

7) Requires a qualified health supervisor at a school district, county office of education, or charter school to obtain, at minimum, one regular and one junior epinephrine auto-injector,

and requires the schools to be responsible for stocking and restocking the epinephrine auto-injectors. (EDC § 49414(g)(1))

8) Provides that any authorized person, as defined, who administers an epinephrine auto-injector, in good faith and not for compensation, to another person who appears to be experiencing anaphylaxis at the scene of an emergency situation is not liable for any civil damages resulting from their acts or omissions in administering the epinephrine auto-injector, if that person has complied with specified requirements and standards. (Civil Code § 1714.23(b)(1); HSC § 1799.102)

Federal law:

9) 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 local educational agencies, schools, early childhood education programs, and other interested entities and individuals, to be implemented on a voluntary basis only. (Public Law 111-353)

10) Prohibits discrimination by a daycare center or educational entity when admitting a child with disabilities into the program under Title III of the Americans with Disabilities Act of 1990. (42 United States Code § 12181 *et seq.*)

FISCAL EFFECT: Unknown, this bill has not been analyzed by a fiscal committee.

COMMENTS:

Background: *Licensed Childcare.* The California Child Day Care Facilities Act governs the licensure, maintenance, and operation of child daycare centers and family daycare homes in the state. This law and the associated regulations found in Title 22 of the CCR establish, among other things, general health and safety requirements, staff-to-child ratios, and provider training requirements. CDSS's Community Care Licensing Division (CCLD) has the responsibility of licensing and monitoring the state's 10,481 childcare centers and 25,205 family childcare homes in 2021. As of January 2024, 158,959 children were served in licensed family childcare homes, 124,708 in childcare centers, and 82,704 in license-exempt settings in fiscal year 2022-23. CCLD is required to conduct unannounced site visits of all licensed child daycare facilities. These visits include random inspections of 30% of facilities annually and each facility must be visited at least once every three years, with certain exceptions warranting more frequent inspections.

What is Anaphylaxis? Anaphylaxis is characterized by a systemic immune response to an allergen that can be life-threatening, causing the body to go into shock, blood pressure drop suddenly and the airways to narrow. Common symptoms include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itchiness, swelling, shock, or asthma. The onset of symptoms usually occurs within minutes, but can be delayed up to 30 minutes and, although rare, even hours after exposure. Food allergies are the most common cause of anaphylaxis, such as eggs, milk, peanuts, tree nuts, wheat, crustacean shellfish, and soy. According to CDC's National Center for Health Statistics, approximately one in five children in California have seasonal allergies and 5.8% have a food allergy in 2021. Boys are slightly more

likely to have seasonal allergies than girls, and among racial and ethnic groups, Black children have a higher prevalence of food allergies.

Other allergens can trigger anaphylaxis, including insect stings or bites, medications, such as antibiotics, nonsteroidal anti-inflammatory drugs, latex, and even exercise. The severity of the reaction can vary depending on factors such as the individual's sensitivity to the allergen and the amount of exposure. In the United States, hospitalizations for anaphylaxis have steadily increased over the past 10 years, with one out of 20 anaphylaxis cases requiring hospitalizations. Nationally, pediatric emergency room visits for children with anaphylaxis increased from 5.7 to 11.7 per 10,000 visits from 2009 to 2013. Twenty-five percent of severe and potentially life-threatening reactions reported at schools happened in children with no previous diagnosis of food allergy.

Certain risk factors increase the likelihood of experiencing anaphylaxis, such as a history of allergies or asthma, previous anaphylactic reactions, and family history of allergic conditions. The prevalence of anaphylaxis has been increasing in recent years, with children disproportionately affected. Childcare settings present unique challenges in allergen management due to the potential for cross-contamination and exposure to various allergens. Shared spaces, communal snacks, and group activities increase the likelihood of accidental allergen exposure, heightening the risk of anaphylactic reactions. Anaphylaxis not only poses immediate health risks but also has long-term implications for children's quality of life, affecting their social interactions, dietary habits, and emotional well-being. Fear of allergic reactions can lead to anxiety and avoidance behaviors, impacting children's participation in everyday activities and social gatherings.

Recognizing the specific risk factors and prevalence of anaphylaxis in children is crucial for developing targeted prevention and management strategies within childcare facilities. This bill seeks to develop a comprehensive anaphylactic policy that includes procedures, a treatment plan, and training of volunteer personnel to provide guidance on allergen avoidance, emergency preparedness, and individualized care plans to effectively protect children with allergies from the potentially life-threatening consequences of anaphylaxis.

Treatment of Anaphylaxis. Anaphylaxis requires prompt recognition and immediate intervention to prevent progression to a life-threatening condition. According to guidelines from the National Institute of Allergy and Infectious Disease (NIAID), epinephrine (also known as adrenaline) is recommended as the primary treatment for anaphylaxis and should be promptly administered upon suspicion of an allergic reaction. An epinephrine auto-injector is a medical device utilized to deliver a measured dose of epinephrine via auto-injector technology, primarily used to manage acute allergic reactions and prevent or address the onset of anaphylaxis. Epinephrine auto-injectors are available exclusively by prescription. Commonly used epinephrine auto-injectors include brand names like the EpiPen and EpiPen Jr., which are designed for smaller children. Mylan, the manufacturer of these products, specifies that the EpiPen contains 0.3mg of epinephrine and is intended for individuals weighing 66 pounds or more, while the EpiPen Jr. contains 0.15mg and is suitable for patients weighing between 33 to 66 pounds.

NIAID recommends the use of an inhaler containing a bronchodilator or antihistamines as supplemental treatment following the administration of epinephrine. According to Mayo Clinic, after administering an epinephrine injection, it is necessary to seek immediate follow-up care at

an emergency room. In situations when epinephrine is not accessible, prompt transportation to the emergency room is essential to prevent potential fatalities.

Epinephrine Auto-Injector Use in Schools. In 46 states, laws or regulations require the stocking of epinephrine in K-12 schools. A study conducted in Massachusetts in 2005 examined epinephrine use in schools and found that, within two years, 48 out of 109 participating school districts reported administering epinephrine on at least one occasion, totaling 115 administrations during the reporting period. Alarmingly, in 24% of these cases, school staff were unaware that the individual had a life-threatening allergy, and administration was prompted solely by the onset of symptoms.

In California, school districts are required to supply emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered to administer them to individuals reasonably believed to be experiencing an anaphylactic reaction. Specifically, elementary schools must have at least one regular epinephrine auto-injector and one junior epinephrine auto-injector readily available. Similarly, junior high schools, middle schools, and high schools must have at least one regular epinephrine auto-injector available, unless there are no students requiring a junior epinephrine auto-injector.

This bill requires childcare facilities to maintain adequate supplies of epinephrine auto-injectors, as well as ensure proper storage and accessibility.

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 it does 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. Because this bill is permissive and allows childcare facilities to opt out of implementing the anaphylactic policy, the ad hoc measures in 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.

Elijah's Law. In November 2017, Elijah Silvera was a three-year-old child who lost his life following an anaphylactic reaction to eating a grilled cheese sandwich at his daycare, despite the daycare being aware of his severe dairy allergy. The daycare staff failed to administer the epinephrine auto-injector, and by the time Elijah reached the hospital, medical intervention was unsuccessful in saving his life.

In response to this incident, New York State enacted "Elijah's Law" in June 2019. This law requires that all daycares in the state implement comprehensive food allergy guidelines aimed at preventing, identifying, and responding to anaphylaxis emergencies. These guidelines encompass various measures, including staff training, the development of individualized healthcare plans for children with allergies, effective communication strategies, and initiatives to minimize allergen exposure within daycare settings.

Following New York's lead, Illinois also passed its version of "Elijah's Law" in 2021. This legislation requires childcare centers and schools to establish standards and provide training to staff members to recognize and mitigate the risks associated with anaphylaxis in children and young adults.

Governor's Veto Message. This bill is substantially similar to AB 2042 (Villapudua) of 2022, which was vetoed by Governor Newsom. The Governor's veto message stated:

> *"This bill would require the California Department of Social Services (CDSS), in consultation with the California Department of Education, the Child Care Providers United-California (CCPU) and others, to create two separate anaphylactic policies for child care center staff and family child care home staff. The policies would be established by July 1, 2024 and then be updated every three years and would include specified components, including training.*
>
> *"It is important for all children in a child care 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 (MOU) between the State and the CCPU.*

"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."

In order to address Governor Newsom's concerns stated above, the author of this bill changed the number of years the policies would need updating from three years to as needed. The bill continues to require developing two distinct anaphylactic policies for childcare center staff and family childcare home staff, each offering unique advantages outlined below.

CDSS plays a crucial role in establishing and enforcing guidelines for anaphylaxis management in childcare facilities. This bill requires CDSS to consult with healthcare professionals, allergy specialists, parents of children with life-threatening allergies, childcare administrators and personnel, and other stakeholders to develop evidence-based policies that prioritize the safety and well-being of children with allergies who attend childcare centers. By implementing standardized protocols and providing adequate training and resources, childcare facilities can create safer environments for children with allergies and mitigate the risks associated with anaphylactic reactions.

Ensuring the safety and well-being of children with allergies extends beyond traditional childcare centers to include family childcare providers who offer services in home-based settings. Recognizing the unique challenges and opportunities presented by family childcare providers, it is imperative to develop inclusive anaphylactic policies that address their specific needs and circumstances. This bill requires CDSS to consult and coordinate with the JLMC established by the state and the CCPU to establish a separate policy for family childcare providers. Collaboration with the CCPU enables family childcare providers to advocate for adequate resources and support services to enhance their capacity in managing anaphylaxis and promoting a safe and supportive environment for children with allergies.

Incorporating family childcare providers into the anaphylactic policy framework demonstrates a commitment to inclusivity and equity in safeguarding the health and well-being of all children in childcare settings. By engaging with providers, offering tailored training and support, and addressing their unique needs, this bill can ensure consistent standards of anaphylaxis management across all childcare settings in California.

Author's Statement: According to the Author, "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 tremendous 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.

"[This bill] is otherwise known as Elijah's Law (passed in the state of New York in 2019) in tribute to Elijah Silvera who suffered from 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:

- Help prevent life-threatening allergic reactions due to food or venom allergies,
- Better recognize the signs and symptoms of anaphylaxis and,
- Treat this condition by utilizing an appropriate weight-based dosage of epinephrine."

Equity Implications: To safeguard the health and well-being of up to 283,667 California children under the care of licensed childcare centers and family daycare homes across the state, enacting this bill is crucial. This bill aims to provide guidelines and procedures for daycare personnel to prevent and manage anaphylactic reactions in children, specifically for children of color who make up the majority of children receiving subsidized childcare services. As previously mentioned, Black children have higher rates of food allergies compared to any other racial and ethnic groups and make up approximately 20% of children enrolled in childcare. By promoting preventative measures and improving emergency response protocols, this bill can mitigate risks associated with anaphylaxis and create a safer and more inclusive environment for all children.

This bill also aims to ensure that daycare personnel are trained in recognizing the signs and symptoms of anaphylaxis and equipped with the knowledge and resources to respond promptly and effectively during a medical emergency. It is crucial to ensure that policies and training materials address cultural and linguistic diversity among childcare providers, families, and children, and should be available in multiple languages to guarantee that information is accessible and understandable to all stakeholders including immigrant and non-English speaking communities, which this bill intends to do.

This bill requires developing an anaphylactic policy that addresses various aspects of allergy management, including allergen identification, emergency response protocols, staff training requirements, and parental communication guidelines. Even if implementing the anaphylactic policy is not required, the bill recognizes the need for standardized anaphylaxis management policies in childcare centers and family daycare homes to ensure consistent and effective practices across all facilities.

Triple referral: Should this bill pass out of this committee, it will be referred to the Assembly Education Committee.

RELATED OR PRIOR LEGISLATION:

AB 2671 (Weber) of the current legislative session, requires licensed family daycare homes to only serve water to children or use water in food preparation that has been filtered with a point-of-use water filtration device and to prioritize providers caring for low-income children. *AB 2671 is pending before this committee and set for a hearing on April 9, 2024.*

AB 2343 (Schiavo) of the current legislative session, authorizes an administrator of a childcare program providing services during Stage One and Stage Two of the CalWORKs program to provide additional enhanced support and navigation services to those recipients experiencing homelessness, escaping domestic violence, or both. *AB 2343 is pending before this committee and set for a hearing on April 23, 2024.*

AB 2206 (Addis) of the current legislative session, requires CDSS to revise its fire safety clearance approval regulations to allow children with exceptional needs be accepted and attend a childcare program before the program has obtained a revised fire safety clearance approval to obtain childcare licensure. *AB 2206 is pending before this committee and set for a hearing on April 9, 2024.*

AB 772 (Jackson) of the current legislative session, exempts "drop-in" daycare centers from verifying, maintaining records, or requiring a physician's assessment upon admission of a child. *AB 772 is pending before the Senate Rules committee.*

AB 2042 (Villapudua) of 2022, was similar to this bill, which would have required CDSS, in consultation with 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. *AB 2042 was vetoed by Governor Newsom.*

AB 1532 (Bauer-Kahan), Chapter 131, Statutes of 2019, established the "Natalie Giorgi Sunshine Act", which requires on or before January 1, 2021, a food handler training course to include instruction on the elements of major food allergens, foods identified as major allergens, the symptoms a major food allergen could cause, and safe handling food practices for major food allergens.

AB 3342 (Bauer-Kahan) of 2020, would have required CDSS to authorize child daycare facilities to keep emergency epinephrine auto-injectors onsite for administration by trained, volunteer personnel in cases when an individual is suffering, or reasonably believed to be suffering, from an anaphylactic reaction. Would have also required CDSS to develop a training program for participating personnel, incorporating various components, such as techniques for identifying symptoms of anaphylaxis and emergency follow-up protocols. *AB 3342 was held in the Assembly Human Services Committee.*

AB 1386 (Low), Chapter 374, Statutes of 2016, permitted 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. Specified 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 1266 (Huff) of 2014, Chapter 321, Statutes of 2014, required school districts, county offices of education, and charter schools to provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered to administer epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction.

AB 559 (Wiggins), Chapter 458, Statutes of 2001, established provisions of law that permit a school district or county office of education to provide emergency epinephrine auto-injectors to trained personnel, and permit trained personnel to utilize these epinephrine auto-injectors to provide emergency medical aid to persons suffering from an anaphylactic reaction at a school or during a school activity.

REGISTERED SUPPORT / OPPOSITION:

Support

Elijah-alavi Foundation (Sponsor)
Association of Regional Center Agencies
Asthma and Allergy Foundation of America
California Society for Respiratory Care
Food Allergy & Research Education
Natalie Giorgi Sunshine Foundation
National Association of Pediatric Nurse Practitioners (NAPNAP)
No Nut Traveler INC

Opposition

None on file.

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