WASN

Wisconsin Association of School Nurses

Testimony to the Senate Committee on Education Regarding SB 375, Relating to the Use of Epipens in School Settings and Activities

December 18, 2013

Requested Changes to SB 375

The Wisconsin Association of School Nurses (WASN) appreciates the heightened awareness surrounding the management of life-threatening allergies in the school setting as reflected in Senate Bill 375. Additionally, we support the provision in the bill that requires the physician to be a key member of the school district's team for the development of a "school plan" for the management of pupils attending the school who have life-threatening allergies. We also support a number of the provisions in the bill, such as the requirement for school staff to receive training to administer epinephrine. We also support the inclusion of language that highlights the school nurse's role in case-managing students with life-threatening allergies.

But as SB 375 is written, WASN is unable to support the legislation. WASN is concerned by a number of items in the bill. The first is that the bill would remove the requirement that schools call 911 after epinephrine has been administered to a student (by a school bus operator, employee or volunteer). Experts in the area of life-threatening allergy management support calling 911 after the administration of epinephrine in the school setting.

Senate Amendment 1, introduced by Senator Vukmir, would reinstate the requirement that 911 be called when epinephrine is administered by staff. We support this change and appreciate the effort by Senator Vukmir to address one of our concerns. We also want to make sure that 911 is called in every situation where epinephrine is administered, including through the new section of the law that will be created by this legislation.

Secondly, the bill does not outline the medication administration training that would be required for school staff. Currently, school staff are required to receive training that is approved by the Department of Public Instruction (DPI). WASN believes any new training requirement should be consistent with current law and require approval by DPI.

Finally, WASN believes that physicians and school nurses are vital members of the teams that develop, implement and evaluate "school plans" for the management of life-threatening allergies. WASN is concerned that SB 375 would allow school nurses "or designated school personnel" to implement the plans. Having a non-health care professional in charge could be problematic, especially when a plan allows epinephrine to be given to students and staff who

do not have the medication specifically prescribed for them (i.e. stocked epipens). To ensure health and safety, school nurses need to be involved in the development of the policies, as is the case under 118.29.

An Alternative: Amend Current Law to Encourage Stocking of Epinephrine

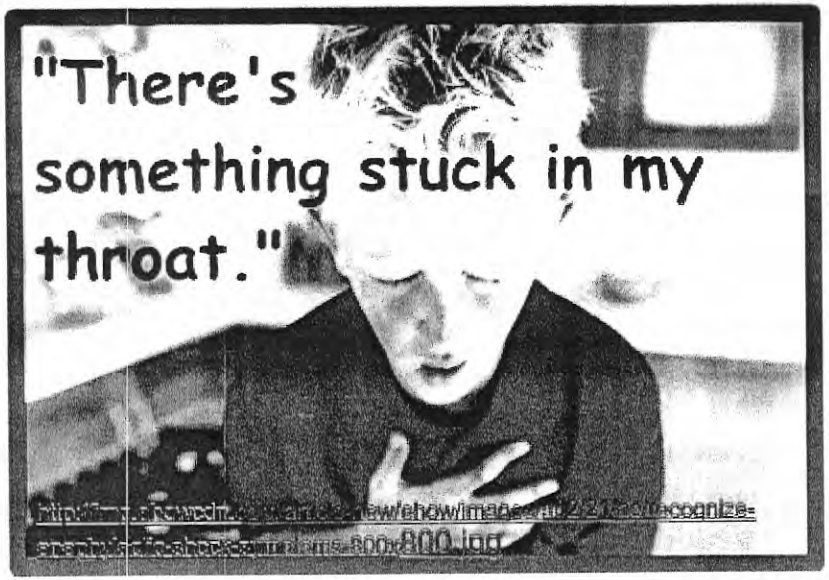
An alternative to the language in SB 375 would be to simply amend "Written Policies" (118.29(4)) to encourage schools to include in their medication policies a policy that allows the stocking of epinephrine auto injectors to be used in the event of a student experiencing a severe allergic reaction, including anaphylaxis, that requires the administration of epinephrine to avoid severe injury or death.

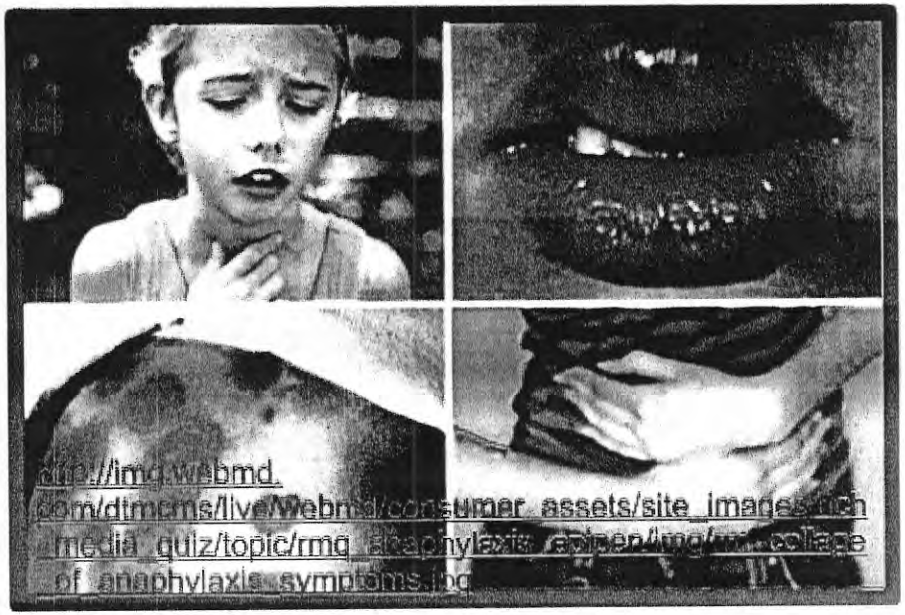
Language could also be added to existing law making it clear that prescriptions can be made in the name of the school for the purpose of stocking.

This would connect the language directly with current law and rules, which already authorize school personnel to administer epinephrine (with DPI-approved training and a requirement to dial 911), allows pupils to self-administer epipens (dialing 911 will be required if SB 416 is adopted), and requires a physician to serve as medical advisor for nursing services.

Anaphylaxis

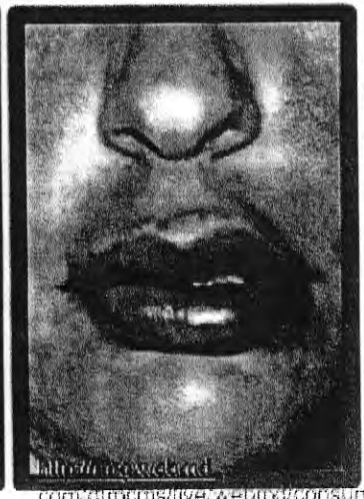
Presentations in Children & Teens





"It feels like there are bugs in there."

Hives

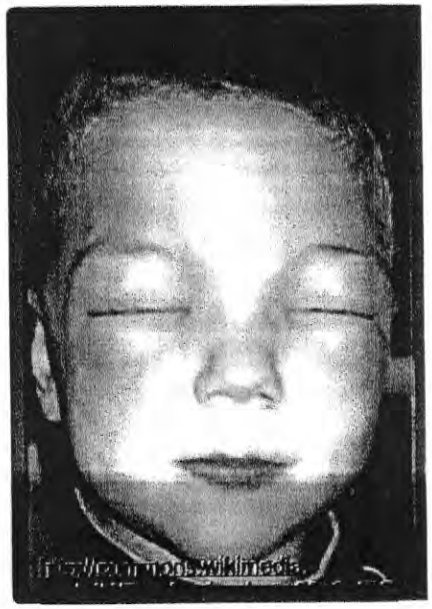


*ADAM.

"My lips feel tight."

"It feels like a bump is on the back of my tongue [throat]."

"My tongue [or mouth] itches."



"My tongue [or mouth] is tingling [or burning]."

Mild Symptoms

LUNG/THROAT:

- **Slight Dry Cough**
- **Sneezing**
- **Nasal Congestion/Runny Nose**

SKIN:

- **A Few Hives Around Mouth/Face**
- **Mild Itch or Rash**
- **Redness of Skin or Around Eyes**

GUT:

- **Nausea or Vomiting**
- **Diarrhea**
- **Mild Discomfort/Stomach Pain**

MOUTH:

- **Itchy Mouth or Ear Canal**
- **Odd Taste**

Are ***two or more*** different body areas affected?..... __YES __NO
Was exposure to allergen ***known or suspected***?..... __YES __NO

If you answered **"YES"** to both questions, **give EpiPen immediately!**

Severe Symptoms

LUNG:

- **Short of Breath**
- **Wheeze**
- **Repetitive Cough**

THROAT:

- **Tight**
- **Hoarse**
- **Trouble Breathing/Swallowing**

HEART:

- **Pale**
- **Blue (lips, face)**
- **Faint**
- **Weak Pulse**
- **Dizzy**
- **Confused**

MOUTH:

- **Swelling (tongue and/or lips)**

These are life threatening, **give EpiPen immediately!**

TESTIMONY OF

Colin Chiles
Director, State Government Relations
Mylan Inc.

Good morning. Thank you for the opportunity to speak with you today.

My name is Colin Chiles and I am the Director of State Government Relations for Mylan Inc. Mylan is a leading U.S. based manufacturer of generic and specialty medications. We have operations in eight states, as well as Puerto Rico, and provide generic medicines in more than 140 countries and territories worldwide.

Food allergies, which can sometimes lead to a life-threatening allergic reaction, or anaphylaxis, are a large and growing public health problem.[1,3] Today, an estimated one out of 13 children in the U.S. has a food allergy, a considerably higher number than previously known.[2]

We support SB 375 which will ensure that Wisconsin schools can be well prepared in the event a student experiences an anaphylactic reaction at school. Schools are a critical component in the effort to increase access to epinephrine auto-injectors for those at risk from food and other allergies. Thirty-one states currently allow (or require) schools to stock and administer epinephrine auto-injectors in schools and three additional states have legislation that has already passed in one chamber of their Legislature. Thank you for considering SB 375 and your interest in adding Wisconsin to this growing list of states.

Schools nationwide have made efforts to reduce exposure to allergens in the school environment—a critical first step in managing the risk of life-threatening allergic reactions. While practicing allergen avoidance is imperative, accidental contact can still happen, which is why it is important that epinephrine auto-injectors are accessible.

Over the past two years, there have been tragedies at schools around the country that resulted in the death of a student from anaphylaxis from exposure to an allergen. Deaths in Illinois (in 2011) and Virginia (in 2012) resulted in significant attention to the issue and much discussion on how to best address it. Sixteen states have already signed legislation into law this year and the Michigan Legislature sent a bill to the Governor just last week that is very similar to the legislation we are here to support today.

In the last several months, the American Red Cross launched a training program on anaphylaxis and administration of epinephrine auto-injectors, and the U.S. Centers for Disease Control and Prevention issued voluntary guidelines for managing food allergies in schools. Oregon now allows entities like restaurants and summer camps to stock and administer epinephrine auto-injectors and New York

State allows summers camps to stock and administer epinephrine auto-injectors. Much progress is being made in the effort to prevent tragedies from food and other allergens.

A Mylan subsidiary, Mylan Specialty, markets and distributes one of several epinephrine auto-injectors in the United States. Mylan Specialty has long-standing relationships with a number of leading patient advocacy organizations, working closely on educational and awareness efforts relating to food and other allergies and anaphylaxis. We look forward to working with this committee, the Legislature and school officials as you work to address this important issue.

In December 2010, the National Institute of Allergy and Infectious Diseases (NIAID), a division of the National Institutes of Health (NIH), introduced the "Guidelines for the Diagnosis and Management of Food Allergy in the United States." These guidelines state that epinephrine is the first-line treatment for anaphylaxis.[5] Epinephrine works to relieve the life-threatening symptoms of anaphylaxis, giving affected individuals more time to seek additional emergency medical treatment.[6]

The more rapidly anaphylaxis develops, the more likely the reaction is to be severe and potentially life-threatening. Prompt recognition of signs and symptoms of anaphylaxis is crucial. If there is any doubt, it is generally better to administer epinephrine.[7] Failure to administer epinephrine early in the course of treatment has been repeatedly implicated with anaphylaxis fatalities.

The NIH-NIAID guidelines also state that antihistamines are not effective in treating the symptoms of anaphylaxis. The use of antihistamines is the most common reason reported for not using epinephrine and may place a patient at significantly increased risk for progression toward a life-threatening reaction.[5]

In 2011, the Illinois Legislature passed legislation to allow schools to stock epinephrine auto-injectors for use in response to an anaphylactic emergency and in 2012, the Virginia, Maryland and Louisiana Legislatures passed legislation that requires schools to stock epinephrine auto-injectors for use in response to an anaphylactic emergency. School nurses and other trained personnel are authorized to administer epinephrine auto-injectors to any student who they believe is experiencing an anaphylactic reaction.

Massachusetts addressed this issue more than a decade ago following the deaths of two students while Missouri and Kansas passed legislation more recently. Georgia passed legislation this year to allow school personnel to administer epinephrine auto-injectors and Rhode Island passed legislation to allow school bus drivers and monitors to administer epinephrine auto-injectors.

To our knowledge, every state, including Wisconsin, now allows students who have been prescribed an epinephrine auto-injector to bring their auto-injector to school although the rules may vary among school districts. Unfortunately, some children who are at risk have never been diagnosed and do not

know they could be subject to an anaphylactic reaction. Massachusetts compiles a report each year of administrations of auto-injectors in their schools. According to the Massachusetts Department of Public Health, a survey conducted in 109 Massachusetts school districts from 2001 to 2003 evaluating the use of epinephrine for anaphylaxis management in schools, found that up to 24% of anaphylactic reactions occurred in individuals who were not known by school personnel to have a prior history of life-threatening allergies. This number is particularly disturbing.

Mylan is committed to working with states on this going forward. That is why I am pleased to have the opportunity to speak with you today. We learned through our discussions with Massachusetts and Illinois officials that cost of epinephrine auto-injectors presented a challenge to school budgets. As a result, we created a program to provide up to four free epinephrine auto-injectors per school year, upon qualification, which includes having a valid prescription, to public and private kindergarten, elementary, middle and high schools in the U.S.

We are pleased that more than 30,000 schools have already taken advantage of this program. There have been a number of situations where schools across the country have used these free epinephrine auto-injectors to treat an anaphylactic reaction, underscoring the positive impact of the program. We will continue to work with stakeholders including physicians, allergy advocacy organizations, school officials, school nurses, the American Red Cross and others to learn more about the ways to address potentially life-threatening food allergies and anaphylaxis in the schools.

There are a number of important statistics that have been cited with regard to food allergies and anaphylaxis, but I would like to mention just four key points here:

- Nearly 6 million or 8% of children in the U.S. have food allergies (~ one in 13).[2]
- The Centers for Disease Control and Prevention report that food allergies result in more than 300,000 ambulatory-care visits a year among children under the age of 18.[10]
- Food allergens account for 30% of fatal cases of anaphylaxis.[7]
- Anaphylaxis results in approximately 1,500 deaths annually.[11]

My colleagues and I at Mylan would like to work with you to ensure that Wisconsin schools are prepared to address anaphylaxis so that emergencies do not turn into tragedies. As I already mentioned, Mylan currently offers a program to help schools address the cost issue associated with stocking of epinephrine auto-injectors and we continue to look for additional ways that we can help.

Thank you for your time and your consideration today. I would be pleased to take any questions and to work with the committee and other interested parties as you consider this legislation.

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People with Life-Threatening Allergies Need to be Better Prepared

The Issue

There is a growing rate of life-threatening allergic reactions, or anaphylaxis, in the U.S., creating a public health concern and a major safety issue. Estimates indicate that anaphylaxis causes approximately 1,500 deaths annually.[1] Children and adolescents are among those most at risk for anaphylaxis.[2]

Food allergies are the most common cause of anaphylaxis, and the prevalence of food allergies is on the rise.[3,4] Today, food allergies affect an estimated one out of 13 children in the U.S., a considerable increase from previously reported figures.[5]

Schools nationwide have made efforts to reduce exposure to allergens in the school environment—a critical first step in managing the risk of life-threatening allergic reactions. While practicing allergen avoidance is imperative, accidental contact can still happen, which is why it is important that epinephrine auto-injectors are accessible.[4,6]

MORE AMERICANS NEED TO

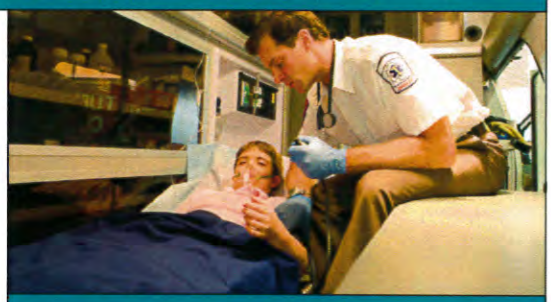
- be **AWARE** of the risk of anaphylaxis,
- understand the signs and symptoms of anaphylaxis,
- be **PREPARED** to respond when anaphylaxis occurs and
- have immediate **ACCESS** to epinephrine auto-injectors.

Epinephrine is the First-line Treatment for Anaphylaxis[7]

According to food allergy guidelines released in December 2010 by the National Institute of Allergy and Infectious Diseases (NIAID), a division of the National Institutes of Health (NIH), epinephrine is the only first-line treatment in all cases of anaphylaxis (including from food allergies) and should be available at all times for people at risk for anaphylaxis. According to the NIAID guidelines, if experiencing anaphylaxis, a person should use an epinephrine auto-injector and seek immediate emergency medical attention.

Common side effects of epinephrine may include upset stomach, vomiting, sweating, dizziness, nervousness, weakness, pale skin, headache and shaking, difficulty breathing and pounding, fast, or irregular heartbeat.[8]

The more rapidly anaphylaxis develops, the more likely the reaction is to be severe and potentially life-threatening. Prompt recognition of signs and symptoms of anaphylaxis is critical.[9] If there is any doubt, it is better to administer epinephrine. Failure to administer epinephrine early in the course of treatment has been repeatedly implicated with anaphylaxis fatalities.[9,10,11]



What is anaphylaxis?
(pronounced a-na-fi-LAX-is)

Anaphylaxis is a life-threatening allergic reaction that is rapid in onset and may cause death, either through swelling that shuts off airways or through a significant drop in blood pressure.[2]

What are the common triggers of anaphylaxis?

Foods, insect stings, medications, latex, other allergens or an unknown trigger.[2]

What are the most common foods to cause anaphylaxis?

Milk, egg, wheat, soy, peanut, tree nut, fish and shellfish.[7]

Did you know?

- A 2010 study indicated that anaphylaxis results in 90,000 emergency department visits per year for food allergies alone.[12]
- In 2008 the CDC reported that an 18% increase in food allergy was seen between 1997 and 2007.[3]
- Food allergens account for 30% of fatal cases of anaphylaxis.[4]
- Data on anaphylaxis incidence and prevalence are sparse and often imprecise; however, estimates indicate that anaphylaxis may affect 3 to 43 million Americans. As evidenced by the range provided, more research needs to be conducted.[1]

IMMEDIATE ACTION IS NEEDED IN SCHOOLS

Recent tragedies have brought significant attention to the issue of managing anaphylaxis at school and raised much discussion on how to best address the problem.

Following the deaths of two students a decade ago, Massachusetts became the first state to address the issue of anaphylaxis management at school. A survey conducted in 109 Massachusetts school districts from 2001 to 2003 evaluating the use of epinephrine for anaphylaxis management in schools, found that up to **24% of anaphylactic reactions occurred in individuals who were not known by school personnel to have a prior history of life-threatening allergies.**[13]

On Dec. 20, 2010, 13-year-old Katelyn Carlson of Chicago, Ill. had a life-threatening allergic reaction to peanut oil from Chinese food ordered for a class party. She was rushed to a nearby hospital and pronounced dead due to anaphylaxis. Katelyn had been previously diagnosed with life-threatening food allergies but did not have an epinephrine auto-injector on hand to administer. As a result, on Aug. 15, 2011, Illinois signed into law the School Access to Emergency Epinephrine Act, permitting access to undesignated epinephrine auto-injectors in Illinois schools for students who suffer from a severe allergic reaction.[14]

On Jan. 2, 2012, seven-year-old Amarria Johnson of Chesterfield, Va. died at school after she suffered an allergic reaction to a peanut product. She did not have an epinephrine auto-injector on hand and was in cardiac arrest by the time emergency crews arrived and was pronounced dead shortly after. Amarria's death caused Virginia to make a change. On April 26, 2012, legislation requiring Virginia schools to stock epinephrine auto-injectors for use by school nurses and other trained personnel to administer to any student who they believe is experiencing an anaphylactic reaction became law.[14]

These are just a few of the tragic examples that demonstrate why each school should have a comprehensive anaphylaxis action plan,[15,16,17] so that students, teachers and school employees:

- Understand the risk of anaphylaxis
- Avoid allergic triggers
- Recognize the signs and symptoms
- Are prepared with access to epinephrine auto-injectors (two doses)[7]
- Know to seek emergency medical care following administration of treatment

THE NEED FOR EPINEPHRINE ACCESS ALSO EXTENDS BEYOND SCHOOLS

A first reaction, whether it is from food, an insect sting or medications, can happen anywhere and may be severe enough to cause death.[4]

On Aug.16, 2011, 15-year-old Jharell Dillard, who had a life threatening allergy to peanuts, went to a shopping center in Atlanta, Ga. with his mother and two sisters. While there, he ran outside to grab a cookie from the car. What he thought was simply a chocolate chip cookie actually contained nuts. He immediately went into anaphylactic shock, and was not carrying his epinephrine auto-injector. By the time he was airlifted to the local children's hospital it was too late. Jharell was pronounced dead due to anaphylaxis.[14]

Change in schools means

- ☐ Standardizing and implementing guidelines for managing life-threatening allergies in schools
- ☐ Allowing schools to maintain a supply of undesignated epinephrine auto-injectors
- ☐ Allowing medical professionals and trained non-medical professionals to administer epinephrine auto-injectors to students with or without a prescription on file
- ☐ Protecting good samaritans who administer an epinephrine auto-injector in an emergency situation
- ☐ Allowing physicians to prescribe epinephrine auto-injectors to an entity, like a school
- ☐ Tracking epinephrine auto-injector administration in schools

A number of states have taken action to address anaphylaxis in schools:

- Examples include: Maryland, Virginia, California, Georgia, Illinois, Kansas, Missouri, Nebraska and Massachusetts[14]
- Rhode Island passed legislation to allow school bus drivers and monitors to administer epinephrine auto-injectors[14]
- Texas published statewide food allergy guidelines, making it the 15th U.S. state requiring public schools and open-enrollment charter schools to implement strategies for special care of students with food allergies[14]

Change beyond schools means

- ☐ **Allowing for undesignated epinephrine auto-injectors at restaurants, camps and other public venues, including public transportation**
- ☐ **Requiring all emergency first responders to carry epinephrine and to be trained and authorized to administer epinephrine auto-injectors**

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(as of Nov. 20, 2012)

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WISCONSIN ASSOCIATION *for* JUSTICE

formerly the Wisconsin Academy of Trial Lawyers

Testimony of
Jeffrey A. Pitman
on behalf of the
Wisconsin Association for Justice
before the
Senate Education Committee
Senator Luther Olsen, Chair
on
2013 Senate Bills 375 and 416
December 18, 2013

CHAIRMAN OLSEN AND MEMBERS OF THE COMMITTEE, my name is Jeffrey A. Pitman, a partner with the Pitman, Kyle, Sicula & Dentice law firm in Milwaukee and the immediate Past President of the Wisconsin Association for Justice (WAJ). I am appearing to oppose the immunity provisions in both Senate Bill 416 (SB-416) and Senate Bill 375 (SB-375). Thank you for this opportunity to testify.

Given the proliferation of allergies – food, insect bites and drugs – among children, WAJ understands why schools need to be prepared to treat potentially life-threatening anaphylactic reactions on school property. Planning and training for school personnel are entirely appropriate to deal with emergency situations when a student is having an anaphylactic reaction. However, WAJ believes these bills go too far in certain areas. WAJ specifically opposes the immunity provisions found in SB-416 and SB-375.

WAJ believes Wisconsin's current civil liability protection law is sufficient to protect school personnel from liability when aid is rendered in an emergency situation. The giving of epinephrine should not be granted an additional or higher level of immunity than any other drug administered by school personnel.

Under Wis. Stat. § 118.29, which covers the administration of epinephrine to students, three separate provisions can be found that provide civil liability protection.[1] The provisions cover school personnel who administer a drug or authorize the administration of a drug if the personnel have received training approved by DPI and if a written policy is adopted by the school board as well as covering aid given to students in emergencies. Professional health care providers are not covered by these immunity provisions.

Second, Wis. Stat. § 118.292 also contains immunity provisions for school personnel when a student self-administers an EpiPen.[2]

Third, Wisconsin has the Good Samaritan law, Wis. Stat. § 895.48(1).[3] This law covers the act of providing care to a person in an emergency situation. There is an exemption for health care professionals when they are paid.

Finally, assuming there was an injury involving the administration of an EpiPen at a school that would fall outside the current provisions in Wis. Stat. § 118.29, the injured person would still have to maneuver through Wis. Stat. § 893.80, which insulates school districts from liability in many circumstances. Under § 893.80 an injured person must

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[1] 118.29(a) 3. Subject to sub. (4m), is immune from civil liability for his or her acts or omissions in administering a nonprescription drug product or prescription drug to a pupil under subd. 1., 2., 2m., or 2r. unless the act is in violation of sub. (6) or the act or omission constitutes a high degree of negligence. This subdivision does not apply to health care professionals.
(b) Subject to sub. (4m), any school district administrator, county children with disabilities education board administrator, cooperative educational service agency administrator, public, private, or tribal school principal, or private or tribal school administrator who authorizes an employee or volunteer to administer a nonprescription drug product or prescription drug to a pupil under par. (a) is immune from civil liability for the act of authorization unless it constitutes a high degree of negligence or the administrator or principal authorizes a person who has not received the required training under sub. (6) to administer a nonprescription drug product or prescription drug to a pupil.
(3) EMERGENCY CARE; CIVIL LIABILITY EXEMPTION. Any school bus operator validly authorized under ss. 343.12 and 343.17 (3) (c) to operate the school bus he or she is operating and any public, private, or tribal school employee or volunteer, county children with disabilities education board employee or volunteer, or cooperative educational service agency employee or volunteer, other than a health care professional, who in good faith renders emergency care to a pupil of a public, private, or tribal school is immune from civil liability for his or her acts or omissions in rendering such emergency care. The immunity from civil liability provided under this subsection is in addition to and not in lieu of that provided under s. 895.48 (1).

[2] (2) No school board, school district, private school, or tribal school, or any employee of the foregoing, is civilly liable for an injury incurred by any of the following:
(a) A pupil as a result of using an epinephrine auto-injector under sub. (1r).
(b) Any person as a result of a pupil possessing or using an epinephrine auto-injector under sub. (1r).

[3] (1) Any person who renders emergency care at the scene of any emergency or accident in good faith shall be immune from civil liability for his or her acts or omissions in rendering such emergency care. This immunity does not extend when employees trained in health care or health care professionals render emergency care for compensation and within the scope of their usual and customary employment or practice at a hospital or other institution equipped with hospital facilities, at the scene of any emergency or accident, enroute to a hospital or other institution equipped with hospital facilities or at a physician's office.

send a notice of claim to the school within 120 days of the injury. Although the lack of a proper notice isn't automatically fatal, the failure to provide notice may preclude a claim against the school. Further, under current law, a school district is immune for actions and decisions made in the course of "legislative, quasi-legislative, judicial or quasi-judicial functions." This immunity applies to many cases coming before our courts concerning any governmental activity. Finally, even if liability were found, the school district's financial responsibility to satisfy a judgment is limited to $50,000 per person.

WAJ understands that epinephrine protection legislation like SB-375 and SB-416 is occurring across the country and maybe in response to national legislation that President Obama recently signed, the School Access to Emergency Epinephrine Act. The new law gives an additional preference to states that allows self-administration of asthma and anaphylaxis medication and the state *makes a certification concerning the adequacy of the state's civil liability protection law* to protect trained school personnel who may administer epinephrine to a student reasonably believed to be having an anaphylactic reaction. (Emphasis added)

The law requires that the State's Attorney General review the civil liability protections to determine if "*trained*" school personnel "who may administer epinephrine to a student reasonably believed to be having an anaphylactic reaction ... provides adequate civil liability protection applicable to such trained personnel." To meet the law's requirement, "the term 'civil liability protection law' means a State law offering *legal protection to individuals who give aid on a voluntary basis in an emergency to an individual who is ill, in peril, or otherwise incapacitated.*"

The immunity provided in Section 5 of SB-375 exceeds the federal law by providing immunity to all school personnel, as well as physicians, advanced practice nurse prescriber or physician assistant. Health care professionals should not be covered in this grant of immunity because they are doing their job – it is not a voluntary situation. Nor does SB-375 specify the medication training that would be required by school staff. The federal legislation clearly calls for training in this area.[4]

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[4] The federal legislation requires elementary and secondary schools to:
(1) permit trained personnel to administer epinephrine to a student reasonably believed to be having such a reaction,
(2) maintain a supply of epinephrine in a secure location that is easily accessible to trained personnel for such treatment, and
(3) have in place a plan for having on the school premises during operating hours one or more designated personnel trained in administration of epinephrine.

Under the current reading of Subsection 5 of SB-375, the exception to immunity is "gross negligence or willful or wanton misconduct." Wisconsin does not recognize gross negligence. See *Bielski v. Schulze*, 16 Wis. 2d 1 (Wis.1962). ("The doctrine of gross negligence as a vehicle of social policy no longer fulfills a purpose in comparative negligence. Much of what constituted gross negligence will be found to constitute a high percentage of ordinary negligence causing the harm.")

It seems that rather than create an entire new section of the statute that is duplicative and unnecessary, amend Wis. Stat. § 118.29 to meet the requirements of the new federal law and do not create any additional immunity provisions. Current law provides adequate protection for those who voluntarily give aid in an emergency to an individual who is ill, in peril, or otherwise incapacitated.

WAJ opposes immunity in any form. Immunity is the equivalent of a permanent "stay out of court" card for wrongdoers. It gives them the power to act unreasonably without regard to public safety or health, with no fear of accountability. **Creation of a statutory immunity is the most serious step the Legislature can take to address a liability issue.** WAJ believes only important public policy considerations can ever justify a grant of immunity, because immunity shields unreasonable conduct.

For SB-416, we understand the author has drafted an amendment which eliminates the immunity provisions. WAJ supports that amendment.

Current law provides adequate protection for school personnel from liability when epinephrine is given to a student in an emergency situation. No additional grant of immunity is warranted. WAJ would not oppose the bills if the immunity provisions were removed from SB-416 and SB-375.

I would be happy to answer any questions.

Thank you.

Pharmacy Society of Wisconsin

DATE: Wednesday, December 18, 2013
TO: Senator Olsen, Chair
Senator Farrow, Vice-Chair
Members, Senate Committee on Education
FROM: Pharmacy Society of Wisconsin

SUBJECT: **Possession and use of an epinephrine auto-injector on school premises**

Pharmacy Society of Wisconsin Position: Supports access to ephinephrine auto-injectors on school premises

Thank you for the opportunity to provide feedback on Senate Bills 375 and 416 which address the possession and use criteria of an epinephrine auto-injector while on school premises. Evidence suggests that the prevalence of allergies and food allergies in school-age children is increasing. In the setting of allergic anaphylaxis, epinephrine is the primary medical therapy; delays in epinephrine administration in these patients is associated with increases in mortality.

Nearly 20% of epinephrine auto-injector administrations occur on school premises.[i] In a survey of epinephrine administration on school premises, approximately 25% of recipients had no previous diagnosis of allergy.[ii] It is with this knowledge that the Pharmacy Society of Wisconsin (PSW) supports efforts to increase access to epinephrine on school premises whether it is patient-specific or designated for school supply.

We would like to take this opportunity to encourage bill authors and cosponsors to consider the complexities in the administration of epinephrine as SB375 and SB416 moves through the legislative process. For example, epinephrine dosing is weight-based and thus school-age children will fall into one of two different dosing regimens. We request that the decision making processes as outlined in either SB375 or SB416 will require policies to clearly delineate dosing decisions and epinephrine storage and administration considerations (i.e. checking product expiration on an annual basis).

PSW offers to be engaged in discussions surrounding these policy discussions during SB375 and SB416 legislative action and law implementation.

The Pharmacy Society of Wisconsin (PSW) is a nonprofit professional association representing nearly 3400 pharmacists, pharmacy technicians, and student pharmacists in the state of Wisconsin. We seek to improve the health outcomes and well-being of patients in Wisconsin, to serve as a unified voice for our members and the practice of pharmacy, and to advance the pharmacy profession.

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[i] Nowak-Wegrzn A, Conover-Walker MK, Wood RA. Food-allergic reactions in school and preschools. Arch Pediatr Adolesc Med 2001;155:790-5.
[ii] McIntyre CL, Sheetz AH, Carroll CR, Young MC. Administration of epinephrine for life-threatening allergic reactions in school settings. Pediatrics 2005;116:1134-40.

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WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION

Tony Evers, PhD, State Superintendent

December 18, 2013
Senate Committee on Education

Department of Public Instruction
Testimony on 2013 Senate Bill 375

Thank you to Chairman Olsen and members of the committee for the opportunity to testify before you today. My name is Jennifer Kammerud and I am the Legislative Liaison for the Department of Public Instruction (DPI) and am here today to testify in opposition to Senate Bill 375 (SB 375) due to concerns over student safety.

SB 375 would create a new section of statutes related solely to the use of epinephrine auto-injector s. It would allow schools who adopt a management plan for life-threatening allergies to provide epinephrine auto-injector s to students and administer an auto-injector to a student regardless of whether there is a prescription on file for that student. It also grants immunity from civil liability for the consequences of using an epinephrine auto-injector under this section of statute.

The department's two main concerns with the bill revolve around the requirement to call 911 and consistency with current law surrounding training.

The bill eliminates the requirement to call 911 after use of an auto-injector. The department would like to see that provision reinstated.

Any use of an auto-injector needs to be followed by a call to 911. The medicine contained in an auto-injector is emergency medication meant to keep a student from an anaphylactic reaction or treat the reaction until further medical attention can be received. When this medicine wears off the life-threatening reaction can return. Moreover, the auto-injector dosage used is based on weight. If the wrong dosage is used, emergency attention needs to be received immediately.

SB 375 would change current law training requirements under Wis. Stats. 118.29 (6). This statute currently requires training for invasive administrations which include inhaled, injected, and rectally administered medicines, and medicines administered through nasogastric, gastrostomy, and jejunostomy tubes. For these types of medication administrations in public schools the state requires DPI approved training.

The department is asking that SB 375 be amended to cross reference this current law requirement and make it clear that the state is not lowering the medication administration standard for care in current law. All safety plans created under this bill should be required to comply with these current law training requirements.

The department appreciates the purpose behind this bill and if the two changes I have discussed regarding 911 and the training requirements were made the department would remove its opposition to the bill.

Thank you for the opportunity to testify and at this time I would be happy to answer any questions you may have.

To:	Chairman Olsen, Members of the Senate Education Committee
From:	Wisconsin Athletic Trainers Association
Date:	December 18, 2013
RE:	Senate Bill 375 and Senate Bill 416, relating to the use of an epinephrine auto-injectors on school premises

With an increasing number of school-aged children inflicted with allergies and at risk of experiencing life-threatening anaphylaxis, we commend you for holding a public hearing on the use of epinephrine auto-injectors on school premises or at school-sponsored activities.

Athletic trainers are state-licensed health care professionals who collaborate with physicians working toward the prevention, diagnosis, treatment, and rehabilitation of emergency, acute, and chronic medical conditions and injuries. In many cases, we are the first responders when a student athlete suffers a medical emergency during an athletic event or practice.

Under current Wisconsin law, it is within our scope of practice to carry and administer epinephrine auto-injectors to treat for anaphylaxis. As the Committee deliberates on the bills before you today, we caution you to make sure that you don't adopt language that would restrict our ability to carry and use lifesaving epinephrine auto-injectors.

As introduced, Senate Bill 375 permits school districts to adopt plans authorizing designated school personnel to administer epinephrine auto-injectors if they have completed a training program as stipulated in the aforementioned plan. Our concern with this language is that it is silent as to the role and responsibility of athletics trainers, as well as other health care professionals.

While plans would vary district to district, one must assume that athletic trainers would be required to complete the same training as other school district personnel, despite the fact that it is duplicative of training we have already completed through our licensure. Further, it isn't a stretch to think that districts will have varying requirements, requiring athletic trainers who work at athletic events for multiple school districts to complete multiple training programs.

As such, we would like to respectfully suggest that the bill be amended to exempt health care providers practicing within the scope of their credential. This will ensure that athletic trainers, as well as other health care professionals, can continue to utilize life-saving epinephrine auto-injectors as warranted.

Thank you for your consideration of these comments.