# ALLERGY INFORMATION SHEET

- Any allergic reaction, including the most extreme form, **anaphylactic shock**, occurs because the body's immune system reacts inappropriately in response to the presence of a substances that it wrongly perceives as a threat.
- The **anaphylactic reaction** is caused by the sudden **release of chemical substances**, including histamine, from cells in the blood and tissues where they are stored.The release is triggered by the **reaction between the allergic antibody** (IgE – which stands for ImmunoglobulinE) and the **substance (or allergen)** that it has been exposed to.
- The body will have been exposed to the allergen on a previous occasion, although the student may not have been aware of this at the time. On that earlier occasion, the allergen was wrongly perceived as a threat and antibodies were made against it, which means that on the next exposure, a severe reaction may occur.
- The mechanism is so sensitive that **minute quantities of the allergen** can cause a reaction.
- The released chemicals act on the blood vessels to cause the **swelling** in the mouth and anywhere on the skin. There is a **fall in blood pressure**, and for people who also have asthma, the effect is mainly on the lungs.

**Types of Reaction**

There are several different types of reaction which could occur:

- ✓ Uniphasic – these have a fast onset and rapidly progressive symptoms, but once treated, the symptoms go and don't return.
- ✓ Bi-phasic – these are reactions which may be mild or severe to start with, followed by a symptom-free period, and then increasing symptoms with respiratory and circulatory problems, which could occur some hours later.
  Bi-phasic reactions are generally thought to be less common – research studies suggest a 1-20% chance of this type of reaction. It's also not possible to predict who might have a bi-phasic reaction. Tip: as a general rule, people who have had a severe allergic reaction should be monitored for 6 – 12 hours within a hospital setting because of the risk of a bi-phasic reaction. The length of the observation period would be for the treating doctor to decide. On very rare occasions, a biphasic reaction has been known to occur as long as 72 hours after the initial reaction. Children are likely to be admitted to hospital overnight. This approach has been endorsed by the National Institute for Health and Care Excellence (NICE).
- ✓ Protracted anaphylaxis – this can last for several days and the patient is likely to need treatment in hospital for some time.

**Common causes of anaphylaxis**

- It is possible to be allergic to anything which contains a protein, however most people will react to a fairly small group of potent allergens.
- Food allergens are the most common cause of severe allergy but some people will have severe reactions to other allergens, including pollen, animals (particularly cats, dogs and horses), stinging insects and even from unknown causes.
- The illustration below shows the most common food allergens

## Pollen food syndrome / idiopathic anaphylaxis / exercise induced anaphylaxis

### Pollen food syndrome

- This is a medical condition in which the person affected gets immediate allergic symptoms in the **lips, mouth** and **throat**, usually when they eat certain kinds of raw fruit, raw vegetables or nuts.
- It's called "pollen food syndrome" because it usually occurs in people who are already allergic to pollens and have hayfever.

Common symptoms can include:

- ✓ Redness, swelling or itching of lips, tongue, inside of mouth, soft palate and ears
- ✓ Itching and swelling affecting the throat
- ✓ Occasionally, symptoms in the oesophagus (gullet) or stomach, including pain, discomfort, nausea or even vomiting
- ✓ Sneezing, runny nose, or eye symptoms including itching, redness, puffiness or watering.

### Idiopathic anaphylaxis

- Sometimes the cause of the severe allergic reaction is unidentified or unknown – this is termed idiopathic anaphylaxis ("idiopathic" means having an unknown cause). People with idiopathic anaphylaxis really do need to be under the care of an allergist to help them manage their symptoms.

### Exercise induced anaphylaxis

- Exercise-induced anaphylaxis is a rare but potentially serious condition in which anaphylaxis occurs during or after physical activity. Sometimes this can be caused when a particular food is eaten before (or more rarely, immediately after) exercise. There are other potential triggers, including aspirin and exposure to cold.

### What is Anaphylaxis?


- Anaphylaxis (pronounced: anna-fil-axis) is an extreme and severe systemic allergic reaction.
- The term comes from the Greek words ***ana*** (against) and ***phylaxis*** (protection). Anaphylaxis is at the extreme end of the allergic spectrum.
- The whole body is affected often within minutes of exposure to the allergen, but sometimes it can be hours later. Allergens are substances that the body's immune system reacts to, because it wrongly perceives the substance (allergen) as a threat. Causes often include foods, insect stings, or drugs.

### What makes anaphylaxis so dangerous?

Anaphylaxis involves one or both of these two features:

- ✓ **severe airway / breathing problems**, and/or
- ✓ **circulatory problems (causing a life-threatening drop in blood pressure)**

**What are the signs and symptoms of anaphylaxis?**

**What to look for:**

- ✓ swelling of the mouth or throat
- ✓ difficulty swallowing or speaking
- ✓ difficulty breathing
- ✓ sudden collapse / unconsciousness
- ✓ hives, rash anywhere on the body
- ✓ abdominal pain, nausea, vomiting
- ✓ sudden feeling of weakness
- ✓ strong feelings of impending doom

**Anaphylaxis is likely if all of the following 3 things happen**:

- **sudden onset** (a reaction can start within minutes) and **rapid progression of symptoms**
- **life threatening airway and/or breathing difficulties** and/or **circulation problems** (e.g. alteration in heart rate, sudden drop in blood pressure, feeling of weakness)
- **changes to the skin** e.g. flushing, urticaria (an itchy, red, swollen skin eruption showing markings like nettle rash or hives), angioedema (swelling or puffing of the deeper layers of skin and/or soft tissues, often lips, mouth, face etc.) Note: skin changes on their own are not a sign of an anaphylactic reaction, and in some cases don't occur at all

**If the student has been** exposed to something they are known to be allergic to, **then it is more likely to be an anaphylactic reaction.**

**Skin reactions**

A number of skin reactions are commonly associated with anaphylaxis:

- **Urticaria** (pronounced: erty-care-eeya) is the intensely itchy, red, swollen skin reaction which often occurs in an allergic reaction.
- **Angioedema** (pronounced: anjee-o-deema) is an urticarial rash (as above) affecting a deeper layer of the tissues causing swelling.
- Flushing of the skin, where the skin goes a pinky red all over.

Angioedema of the lip

Severe angioedema

Small urticarial rash

Large urticarial rash

**The link with asthma**

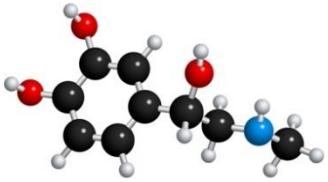
- People who have food allergies and also have asthma are at much greater risk of a fatal or near-fatal outcome from anaphylaxis
- For children with severe allergies **and** asthma a vital part of the management of their condition is to ensure that their asthma is **very** well controlled.
- If asthma develops in children who already have significant food allergies, they should get a reassessment by an allergy specialist, as their risk of a severe reaction will be much higher, and they need specific advice on how to manage this.

**Treatment with adrenaline**

- Anaphylaxis can develop very rapidly, so a treatment is needed that works rapidly. **Adrenaline** is the mainstay of treatment and it starts to work within seconds. Adrenaline should be administered by an **injection into the muscle** (intramuscular injection) – see "administering adrenaline" on the next page.
- **Adrenaline** is the name we use for this drug in the UK, **Epinephrine** is the internationally recognised name.

**What does adrenaline do?**

- ✓ It opens up the airways
- ✓ It stops swelling
- ✓ It raises the blood pressure



Adrenaline must be administered with the **minimum of delay** as it is more effective in preventing an allergic reaction from progressing to anaphylaxis than in reversing it once the symptoms have become severe.

## Administering adrenaline

**Intramuscular administration** (directly into a muscle) is the preferred and safest route. Adrenaline injectors (see following pages in this section) are designed for use in the **upper, outer thigh muscle** of the leg.

**Who should be given an adrenaline injector?**

- As a general rule, patients who have had **significant allergic reactions** affecting breathing or **circulation**, or have an **acknowledged risk of anaphylaxis** alongside **asthma**, are likely to be given an adrenaline injector.
- If you suspect a reaction is serious, or becoming serious, **use the adrenaline injector immediately** – any delay could be extremely serious. Dial 999 or get someone else to do this. If the person's condition deteriorates after making the initial 999 call, a second call to the emergency services should be made to ensure an ambulance has been dispatched. Immediately after the adrenaline has been administered you will need to get the child to hospital because the symptoms can return and they may need further treatment.

**Using an adrenaline injector in an acute allergic reaction**

- **Determine where to inject** – the auto-injector should always be given into the muscle in the outer thigh. In order to find the best position, you should draw an imaginary line down the centre and across the leg, making 4 squares.
- **Preparing to inject** – hold the adrenaline injector with the needle tip facing down. Remove the safety cap (EpiPen® and Jext®) or end cap (Emerade®). If necessary, hold the child's leg gently to prevent the child moving while you are using the injector.
- **Inject and hold in place** -if using Epipen®, hold the adrenaline injector a few centimetres away from the leg and jab firmly. If using Jext® or Emerade®, press the adrenaline injector against the thigh and push firmly. You will hear the injector fire. Hold in place for the length of time indicated on the instructions -10 seconds for Jext®, 5 seconds for Emerade®, 3 seconds for EpiPen®.
- **Rub** – (Jext® and Emerade® only) Gently rub the injection site for a few seconds.
- **Call an ambulance** – make a note of the time you administered the auto-injector so that you can tell the paramedics when they arrive. ALL patients must go to hospital after using their auto-injector, where they should be monitored for at least 6 hours.
- The Medicines & Healthcare Products Regulatory Agency (MHRA) **guidance on aftercare** is that after every use of an adrenaline auto-injector, an ambulance be called (even if symptoms are improving), the individual should lie down with their legs raised and, if at all possible, should not be left alone. If the

person's condition deteriorates after making the initial 999 call, a second call to the emergency services should be made to ensure an ambulance has been dispatched.

- **In an emergency, if someone has a reaction, can I use another person's adrenaline injector on them?**
- Adrenaline injectors should only be used on the person for whom they have been prescribed. From October 2017 all schools in the UK are able to purchase spare adrenaline autoinjectors for emergency use on children who have been prescribed adrenaline but whose own devices are not available or not working. See "Healthcare management / action plans" further on in this course for more detailed guidance.

**Patient positioning**

- The positioning of your patient will depend on the symptoms they are experiencing:

## Symptoms only affecting breathing

If symptoms are only affecting the **airway** (breathing), the patient may be more comfortable sitting up or in a **semi-recumbent** position

## Symptoms of low blood pressure

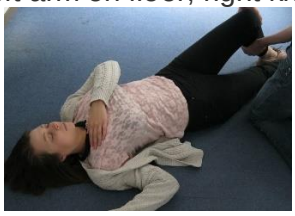
If the patient is showing any signs of **low blood pressure**, (being cold, clammy, sweaty, dizzy or feeling weak) they should **lie down with their legs raised** to ensure that the heart is the lowest part of the body. (If they are also having breathing problems, they may need to be semi-recumbent with legs propped up e.g. on a cushion. You can seek advice on this from the 999 operator). It is very important that they **do not sit up or stand after getting adrenaline** as a sudden change of position may lower blood pressure drastically and worsen their condition, potentially fatally.

## Unconscious patient

If the patient is unconscious, they should be placed in the **recovery position**.
(If left-side recovery position is required, place right arm across chest, left arm on floor, right knee up, etc.)

**Right arm flat on floor with palm up**

**Bring left knee up**



**Turn onto right side**

**Left arm across chest**

**Place left foot on floor**

**Recovery position (Right side)**

**What can happen after an allergic reaction**

After an allergic reaction, a number of key steps should be taken by the hospital doctors or the child's GP:

- Children should be monitored for at least 6 – 12 hours in a hospital setting and will usually be admitted overnight for monitoring, following an anaphylactic reaction.
- Appropriate tests and medication will be given.
- Adrenaline auto-injectors should be prescribed / replenished if there is a continued risk of anaphylaxis.

**Anaphylaxis management in schools**

- Some school staff may not imagine that they are ever likely to be with someone who might need to use their auto-injector in an emergency, or they may believe that "someone else" is responsible and will know what to do.
- In reality it is important to understand that any member of staff at any time might be with a child or adult who is experiencing a severe allergic reaction, and therefore that all staff need to understand three key issues:
  1) **Allergen avoidance**: in order to prevent children coming into contact with their allergen.
  2) **Early recognition of symptoms**: how to spot the signs early and understand about patient positioning – which could save a child's life.
  3) **Crisis management**: which would include using an adrenaline injector and understand about patient positioning which could save the child's life
- Anaphylaxis training involves **all of these 3 elements** and should encourage a 'whole school or organisation approach' to participation in the training.

**Allergen avoidance in schools**

**Here are some things to think about when trying to avoid children coming into contact with their allergens:**

**Cooking/DT activities/lessons**

- If staff are carrying out any cooking or food tasting activity this is risk assessed and a discussion takes place with the Office Manager regarding the purchasing of food items. For cooking activity these activities and ingredients are fully NUT FREE. All ingredients are checked thoroughly by the staff member involved and the office manager/SENDCO.
- All surfaces should be wiped down before the lesson to ensure no allergens remain from a previous lesson.
- All utensils and cookware must also be washed carefully in warm soapy water.
- It's best to separate cookery areas from general teaching areas.
- Know which specific allergens the child in your cookery class needs to avoid and make sure the allergen is not present, as there is a risk of cross-contamination even if it is on a separate table to the allergic child.
- Identify alternative recipe ingredients.

**School dinners**

- Some schools will be able to supply school dinners which are allergen free.
- It is essential to talk regularly to your catering supplier and staff about the specific needs of allergic children in the school to ensure safety.
- Dinner supervisors and kitchen staff should know each child in the school who has severe allergies.
- The other children should also understand the risk that allergies pose for some of their friends.
- Dinner tables should be cleaned thoroughly with warm soapy water before and after lunch and break sessions.

**Lunch boxes** are more difficult to control.

- Lunch-time supervisors need to be vigilant, discourage food sharing but also try not to isolate the allergic child.
- Lunch-time supervisors should encourage hand washing after lunch to prevent contamination.

**Cake sales/school events involving food** to raise money for charity are a common feature of school life.

- There is no reason why these should not go ahead provided that severely allergic children are aware that eating food or cakes brought in by other pupils may inadvertently contain allergens which could pose a serious risk to their health.
- If a cake sale is to be held, parents of allergic children could be encouraged to provide a special, non-allergic treat for their child so that they do not feel left out.

It's not just food…

**Wasps and Bees**

- Insect stings can be a particular problem in the summer, and when students are away on school trips. Children need to take special care outdoors, wearing shoes at all times and making sure that any food or drink is covered. Litter bins on the school campus need to be regularly emptied.

**Pollen**

- Pollen can cause severe allergic reactions and also exacerbate asthma in hay fever sufferers. There is nothing you can do to avoid pollen but it is important, when the pollen count is high, to be on extra alert for the signs of an allergic reaction.

**School Pets/Therapy Dogs**

- Not many schools have small furry pets now, but where they do these furry friends may be fed a mixture of foods which could contain allergens. Furry animals (e.g. Guinea pigs, cats, horses) can also cause severe reactions in some children.
- Many schools are now introducing therapy dogs - consider how these can be safely managed rather than excluding altogether.

**Forest Schools/Nature Activities**

- Most schools like to encourage an awareness of wildlife and forest schools are also becoming popular. If nuts and seeds are involved in activities there is likely to be a risk of contamination. To reduce the risk, consider what alternatives could used. Schools often worry about acorns, conkers, chestnuts and other plant products unrelated to peanuts and tree nuts, but unless the child has a known allergy they are very unlikely to pose any risk.

**Nut trees in playgrounds**

- Some children with tree nut allergies may react to the shells and/or husks while others will not do. Unless they eat the shells, they will not have severe reactions but likely only contact urticarial (rash).
- In term of an airborne threat, it is known that nut protein does not easily become airborne and therefore significant exposure to protein via inhalation is unlikely.
- Schools may wish to just keep on top of this problem, having the caretaker for example clearing away any nuts in or out of their shells frequently, reminding staff to be aware of the tree and the possible risk. Or they may wish to contact the Local Authority and see if they would be happy for the tree to be removed
- Things you need to think about

**Information from Parents**

- If you have an allergic child who is about to join a new class, you need to help from their parents to find out about the child's allergy.
- Previous allergy history
- Does the child react to eating the allergen, skin contact, or even just inhaling the allergen?
- What will the child will definitely have to avoid, under what circumstances, and what substitutions could be used instead?

**Risk assessment**

- When planning lessons or activities, staff should think about the children who will be in the class.
- Do any of the activities present a risk for any of the children?
- For example, a nature walk through the woods – are there nuts falling off the trees?
- Are materials used in collages potentially contaminated by egg, milk, nuts?
- You may find this example risk assessment helpful when considering the risks for an allergic child (courtesy of Wiltshire Children's Services). Click on the link below to download the assessment. Please note that this document does not OPEN, it downloads immediately to your device.

**Anaphylaxis Risk Assessment**

**How can I ensure that the allergic child's development is not impaired?**

- Children who are at risk of severe allergic reactions are not ill in the usual sense. They are normal children in every respect – except if they come into contact with their allergen(s), in which case they may become unwell.

- It is important that these children are allowed to develop in the normal way and are not stigmatised or made to feel different. All efforts should be made to ensure that the allergic child has the opportunity to participate in **all** school activities, are not made to feel self-conscious or excluded.

**Educating the whole school**

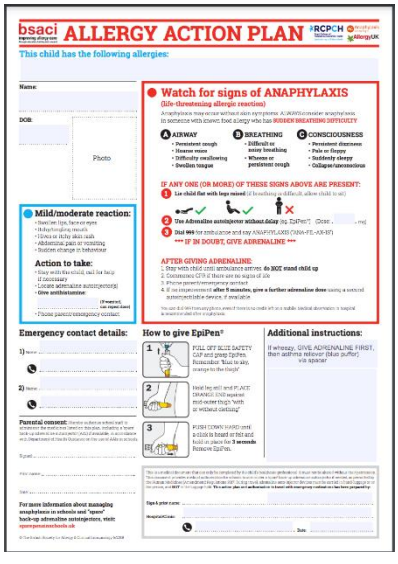
- Educating pupils about the facts and science relating to allergies is now part of the statutory **RSE curriculum** introduced from September 2020.
- Educate the school pupils about food allergy, maybe in the form of an awareness day, class awareness and activities or as a fundraising event, such as during Anaphylaxis UK's Allergy Awareness Week.
- Find out more about Anaphylaxis UK's whole school allergy awareness approach here: Safer Schools Programme

**School trips**

- All the activities on a school trip should be risk assessed to see if they pose a threat to allergic pupils and alternative activities planned to ensure inclusion.
- Overnight school trips may be possible with careful planning.
- Staff at the venue for an overnight school trip should be briefed early on that an allergic child is attending and will need appropriate food (if provided by the venue).
- Teenage allergic pupils may be able to cook their own food if the group food is not suitable.
- A microwaveable meal could be provided from home.
- A meeting for parents with the lead member of staff planning the trip would be advisable.
- Allergic children should have every opportunity to attend sports trips to other schools.
- The school needs to ensure that their P.E. teachers are fully aware of the situation.
- The school being visited need to be aware that a member of the team has an allergy when arranging the fixture.
- A member of staff trained in administering adrenaline should accompany the team.
- If another school feels that they are not equipped to cater for any food-allergic child the school will need to arrange for the child to take their own food.
- Most parents are keen that their children should be included in the full life of the school where possible, and the school will need their co-operation with any special arrangements required.
- Every child who is at risk of a severe allergic reaction, should have an up-to-date and accurate healthcare management / action plan in place in school.
- These plans should be familiar to all staff in the school.

**BSACI Allergy Action Plans**

- The British Society for Allergy and Clinical Immunology (BSACI) have developed **Allergy Action Plans** for Children, detailing the steps to be taken in an emergency.
- There are 4 types of Allergy Action Plans available:
  - ✓ Action plan for someone prescribed an EpiPen® autoinjector
  - ✓ Action plan for someone prescribed a Jext® autoinjector
  - ✓ Action plan for someone prescribed an Emerade® autoinjector
  - ✓ Generic action plan for someone not prescribed an adrenaline autoinjector




Alongside their Allergy Action Plan the student may also have a Healthcare management plan. Click here to see an **example plan**.

- It is very important that emergency medication kits can be immediately accessed when needed and that the adrenaline injectors are stored in a suitable container.
- It is important that the emergency kit is accessible when pupils are in the school, even if this is after the official day
- For younger children, who cannot be expected to carry their own medication there should be an emergency kit which is kept safely, not locked away and **accessible to all staff.**
- Medication should be stored in a rigid box and clearly labelled with the child's name and a photograph.
- The child's medication storage box should contain:

✓ adrenaline injectors i.e. EpiPen®, Jext® or Emerade® (two of the same type being prescribed)

- ✓ an up-to-date healthcare action / management plan
- ✓ antihistamine as tablets or syrup (if included on plan)
- ✓ spoon if required
- ✓ asthma inhaler (if included on plan).

- It is the responsibility of the child's parents to ensure that the emergency kit is up-to-date and clearly labelled.
- If the adrenaline injectors over run their expiry date, the school may refuse to have the child in school until the medication has been replaced. Some local education authorities (LEAs) will not indemnify staff who use out-of-date medication, so the staff might be unable to keep the allergic child safe.
- Parents can subscribe to expiry alerts for the relevant adrenaline auto-injectors their child is prescribed, to make sure they can get replacement devices in good time (see earlier module on Adrenaline auto-injectors for the links).
- All schools should purchase additional 'spare' adrenaline auto injectors for emergency use in children who are risk of anaphylaxis but their own devices are not available or not working. These should be kept safely, not locked away and **accessible to all staff.**

**Older children and medication**

- Older children and teenagers should, whenever possible, assume complete responsibility for their emergency kit under the responsibility of their parents.
- However symptoms of anaphylaxis can come on **very suddenly**, so school staff need to be prepared to administer medication if the young person cannot.


**Who is responsible for what?**
**What are the family's responsibilities?**
Parents / carers of the child should:

- Notify the school of the child's allergies.
- Work with the school to develop a plan that meets the child's needs throughout the school including in the classroom, in dining areas, in after-school programmes, during school sponsored activities and on the school bus.
- Provide written medical documentation, instructions and in-date medications as directed by a doctor, clearly labelled with the child's name.
- Replace medications after use or upon expiry.
- Check emergency kits termly to ensure they are stored correctly, are still in date, and ready for use.
- Teach the child about managing their allergies including what foods are safe and unsafe, ways to avoid allergens, how to read food labels, how to spot symptoms of a reaction, and how to tell an adult if they think they are having a reaction.
- Provide a "stash" of safe snacks for special school events (to be stored in school).

**What are the school's responsibilities?**
To ensure the safety of an allergic child the school should:

- To follow and implement the statutory supporting pupils at school with medical conditions guidance (see link below)
- Identify a core team to work with parents to set up prevention and treatment strategies.
- Arrange training for all staff, including how to use an adrenaline auto injector.
- Ensure that all staff can recognise symptoms; know what to do in an emergency and work to eliminate the use of allergens in the allergic pupil's meals, educational tools, arts and crafts projects, etc.
- Ensure that catering supervisors are aware of an allergic child's requirements. Review health records submitted by parents.
- Include food-allergic children in school activities. Pupils should not be excluded based on their allergy. School activities should be designed and developed to ensure the inclusion of food allergic pupils.
- Ensure that medications are appropriately stored, and easily accessible in a secure location (but not locked away).
- It is good practice for schools to check emergency kits termly to ensure they are stored correctly, are still in date, and ready for use.
- Review policies and procedures after a reaction has occurred.

**What are the pupil's responsibilities?**

- To be sure not to exchange food with others.
- To avoid eating anything with unknown ingredients.
- To be proactive (age permitting) in the care and management of their food allergies and reactions.
- To notify an adult if they have eaten something that they believe may have contained the food to which they are allergic, or if they believe that they are having a reaction.
- To wear their medical alert bracelet or form of medical identification if they are happy to do so.

**Department for Education Guidance**

- The Dept. for Education's Guidance on supporting pupils at school with medical conditions also provides a comprehensive guide to the expected care standards in school.

Frequently asked questions in schools

**How many injectors should an allergic pupil have at school?**

The UK's Medicines and Healthcare Products Regulatory Agency (MHRA) advised in June 2014 that anyone who is at risk of suffering anaphylaxis should always have at least **two** adrenaline injector devices immediately available for use. The MHRA report said: "*It is acknowledged that in some cases, a single injection is not sufficient to achieve a response for a number of reasons, including severity of attack as well as the possibility that a dose has not been effectively administered; a second injection may therefore be needed*."

**Who is allowed to administer adrenaline in an emergency?**

Any member of school staff may be asked to provide support to pupils with medical conditions, though they cannot be required to do so.

**Regulation 238** of the Human Medicines Regulations 2012 allows for certain prescription only medicines to be administered by **anyone for the purpose of saving life in an emergency**. This includes adrenalin 1:1000 up to 1mg for intramuscular use in anaphylaxis.

**ALL** staff should be aware of the likelihood of an emergency arising and know what action to take if an emergency does occur. It is important to understand that **any member of staff at any time** might be with a child or adult who is experiencing a severe allergic reaction, and all staff need to be able to act appropriately, not wait for "someone else" to deal with the situation.

**If I have to administer adrenaline, how quickly will it work?**

Signs of improvement should be seen fairly rapidly – usually within minutes. If there is no improvement, or the symptoms are getting worse, then a second injection may be administered after five to ten minutes.

**What will happen if I give adrenaline and the child is NOT having a reaction?**

The heartbeat could increase and the child may have palpitations for a few minutes. There should be no serious side effects unless the child has coexisting heart problems. The child should still be taken to A&E for ongoing assessment.

**Once the injector has been used, what do I do with it?**

Give to the paramedic or take it to the hospital with you to show the A&E staff what has been used. The hospital will then dispose of it for you.

**What is the difference between an asthma attack and an allergic reaction?**

While a severe allergic reaction could include asthma there would probably be other symptoms present. These may include swelling in the throat and mouth, nettle rash anywhere on the body, generalised flushing of the skin, abdominal cramps, nausea or vomiting. If the symptoms look particularly severe – for example, if the allergic child is going floppy – then this is very likely to be a severe allergic reaction requiring immediate treatment.