Inquiry into allergies and anaphylaxis

To the Committee,

I write this submission as a mother of a child who was diagnosed as being allergic and anaphylactic to dairy, eggs and walnuts at 18 months of age. Our child is now six years old and annual skin prick tests and anaphylactic episodes have shown that he is still allergic and anaphylactic to these foods. I base the following opinions on my personal experiences. I am not allergic to any foods personally, neither is my husband or our daughter, and our family history does not appear to show any allergy tendencies. The area of allergies and anaphylaxis was completely new to me when our son tested being allergic and anaphylactic to dairy, eggs and walnuts and I have learnt many things over the last 4.5 years, the primary concern being the health of my child.

I submit the following opinions and solutions to submit to the Committee:

Term of Reference 2: The adequacy of food and drug safety process and food and drug allergy management auditing and compliance. **I would like to submit that:**

- Introduction of food labels in standalone bakeries There tends to be a general lack of labelling and disregard for people allergies for food prepared in 'stand-alone' bakeries for consumption outside the premises. My current experience with bakeries is that food is packaged in plain plastic. Loaves of bread, bread rolls and other staple foods baked in a bakery should contain a label with an allergy statement so that allergy sufferers can make informed food choices.

Term of Reference 3: The adequacy and consistency of professional education, training, management/treatment standards and patient record systems for allergy and anaphylaxis. **I would like to submit that:**

- Training of early educators and school teachers needs to be improved: There a general lack of awareness of how serious anaphylaxis can be in relation to all types of allergies (not just nut related allergies). I have had personal experience with early education teachers questioning my child's anaphylaxis action plan (duly signed by a Medical Practitioner) as they could not understand how someone could be anaphylactic to dairy products.
- Training of early educators and school teachers needs to be improved on how the symptoms of anaphylaxis present : Anaphylaxis can present in many forms, which include coughing and wheezing with little or no other symptoms. When I explain this to early educators and school teachers, they are often surprised.

Term of Reference 4: Access to and cost of services, including diagnosis, testing management, treatment and support. **I would like to submit that:**

- Regional areas need more allergy specialists Living in Gippsland (Victoria), there is an inadequate access of specialists in the area of allergy testing and management in regional areas. There is a 4-6 month waiting list for an allergy skin test at our local hospital Consulting Rooms, which is unreasonable, particularly if you are looking for an allergy diagnosis for a young child.

- The number of adrenaline auto injectors per individual at risk of anaphylaxis covered under the PBS should be increased by two (2) to three (3) From my experience, schools and kindergartens ask for one adrenaline auto injector with the child in their classroom (or in their school bag) and an additional auto injector in the school first aid/medical cabinet. Of course this makes sense if my child has an anaphylactic episode, the auto injector must be easily accessible. An auto injector is also required for home, so the number of adrenaline auto injectors covered by the PBS is currently inadequate. The cost of adrenaline auto injectors without a prescription is $80-$100 and as they only have a shelf life of 1-2 years from the date of manufacture, this additional adrenaline auto injector can add up to a significant cost for parents.

Thank you for your consideration on these matters.